Department of Health & Social Care

The Leng review: an independent review into the physician associate and anaesthesia associate professions

Survey of healthcare professionals: summary of responses

Published 16 July 2025

Contents

Background

The review committed to draw upon a range of available evidence to answer the central question about safety and effectiveness of physician associates (PAs) and anaesthesia associates (AAs). This included a bespoke survey to PAs, AAs and those that work with them, results of which are presented in full here. The review's main report also contains a summary of selected findings.

Methodology

The Leng review ran a cross-sectional online survey designed to target:

- PAs
- AAs
- other healthcare professionals who work with PAs or AAs as part of a multidisciplinary team

The survey was developed using the Department of Health and Social Care (DHSC)'s SurveyOptics system. It was made accessible on GOV.UK and shared through the review's regular newsletter and 'X' account. It was open for completion from 7 March 2025 to 30 March 2025. Stakeholders were also encouraged to distribute the link among their networks to ensure that the response received was as representative as possible.

Questions were designed by the review team, developed in line with the terms of reference for the review and aligned where practical with questions from previous comparable surveys. The format was predominantly quantitative in structure, but also included a number of qualitative open-ended questions.

Methods of adding validation to the survey to ensure respondents could only submit a single response and/or to target the survey to people in specific healthcare roles were considered. However, no robust methods of implementing validation without potentially restricting legitimate responses or affecting the data quality were identified. Therefore, an open approach was taken to allow any healthcare professional who wanted to share their views an option for completing the survey without needing to incorrectly complete the background questions (for example regarding their profession).

The review received feedback from various stakeholders regarding the potential influence of duplicate or inaccurate responses, such as targeted campaigns guiding survey completion. Responses were checked for any indication of scripted, duplicate or non-human answers. There was no evidence of a significant impact of duplicate responses,

interference on the results of the survey, or clear signs of automated or highly choreographed responses that indicate duplication or action without thought.

The Leng review survey was triangulated against a range of other UK-based surveys identified through the call for evidence, mailbox and additional assessment of the literature. Surveys were prioritised for triangulation and/or supplementation by considering:

- response rate
- respondent type
- size
- date of publication or data collection
- relevance
- methodology
- completion rates
- geography

Note on the data

This document provides results for each of the questions that appeared in the PA and AA surveys. This is broken down by the job role of the respondents (for both the PA and AA survey) and by healthcare setting (for the PA survey only).

The data presented in this report

The review was keen to gather the views of PAs, AAs, and of those they work with on the development of these roles. Therefore, while any healthcare professionals were able to complete the survey it was targeted primarily to those who work in services where PAs are currently part of multidisciplinary teams.

Section 1 (background questions) for each survey includes all data from all respondents, regardless of how recently they last worked with PAs or AAs. However, in all other sections unless otherwise stated, the data only includes responses from PAs, AAs and/or those that have recently (within the last 5 years) worked alongside PAs or AAs as part of their multidisciplinary team. This is stated in the description for each table and chart.

The views of all survey respondents have been reviewed, and for some of the questions additional analysis is provided that includes those who have not recently worked alongside PAs or AAs. This is also clearly indicated in the data below where this is the case.

Changes to the survey following initial publication

Following the launch of the survey, feedback was received resulting in 2 changes:

1. Partway through data collection, the job role options in the AA survey were updated. The ‘anaesthetist’ option was replaced with ‘consultant’ because feedback was received that ‘anaesthetist’ was a confusing term that could apply to doctors at different career stages. It is not accurate to combine the responses from these 2 separate options, so they have been presented separately in the results. Readers of the report should note that the ‘anaesthetist’ category likely contains a mix of job roles, while the ‘consultant’ category does not.

2. Update to the descriptive text in the ‘Day-to-day practice of PAs/AAs’ sections, to clarify that the questions applied to both frequency of current practice and appropriateness for future practice. Results from before and after this change are presented together.

Rounding of figures and percentages in the tables

The percentages quoted in this report have been rounded to the nearest whole percent. Owing to this rounding some tables may total more or less than 100%.

Where a question was multiple choice, which has been indicated in the description for relevant questions, the total of the table may be greater than 100%. The values quoted in these tables reflect the percentage of the relevant respondents who selected each individual answer option.

Where a table or chart in this document quotes a percentage of respondents this relates to the number of relevant responses to the specific question, not to the overall numbers of respondents completing the survey.

Analysis of the qualitative questions

The qualitative questions were analysed using a bespoke theme finder programme, which used a large language model on a sample of up to 500 responses for each of the following categories:

- PAs in primary care
- those that work with, or have recently worked with, PAs in primary care
- PAs in secondary care
- those that work with, or have recently worked with, PAs in secondary care

- AAs in primary or secondary care
- those that work with, or have recently worked with, AAs in primary or secondary care

The theme finder programme mapped individual responses mapped to themes that it drew out. This approach identified common themes among written responses. Where the software identified 2 themes that were very similar these have been grouped together for the significant themes included in this report. Up to 5 significant themes have been included in this report for each of the categories listed above, with some common to multiple settings.

The information presented is not intended to be an exhaustive quantitative analysis, but to highlight important messages.

In addition, the review's main report also draws on the qualitative output where applicable for specific additional examples of the responses received.

Overall numbers completing the 2 surveys

The number of PAs and AAs in employment in the table below is based on latest available NHS data.[1] It should be noted that the survey may also include responses from healthcare professionals who are currently not actively employed or are in training.

Table 1: which survey would you like to complete?

Survey route	Total respondents	PA and AA respondents	Number in employment
PA survey	6,864	1,141	3,555 PAs working across primary and secondary care
AA survey	1,694	131	120 AAs currently working

[1] England N. NHS Workforce Statistics - December 2024 (Including selected preliminary statistics for January 2025) Available: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/december-2024

Physician associate (PA) survey

1 Background questions

1.1 Job role of respondents

Table 2: do you work (currently or previously) as one of the following? (Select the most relevant)

Job role	Respondents
PA	1,141
Consultant	1,178
GP (including GP speciality trainees)	888
Resident doctor, including foundation years	2,586
Speciality and associate specialist doctor	289
Other	782

The table below contains a breakdown of the 782 respondents who selected ‘other’. Some of these have been grouped together. For example. 'nursing' includes those who selected roles such as matrons, Advanced Care Practitioners who specified nursing and ward sisters.

Table 3: breakdown of those who selected 'other' for the question 'Do you work (currently or previously) as one of the following? (Select the most relevant)'

Respondent answer for 'other' role	Respondents
Nursing (including advanced care practitioners where nursing specified)	288
Medical and healthcare trainees (including recently graduated)	167
Pharmacy	55
Other advanced care practitioners	55
Administrative, managerial and non-healthcare roles	52
Other healthcare professionals	41
Healthcare assistants and support workers	38
Paramedics	31
Other doctors	19
Patients and members of the public	11
Allied Health professionals	11
Education and training	6
Retired or unemployed	5

Respondent answer for 'other' role	Respondents
Research and medical science	3

1.2 Healthcare setting

Two questions were asked regarding the healthcare setting most appropriate to respondents:

- PAs: In which healthcare setting do you work?
- other healthcare professionals: In which healthcare setting did you most recently work in a team with PAs? (If not relevant, please enter your current setting)

The table below combines these responses.

Table 4: healthcare setting most relevant to respondents

Healthcare setting	Percentage of respondents
Primary Care	24%
Secondary Care	72%
Mental health trust	2%
Other	2%

1.3 Region

Two questions were asked regarding region of the respondent's most recent work with a PA, which were:

- PAs: In which region is the service where you most recently worked as a PA based? (Select all that apply)

- other healthcare professionals: In which region is the service where you most recently worked with PAs based? (Select all that apply)

The table below combines these responses.

Table 5: region of respondents to the PA survey

Healthcare setting	**Percentage of respondents**
East Midlands	7%
East of England	6%
London	17%
North East England	4%
North West England	13%
South East England	14%
South West England	13%
West Midlands	9%
Yorkshire and the Humber	9%
Scotland	4%
Wales	6%

1.4 When did you last work in a healthcare setting where PAs were part of the multidisciplinary team?

Table 6: when did you last work in a healthcare setting where PAs were part of the multidisciplinary team?

Answer	Percentage of respondents
Within the last 2 years	87%
Between 2 and 5 years ago	8%
More than 5 years ago	2%
Never	3%

As stated in the 'note on the data section' above, the survey was targeted primarily to those who work in services where PAs are currently deployed as part of a multidisciplinary team. The tables in this background section include the numbers of all respondents. Unless otherwise stated the tables in the subsequent sections only include respondents who selected 'within the last 2 years' or 'between 2 and 5 years ago'.

The views of all survey respondents have been reviewed, and some of the questions in subsequent sections include additional data to show the responses from those who selected 'more than 5 years ago' and 'never' This is clearly indicated in the data below where this is the case.

2 Initial training and development

2.1 When did you qualify as a PA?

Table 7: when did you qualify as a PA?

Answer	Percentage of respondents
Within the last 2 years	44%

Answer	Percentage of respondents
Between 2 and 5 years ago	34%
More than 5 years ago	23%

2.2 Before becoming a PA did you have any experience working in a health or care role or setting?

Table 8: before becoming a PA did you have any experience working in a health or care role or setting?

Answer	Percentage of respondents
Yes	71%
No	29%

2.3 What other roles in a health or care setting did you hold before training to become a PA?

Respondents who had stated they had previous experience in a health or care setting prior to training as a PA provided information on their previous roles. This was optional and not all respondents provided an answer. Some respondents listed more than one previous role.

Responses have been combined into the groups in the table below. Duration of previous experience was not provided.

Table 9: what other roles in a health or care setting did you hold before training to become a PA? (only respondents with previous roles)

Role	Number
Healthcare Assistant	196

Role	Number
Adult social care	94
Biomedical	61
Nursing	59
Other	38
Clinical research	34
Administrative	33
Pharmacy	30
Laboratory	27
Phlebotomy	20
Radiography	20
Healthcare support worker	19
Ambulance (including Ambulance Care Assistants)	15
Theatre Assistant / Support	11

Role	Number
Clinical support / assistant	9
Mental health	9
Podiatry	9
Ophthalmology	7
Dental	6
Community care	5
NHS 111	5
Children's Services	4
Midwifery	4
Psychology	4
Armed forces	3
Audiology	3
Immunisation	3

Role	Number
Cardiography	2
Drugs and Alcohol Services	2
Medical Assistant	2
Physician Assistant	2
Health advice	1
Health Educator	1
Porter	1

3 Day to day activities of PAs

3.1 How often do PAs in your service conduct these activities?

Respondents were asked how often PAs within their service conduct a list of defined activities. The table below compares the percentage of respondents who selected ‘daily’ for each activity.

As flagged in the 'note on the data' section above, after initial launch of the survey the review updated the descriptive text in the ‘Day-to-day practice of PAs/AAs’ sections of the surveys to clarify that the questions applied to both frequency of current practice and appropriateness for future practice. All responses were included for analysis and the impact of the changes has been considered when interpreting the results.

Table 10: percentage of respondents (PAs and those that have recently worked with PAs) that answered 'daily' to how often PAs in their service conduct these activities?[2]

Activity	All job roles	PA	Consultant	GP (including GP specialty trainees)	Resident doctor	Specialty and associate specialist doctor	Other
Provide clinical assessments on patients	89%	96%	80%	93%	89%	86%	90%
Perform physical examinations on patients	88%	95%	77%	91%	88%	83%	89%
Take medical histories from patients	86%	94%	75%	92%	84%	81%	87%
Review test results	84%	91%	78%	66%	89%	81%	83%
Interpret, monitor and respond to clinical readings and patients' parameters	82%	88%	72%	81%	85%	78%	83%
Develop management plans	81%	90%	66%	89%	82%	71%	75%

[2] Each activity included a 'not applicable' option - examples of where this may have been selected may include where an activity was not relevant to the service or speciality relevant to the respondent. The 'not applicable' responses have been excluded when calculating these percentages. The calculation did include any respondents who selected 'not sure'.

Activity	All job roles	PA	Consultant	GP (including GP specialty trainees)	Resident doctor	Specialty and associate specialist doctor	Other
Diagnose illnesses	79%	85%	66%	90%	79%	78%	76%
Manage care for patients with long-term chronic conditions	68%	75%	54%	70%	69%	61%	71%
Provide health promotion and disease prevention advice to patients	66%	88%	50%	74%	58%	60%	76%
Perform diagnostic and therapeutic procedures	51%	50%	40%	38%	59%	48%	59%
Teach, supervise and assess other team members	26%	21%	19%	12%	32%	30%	34%
Support innovation, audit and research	22%	25%	16%	16%	25%	21%	27%
Prescribe medications	15%	6%	8%	25%	18%	18%	16%

Activity	All job roles	PA	Consultant	GP (including GP specialty trainees)	Resident doctor	Specialty and associate specialist doctor	Other
Order ionising radiation	13%	4%	10%	16%	16%	17%	11%
Provide contraceptive services	10%	17%	2%	22%	6%	6%	11%
Deliver antenatal care	7%	5%	4%	6%	9%	8%	10%
Deliver immunisations	5%	4%	3%	5%	5%	6%	9%

Results have also been broken down by PA respondents compared to those from all other roles (those that have recently worked with PAs).

Figure 1: percentage of respondents (PAs and those that have recently worked with PAs) that answered 'daily' to how often PAs in their service conduct specific activities

Table 11: percentage of respondents (PAs and those that have recently worked with PAs) that answered 'daily' to how often PAs in their service conduct specific activities

Activity	**Letter (in reference to figure 1)**	**PA**	**All other job roles**
Provide clinical assessments on patients	A	96%	88%
Perform physical examinations on patients	B	95%	86%
Take medical histories from patients	C	94%	84%
Review test results	D	91%	82%

Activity	Letter (in reference to figure 1)	PA	All other job roles
Develop management plans	E	90%	79%
Provide health promotion and disease prevention advice to patients	F	88%	62%
Interpret, monitor and respond to clinical readings and patients' parameters	G	88%	81%
Diagnose illnesses	H	85%	78%
Manage care for patients with long-term chronic conditions	I	75%	66%
Perform diagnostic and therapeutic procedures	J	50%	51%
Support innovation, audit and research	K	25%	22%
Teach, supervise and assess other team members	L	21%	27%
Provide contraceptive services	M	17%	9%
Prescribe medications	N	6%	17%
Deliver antenatal care	O	5%	8%
Deliver immunisations	P	4%	5%

Activity	Letter (in reference to figure 1)	PA	All other job roles
Order ionising radiation	Q	4%	15%

Responses were also analysed by respondents' healthcare setting.

Figure 2: percentage of respondents (PAs and those that have recently worked with PAs) that answered 'daily' to how often PAs in their service conduct specific activities - showing the difference between respondents in primary and secondary care services

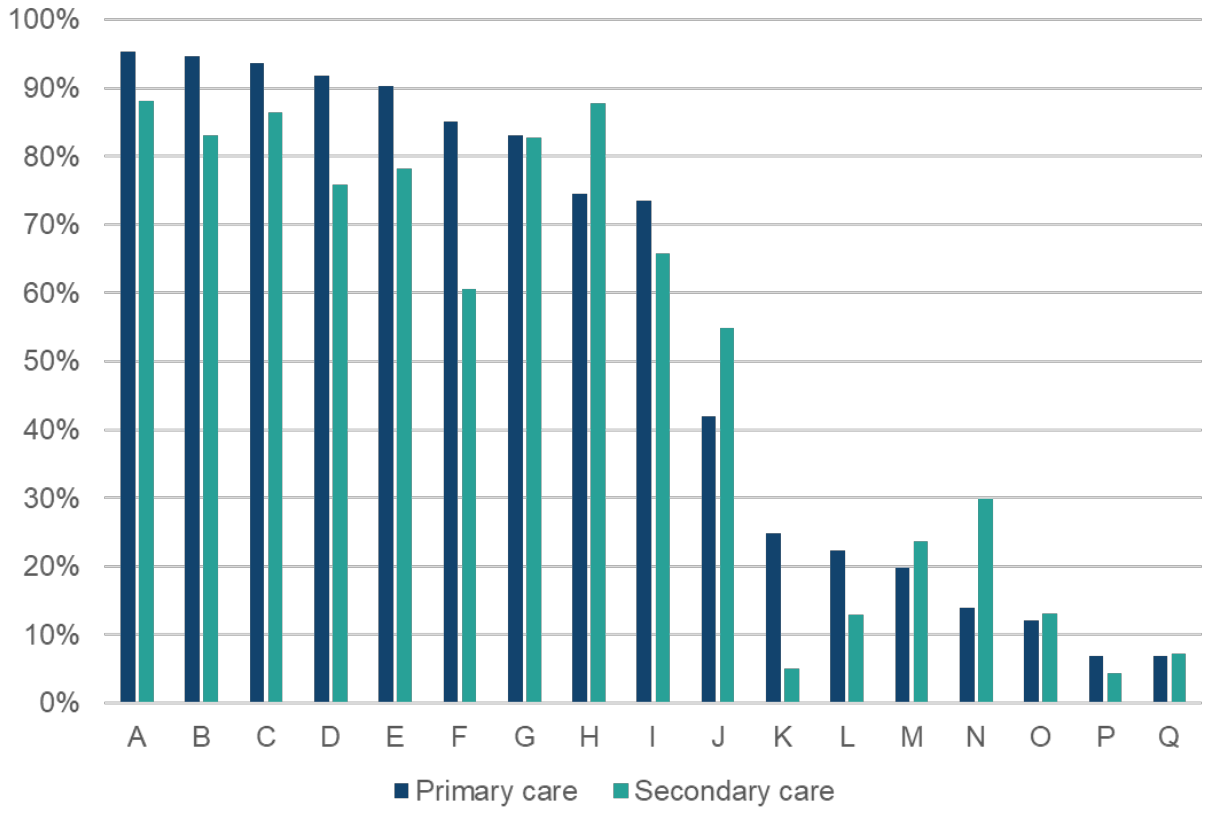

Table 12: percentage of respondents (PAs and those that have recently worked with PAs) that answered 'daily' to how often PAs in their service conduct specific activities - showing the difference between respondents in primary and secondary care services

Activity	**Letter (in reference to figure 2)**	**Primary care**	**Secondary care**
Provide clinical assessments on patients	A	95%	88%
Take medical histories from patients	B	95%	83%
Perform physical examinations on patients	C	94%	86%
Diagnose illnesses	D	92%	76%
Develop management plans	E	90%	78%
Provide health promotion and disease prevention advice to patients	F	85%	61%
Interpret, monitor and respond to clinical readings and patients' parameters	G	83%	83%
Review test results	H	75%	88%
Manage care for patients with long-term chronic conditions	I	74%	66%
Perform diagnostic and therapeutic procedures	J	42%	55%
Provide contraceptive services	K	25%	5%

Activity	Letter (in reference to figure 2)	Primary care	Secondary care
Prescribe medications	L	22%	13%
Support innovation, audit and research	M	20%	24%
Teach, supervise and assess other team members	N	14%	30%
Order ionising radiation	O	12%	13%
Deliver immunisations	P	7%	4%
Deliver antenatal care	Q	7%	7%

3.2 Do you believe it is appropriate for PAs to conduct these activities?

Respondents were asked a follow up question about whether they believed the same activities were appropriate for PAs to conduct. The table below compares the percentage of respondents who said ‘yes’ for each activity.[3]

As flagged in the 'note on the data' section above, after initial launch of the survey the review updated the descriptive text in the ‘Day-to-day practice of PAs/AAs’ sections of the surveys to clarify that the questions applied to both frequency of current practice and appropriateness for future practice. All responses were included for analysis and the impact of the changes has been considered when interpreting the results.

[3] It is not assumed that all other respondents believed an activity was not appropriate for PAs to conduct. The answer options were: 'yes', 'no' and 'unsure'.

Table 13: percentage of respondents (PAs and those that have recently worked with PAs) that answered 'yes' to whether they feel the following activities are appropriate for physician associates to conduct

Activity	All job roles	PA	Consultant	GP (including GP speciality trainees)	Resident doctor, including foundation years	Specialty and associate specialist doctor	Other
Provide health promotion and disease prevention advice to patients	72%	99%	71%	73%	59%	62%	81%
Perform physical examinations on patients	47%	99%	49%	39%	21%	34%	66%
Take medical histories from patients	53%	99%	58%	49%	28%	42%	69%
Provide clinical assessments on patients	43%	99%	47%	36%	14%	28%	63%
Develop management plans	35%	97%	35%	28%	6%	17%	51%
Review test results	44%	97%	51%	27%	20%	31%	60%
Support innovation, audit	67%	97%	73%	62%	53%	60%	70%

Activity	All job roles	PA	Consultant	GP (including GP speciality trainees)	Resident doctor, including foundation years	Specialty and associate specialist doctor	Other
and research							
Interpret, monitor and respond to clinical readings and patients' parameters	45%	97%	49%	36%	22%	29%	60%
Diagnose illnesses	35%	96%	33%	28%	6%	17%	51%
Manage care for patients with long-term chronic conditions	40%	96%	38%	33%	14%	22%	58%
Perform diagnostic and therapeutic procedures	36%	93%	38%	23%	10%	17%	53%
Provide contraceptive services	37%	89%	24%	38%	17%	24%	46%
Deliver immunisations	59%	86%	49%	55%	52%	45%	61%
Teach, supervise and	33%	86%	36%	17%	10%	20%	51%

Activity	All job roles	PA	Consultant	GP (including GP speciality trainees)	Resident doctor, including foundation years	Specialty and associate specialist doctor	Other
assess other team members							
Deliver antenatal care	19%	61%	11%	12%	4%	12%	28%
Order ionising radiation	22%	56%	23%	16%	6%	10%	30%
Prescribe medications	18%	46%	18%	14%	4%	11%	31%

Figure 3: do you believe it is appropriate for PAs to conduct these activities? Percentage of respondents (PAs and those that have recently worked with PAs) answering 'yes'

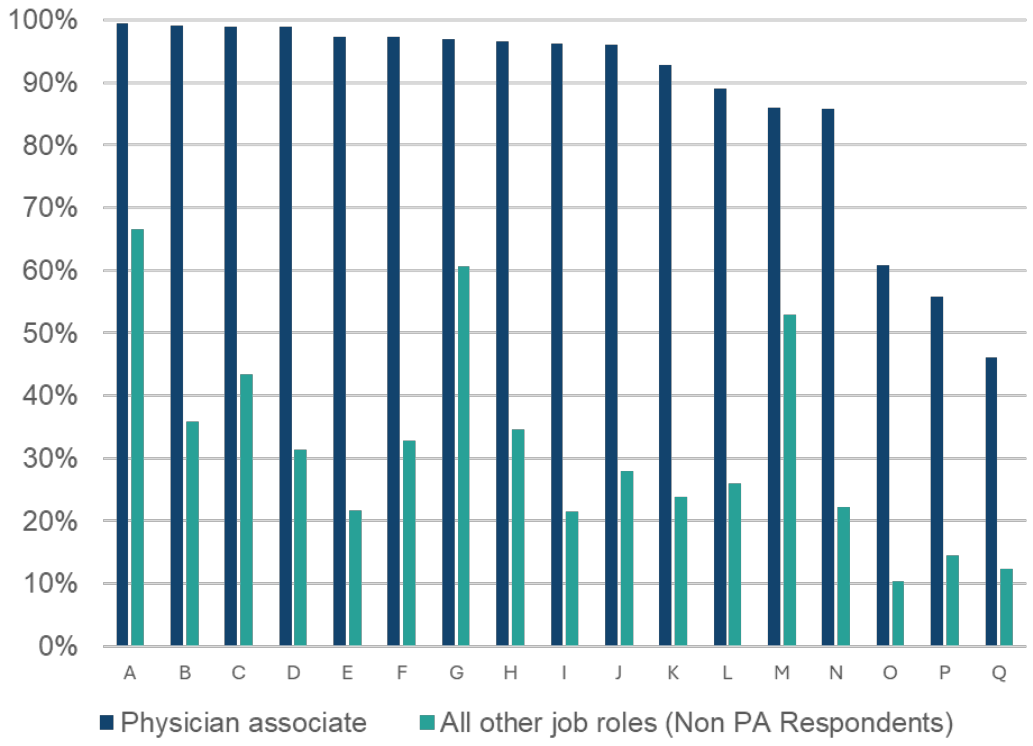

Table 14: 'do you believe it is appropriate for PAs to conduct these activities?' Percentage of respondents (PAs and those that have recently worked with PAs) answering 'yes'

Activity	**Letter (in reference to figure 3)**	**PA**	**All other job roles**
Provide health promotion and disease prevention advice to patients	A	99%	66%
Perform physical examinations on patients	B	99%	36%
Take medical histories from patients	C	99%	43%
Provide clinical assessments on patients	D	99%	31%
Develop management plans	E	97%	22%
Review test results	F	97%	33%
Support innovation, audit and research	G	97%	61%
Interpret, monitor and respond to clinical readings and patients' parameters	H	97%	35%
Diagnose illnesses	I	96%	21%
Manage care for patients with long-term chronic conditions	J	96%	28%
Perform diagnostic and therapeutic procedures	K	93%	24%

Activity	Letter (in reference to figure 3)	PA	All other job roles
Provide contraceptive services	L	89%	26%
Deliver immunisations	M	86%	53%
Teach, supervise and assess other team members	N	86%	22%
Deliver antenatal care	O	61%	10%
Order ionising radiation	P	56%	14%
Prescribe medications	Q	46%	12%

Responses were also analysed by the respondents' healthcare setting.

Figure 4: those answering yes to the question 'do you believe it is appropriate for PAs to conduct these activities?' Split by setting (PAs and those that have recently worked with PAs)

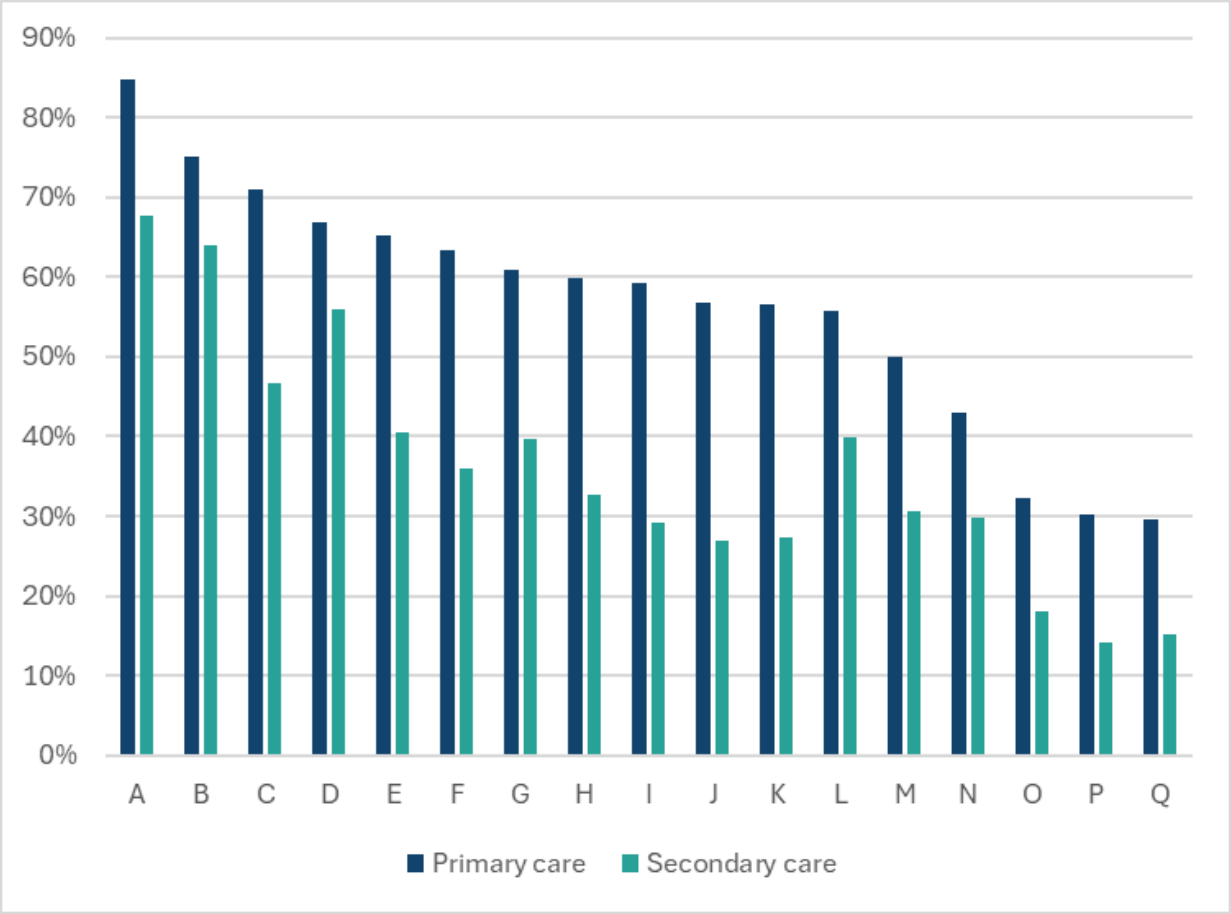

Table 15: those answering yes to the question 'do you believe it is appropriate for PAs to conduct these activities?' Split by setting (PAs and those that have recently worked with PAs)

Activity	**Letter (in reference to figure 4)**	**Primary care**	**Secondary care**
Provide health promotion and disease prevention advice to patients?	A	85%	68%
Support innovation, audit and research?	B	75%	64%

Activity	Letter (in reference to figure 4)	Primary care	Secondary care
Take medical histories from patients?	C	71%	47%
Deliver immunisations?	D	67%	56%
Perform physical examinations on patients?	E	65%	40%
Provide clinical assessments on patients?	F	63%	36%
Interpret, monitor and respond to clinical readings and patients' parameters?	G	61%	40%
Manage care for patients with long-term chronic conditions?	H	60%	33%
Provide contraceptive services?	I	59%	29%
Diagnose illnesses?	J	57%	27%
Develop management plans?	K	57%	27%
Review test results?	L	56%	40%
Perform diagnostic and therapeutic procedures?	M	50%	31%
Teach, supervise and assess other team members?	N	43%	30%

Activity	Letter (in reference to figure 4)	Primary care	Secondary care
Order ionising radiation?	O	32%	18%
Prescribe medications?	P	30%	14%
Deliver antenatal care?	Q	30%	15%

3.3 Please describe any other activities that PAs in your service carry out

The significant themes identified in the qualitative answers to this question are listed below.

PAs in primary care listed:

- training and supervision: PAs receive supervision, participate in training sessions, supervise students, and can take on additional responsibilities with the right training
- specialist clinic management: PAs manage specialist clinics, including dermatology, hypertension, and long-term conditions like diabetes
- home visits: PAs conduct home visits, care home reviews, and participate in virtual ward rounds
- diagnostic procedures: PAs perform ECGs, spirometry, minor surgeries, and other diagnostic and therapeutic procedures
- medication management: PAs manage medication under supervision, suggest prescriptions, and request ionising radiation

Those that have recently worked with PAs in primary care listed:

- independent clinics and procedures: PAs run independent clinics, perform procedures, and manage specialised tasks like cervical screening
- triage and emergency care: PAs perform triage, handle acute patient problems, and manage urgent care

- support and supervision activities: PAs are involved in teaching, mentoring, supervising medical students, and are monitored by senior clinicians
- mental health and learning disability assessments: PAs conduct mental health assessments and reviews, including learning disability checks
- home visits and complex patient reviews: PAs conduct home visits, review complex patients in nursing homes, and manage mental health patients

PAs in secondary care listed:

- advanced clinical procedures: PAs perform advanced medical procedures such as lumbar punctures, chest drains, and minor surgeries
- supervised practice limitations: PAs work under supervision, cannot prescribe medications, and must consult on diagnoses and management plans
- support and continuity of care: PAs help new team members, ensure patient care continuity, and assist in discharge planning
- outpatient and specialist clinics: PAs manage outpatient and specialist clinics, including skin surgery and virtual wards
- non-clinical and administrative roles: PAs contribute to service development, manage administrative tasks, and support departmental operations

Those that have recently worked with PAs in secondary care listed:

- surgical assistance and theatre management: PAs assist in surgeries, manage theatre lists, and perform surgical procedures
- advanced and invasive procedures: PAs perform advanced procedures such as lumbar punctures and bone marrow aspirates
- administrative and rota management: PAs manage doctor rotas, handle administrative tasks, and organise ward rounds
- emergency and resuscitation care: PAs provide emergency care and manage critically unwell patients in emergency departments
- outpatient and specialty clinics: PAs manage outpatient services, run specialty clinics, and provide virtual advice with consultant support

3.4 Are there other activities that could be assigned to PAs?

Table 16: are there additional activities that you feel your service could assign to PAs? (By job role. PAs and those that have recently worked with PAs)

Job role	Yes	No	Unsure
Consultant	32%	48%	20%
GP (including GP speciality trainees)	32%	53%	15%
PA	47%	19%	34%
Resident doctor, including foundation years	41%	50%	10%
Specialty and associate specialist doctor	32%	44%	24%
Other	32%	33%	35%
All job roles	43%	28%	29%

Table 17: are there additional activities that you feel your service could assign to PAs? (By setting. PAs and those that have recently worked with PAs)

Setting	Yes	No	Unsure
Primary care	31%	43%	26%
Secondary care	40%	44%	16%
Mental health trust	33%	45%	21%

Setting	Yes	No	Unsure
Other	31%	29%	40%
All settings	38%	43%	19%

We asked respondents who answered 'yes' to this question what additional activities could be assigned to PAs. The significant themes identified in the responses are listed below.

PAs in primary care listed:

- contraception and minor procedures: PAs could provide contraception services and perform minor procedures like joint injections
- prescribing and diagnostic procedures: PAs should be allowed to prescribe medications and perform diagnostic procedures with proper training
- specialist clinics and advanced training: PAs could run specialist clinics with advanced training in areas like dermatology and allergy
- community care and home visits: PAs could be involved in community care, including home visits and managing care homes
- research, audits, and quality improvement: PAs could undertake research and quality improvement projects to enhance healthcare

Those that have recently worked with PAs in primary care listed:

- administrative and clerical tasks: PAs should focus on administrative duties such as documentation, discharge summaries, referral letters, and managing insurance reports
- health promotion and chronic Disease Management: PAs can engage in health promotion, manage chronic diseases, and provide patient coaching with appropriate training
- prescribing and ordering tests: With additional training, PAs could take on prescribing responsibilities, request ultrasounds, order x-rays, and manage medication

- home visits and community care: PAs could conduct home visits, manage care for patients in residential or nursing homes, and assist with community healthcare services

- basic clinical tasks: PAs can perform basic clinical tasks like taking bloods, ECGs, and swabs, but should not be involved in diagnosis or treatment plans

PAs in secondary care listed:

- running clinics: PAs should run various types of clinics, including routine, specialty, and outpatient clinics, to manage patient care and reduce waiting times

- prescribing and diagnostic rights: PAs should be allowed to prescribe medication and order diagnostic tests with appropriate training and supervision

- respect and career progression: PAs should be given respect and recognition for their roles, with opportunities for leadership and career progression within the healthcare system

- supervision and mentoring: PAs should be involved in supervising and educating students and junior staff, contributing to departmental education programs

- performing advanced procedures: PAs should be trained to perform advanced procedures such as lumbar punctures and surgical assistance

Those that have recently worked with PAs in secondary care listed:

- clinical documentation and scribing: PAs should assist with clinical documentation, including writing discharge letters, documenting ward rounds, scribing during ward rounds, and taking notes in meetings

- routine clinical procedures: PAs should perform routine clinical procedures such as venepuncture, peripheral venous cannulation, urinary catheterisation, and ECGs

- supporting doctors and clinical teams: PAs should support doctors and clinical teams by performing tasks that free up doctors' time, such as updating family members, assisting with ward rounds, and managing junior staff

- patient and family communication: PAs should educate patients about common conditions, provide health promotion advice, update families, and handle communication tasks such as liaising with other clinicians and arranging referrals

- clinical and procedural support: PAs could assist with low-risk clinical tasks such as taking bloods, inserting cannulas, performing phlebotomy, and other routine clinical procedures

3.5 Are there any activities respondents are uncomfortable about PAs conducting?

The survey asked PAs and those in other job roles different versions of this question:

- PA: Are there any activities that you currently conduct that you feel uncomfortable about carrying out? (This could include activities you think are potentially unsafe)

- Other job roles: Are there any elements of work that you feel uncomfortable about PAs carrying out? (This could include activities you think are potentially unsafe for PAs to conduct)

The answers to these questions have been combined in the table below, but are reported separately to highlight setting level breakdown in the tables below.

Table 18: are there any activities respondents are nervous of PAs conducting? PA and other job role questions combined - split by job role (PAs and those that have recently worked with PAs)

Job role	**Yes**	**No**	**Unsure**
PA	5%	93%	2%
Consultant	71%	23%	6%
GP (including GP speciality trainees)	76%	19%	5%
Resident doctor, including foundation years	94%	5%	2%
Specialty and associate specialist doctor	81%	14%	5%
Other	44%	49%	7%

Table 19: are there any activities that you currently conduct that you feel uncomfortable about carrying out? (This could include activities you think are potentially unsafe). Split by setting

PA respondents by setting	**Yes**	**No**	**Unsure**
Primary care	5%	92%	3%
Secondary care	5%	93%	2%
Mental health trust	4%	91%	4%
Other	4%	92%	4%
All PA respondents	5%	93%	2%

Table 20: are there any elements of work that you feel uncomfortable about PAs carrying out? (This could include activities you think are potentially unsafe for PAs to conduct). All other job roles (those that have recently worked with PAs), split by setting

All other respondents (non-PAs) by setting	**Yes**	**No**	**Unsure**
Primary care	65%	30%	5%
Secondary care	83%	14%	3%
Mental health trust	83%	14%	3%
Other	61%	33%	6%

All other respondents (non-PAs) by setting	Yes	No	Unsure
All other respondents (non-PAs) in all settings	79%	17%	4%

Further analysis below compares the responses from all non-PA respondents according to how recently they last worked in a setting where PAs were part of the multidisciplinary team.

Figure 5: are there any elements of work that you feel uncomfortable about PAs carrying out? (This could include activities you think are potentially unsafe for PAs to conduct) - split by length of time since last worked in a setting where PAs were part of the multidisciplinary team

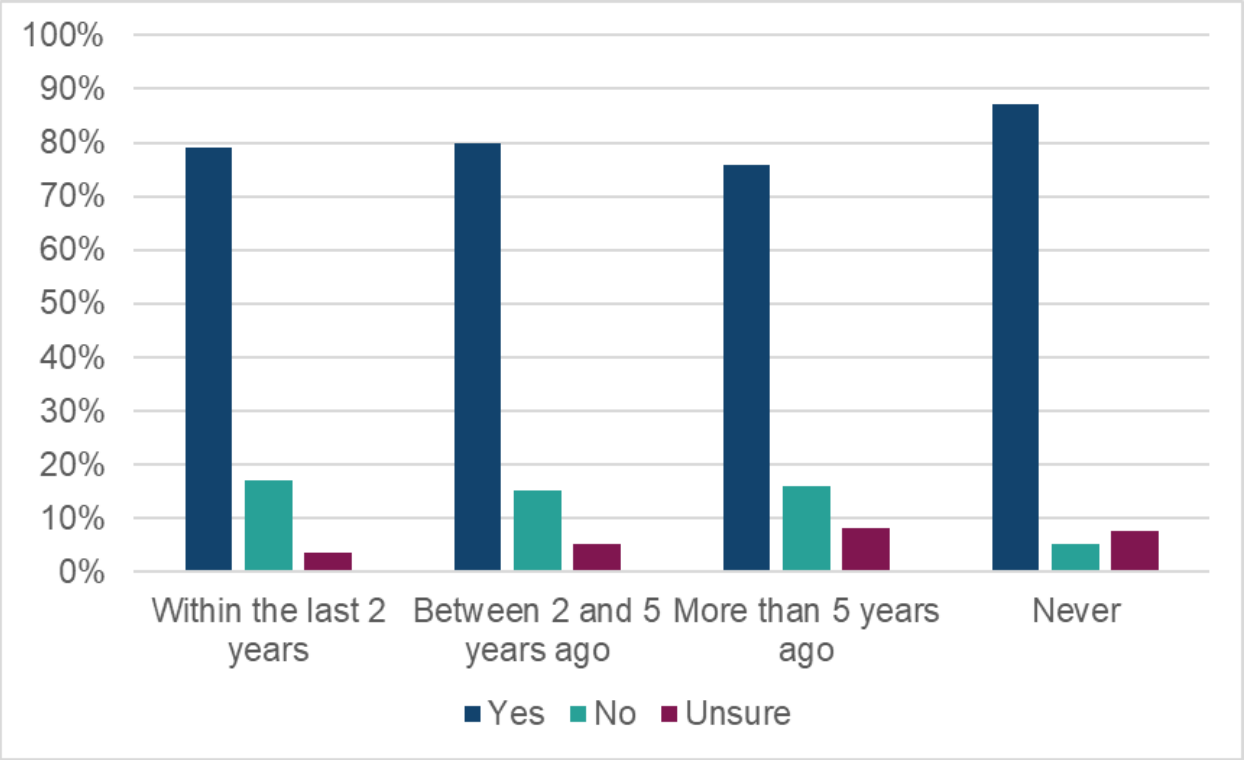

Table 21: are there any elements of work that you feel uncomfortable about PAs carrying out? (This could include activities you think are potentially unsafe for PAs to conduct) - split by length of time since last worked in a setting where PAs were part of the multidisciplinary team

Time since last worked with PAs	Yes	No	Unsure
Within the last 2 years	79%	17%	4%
Between 2 and 5 years ago	80%	15%	5%
More than 5 years ago	76%	16%	8%
Never	87%	5%	8%
All respondents	79%	17%	4%

We asked respondents who answered 'yes' to these questions what activities they were uncomfortable with PAs conducting. The significant themes identified in the responses are listed below.

PAs in primary care listed:

- handling specific patient groups: discomfort with managing children, infants, pregnant women, and patients with learning disabilities or multi-morbidities due to lack of training and supervision
- managing complex conditions: discomfort with reviewing complicated patients, conducting medication reviews, and handling specialist medications
- discomfort with home visits: concerns about safety and preference for GP involvement when conducting home visits, especially for complex or elderly patients
- diagnoses and prescribing: general discomfort with making diagnoses, prescribing medications, and ordering ionising radiation due to insufficient training

- bullying and lack of respect: concerns about bullying from doctors and lack of respect, impacting patient safety and multidisciplinary work

Those that have recently worked with PAs in primary care listed:

- handling complex cases: PAs may struggle with managing complex and undifferentiated cases due to limited training and diagnostic skills
- patient safety risks: PAs may compromise patient safety due to limited training, leading to potential misdiagnosis, inappropriate treatment, and patient harm
- specific clinical task concerns: discomfort with PAs performing tasks like prescribing, invasive procedures, and ordering ionizing radiation
- need for supervision: PAs require close supervision and ongoing training to ensure patient safety and effective practice
- role clarity issues: concerns about the clarity and scope of PA's roles, potentially leading to misrepresentation compared to other healthcare professionals

PAs in secondary care listed:

- inadequate training for procedures: performing therapeutic and invasive procedures like chest drains, endoscopy, abdominal paracentesis, lumbar punctures, and suturing without adequate training or supervision
- independent patient care challenges: assessing and seeing patients independently without supervision, especially during ward rounds, new admissions, and reviews of acutely unwell patients
- fear of professional repercussions: anxiety about being disparaged, scrutinized, or humiliated for mistakes, potentially leading to a career change
- hostile work environment: discomfort due to hostile views towards PAs and political scrutiny, leading to fear of unfair judgment for mistakes
- medication management stress: stress in answering medication queries and making recommendations as a non-prescriber due to reliance on inconsistent information from other staff members

Those that have recently worked with PAs in secondary care listed:

- inadequate training and supervision: concerns about PAs performing clinical tasks due to inadequate training and lack of proper supervision

- patient safety risks: belief that PAs pose a risk to patient safety due to their limited medical qualifications and experience, especially in acute and emergency settings
- independent patient management: discomfort with PAs managing patients independently, including making diagnoses, formulating management plans, and discharging patients without direct supervision
- role clarity and ethical concerns: concerns about PAs misrepresenting themselves as doctors and the clarity of their roles, leading to potential safety issues
- complex and invasive procedures: discomfort with PAs performing complex or invasive procedures without adequate training is seen as unsafe

4 Identifying PAs

4.1 At your service, are patients told when they are seeing a PA?

Figure 6: at your service, are patients told when they are seeing a PA? By job role (PAs and those that have recently worked with PAs)

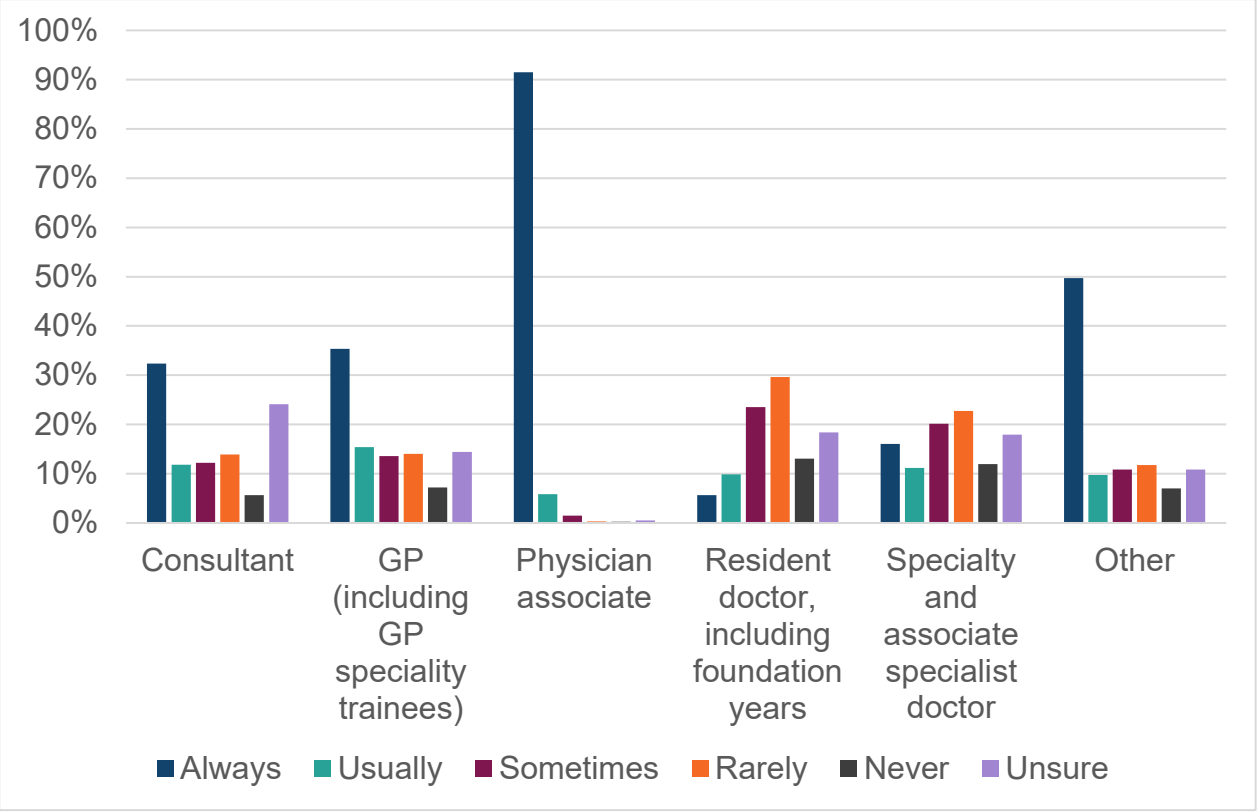

Table 22: at your service, are patients told when they are seeing a PA? By job role (PAs and those that have recently worked with PAs)

Job role	Always	Usually	Sometimes	Rarely	Never	Unsure
Consultant	32%	12%	12%	14%	6%	24%
GP (including GP speciality trainees)	35%	15%	14%	14%	7%	14%
PA	91%	6%	1%	0%	0%	1%
Resident doctor, including foundation years	6%	10%	23%	30%	13%	18%
Specialty and associate specialist doctor	16%	11%	20%	23%	12%	18%
Other	50%	10%	11%	12%	7%	11%
All respondents	34%	10%	15%	18%	8%	15%

Figure 7: at your service, are patients told when they are seeing a PA? By setting (PAs and those that have recently worked with PAs)

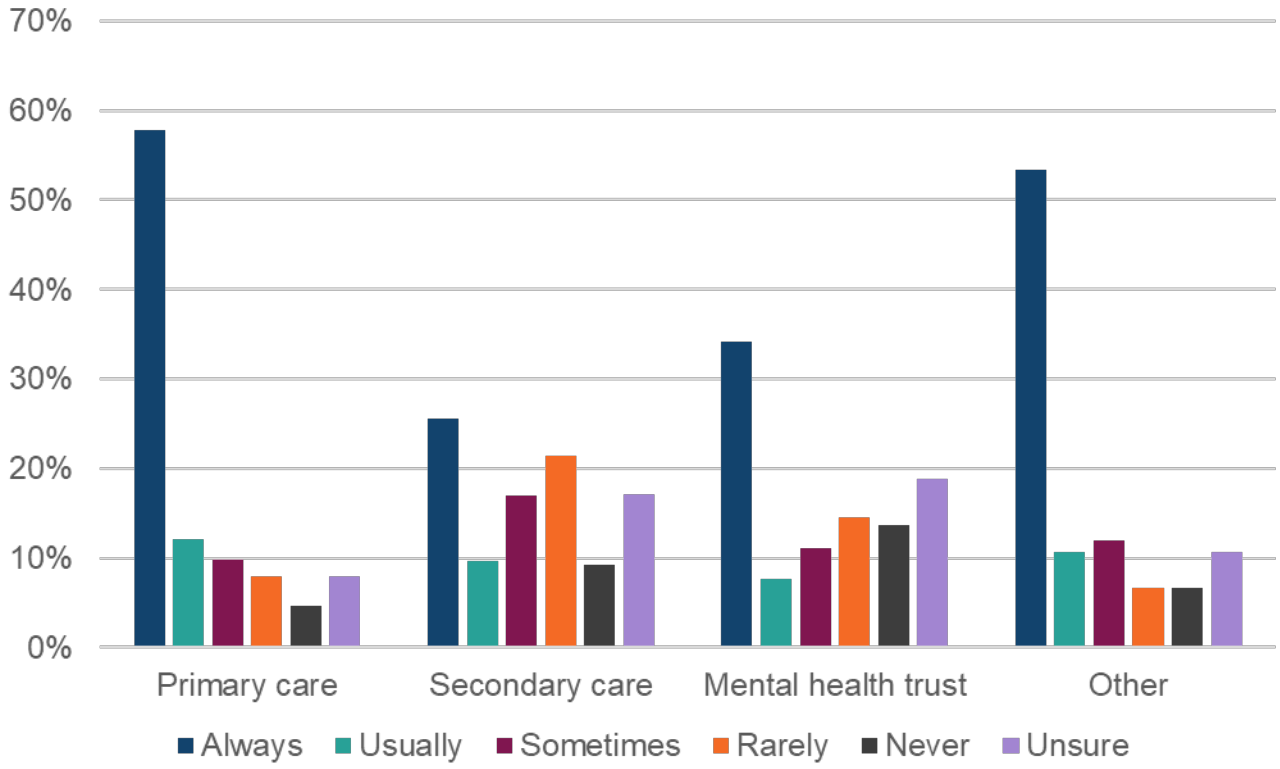

Table 23: at your service, are patients told when they are seeing a PA? By setting (PAs and those that have recently worked with PAs)

Setting	Always	Usually	Sometimes	Rarely	Never	Unsure
Primary care	58%	12%	10%	8%	5%	8%
Secondary care	26%	10%	17%	21%	9%	17%
Mental health trust	34%	8%	11%	15%	14%	19%
Other	53%	11%	12%	7%	7%	11%
All settings	34%	10%	15%	18%	8%	15%

4.2 How often do PAs in your service wear the following items and/or clothing to identify their role to patients and staff?

Figure 8: how often do PAs in your service wear the following items and/or clothing to identify their role to patients and staff? All respondents (PAs and those that have recently worked with PAs)

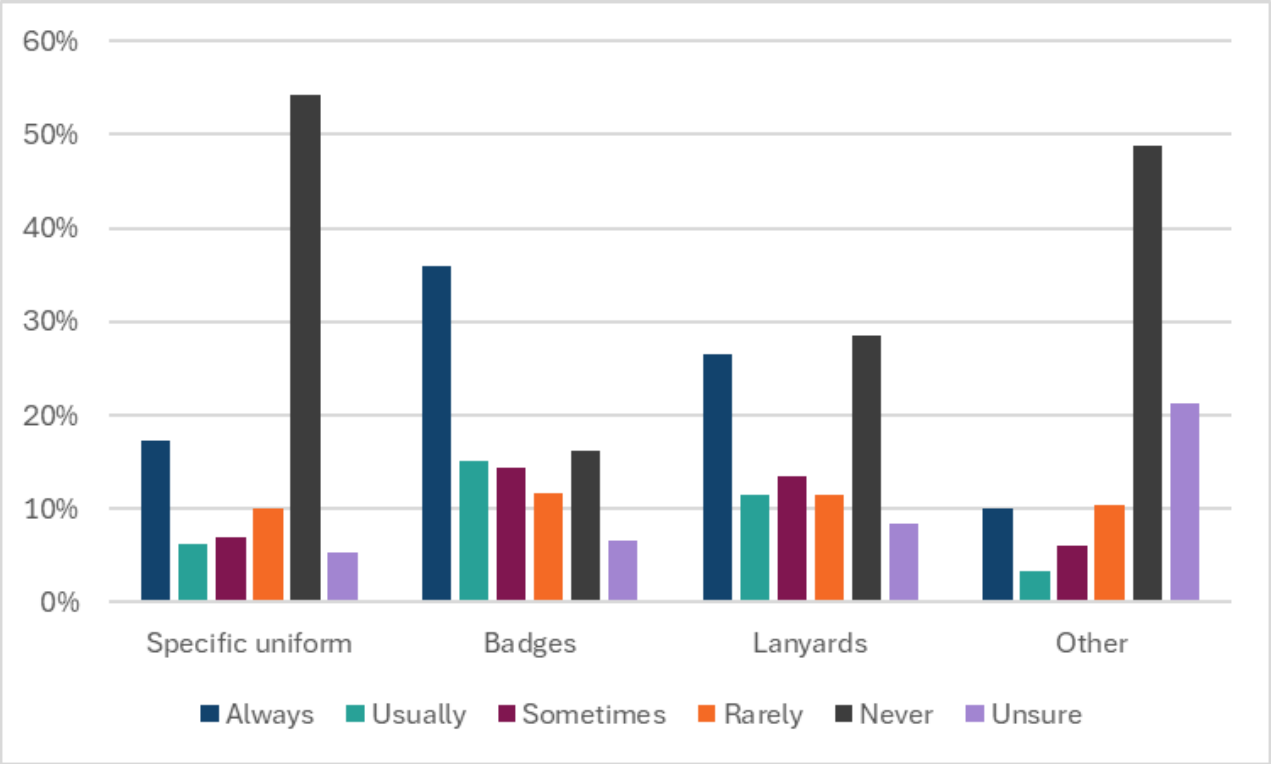

Table 24: how often do PAs in your service wear the following items and/or clothing to identify their role to patients and staff? All respondents (PAs and those that have recently worked with PAs)

Frequency	**Specific uniform**	**Badges**	**Lanyards**	**Other**
Always	17%	36%	27%	10%
Usually	6%	15%	12%	3%
Sometimes	7%	14%	13%	6%

Frequency	Specific uniform	Badges	Lanyards	Other
Rarely	10%	12%	12%	10%
Never	54%	16%	29%	49%
Unsure	5%	7%	8%	21%

Responses broken down by PAs compared to other healthcare professionals selecting the 'always' option are shown below.

Figure 9: respondents who answered 'always' to the question, 'how often do PAs in your service wear the following items and/or clothing to identify their role to patients and staff?' Split to show PAs and all other roles (those that have recently worked with PAs)

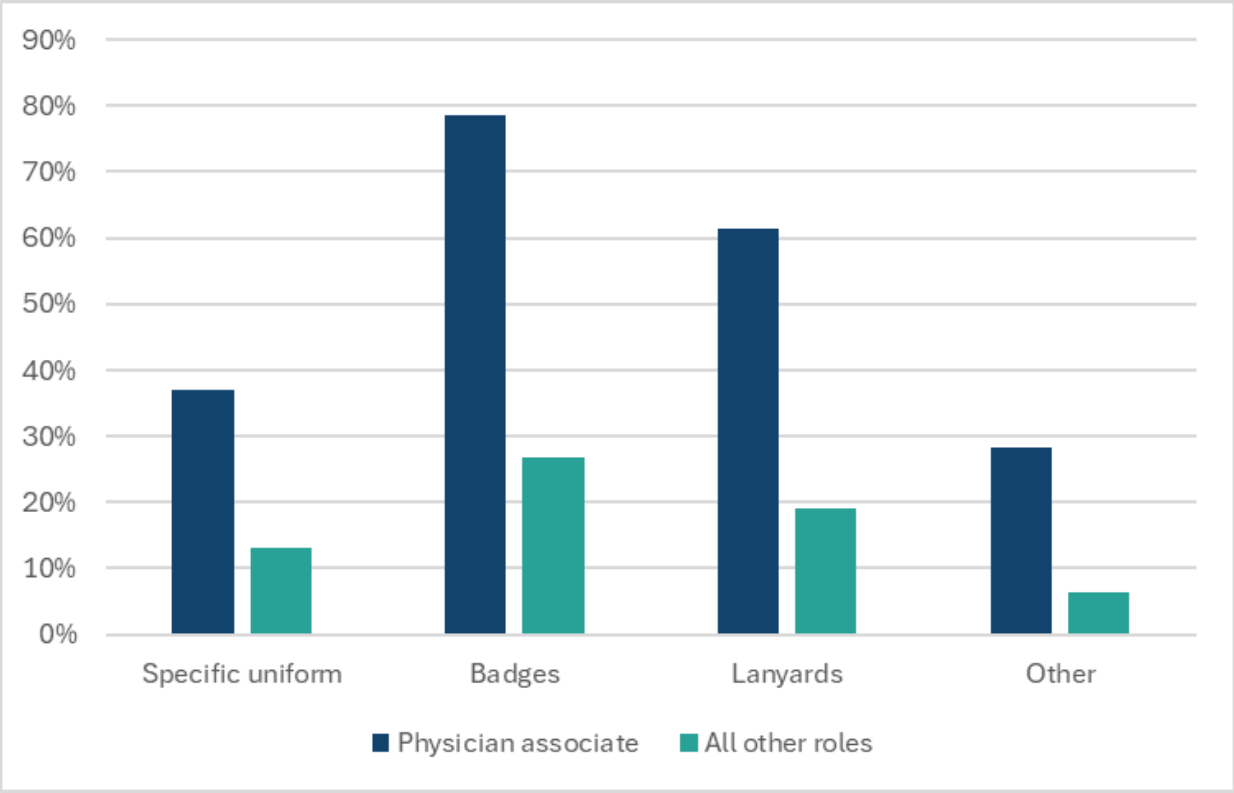

Table 25: respondents who answered 'always' to the question, 'how often do PAs in your service wear the following items and/or clothing to identify their role to patients and staff?' Split to show PAs and all other roles (those that have recently worked with PAs)

Type of identification	**PA**	**All other roles**
Specific uniform	37%	13%
Badges	79%	27%
Lanyards	61%	19%
Other	28%	6%

Responses broken down by setting type where respondents selected the 'always' option are shown below.

Figure 10: respondents who answered 'always' to the question, 'how often do PAs in your service wear the following items and/or clothing to identify their role to patients and staff?' Split by setting (PAs and those that have recently worked with PAs)

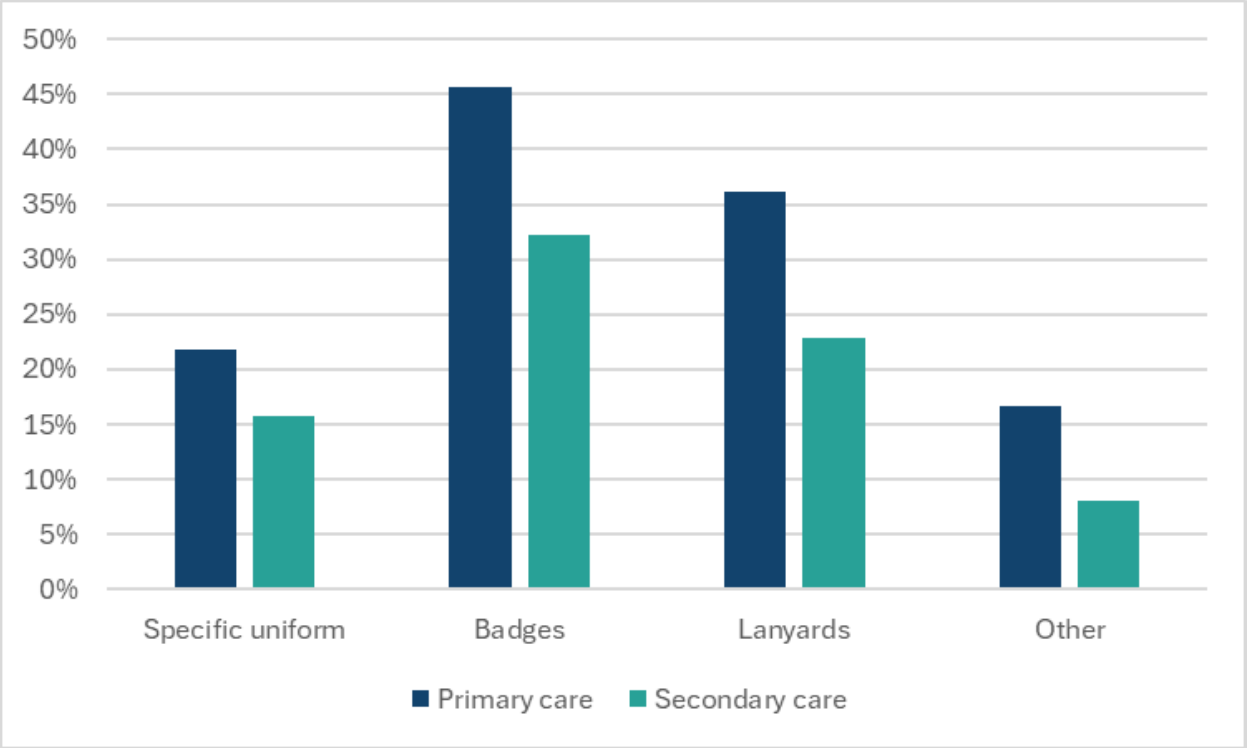

Table 26: respondents who answered 'always' to the question, 'how often do PAs in your service wear the following items and/or clothing to identify their role to patients and staff?' Split by setting (PAs and those that have recently worked with PAs)

Type of identification	Primary care	Secondary care	Mental health	Other
Specific uniform	22%	16%	8%	33%
Badges	46%	32%	38%	63%
Lanyards	36%	23%	32%	41%
Other	17%	8%	7%	11%

The survey asked respondents who answered ‘Always’, ‘Usually’, ‘Sometimes’ or ‘Rarely’, what other identifying items and/or clothing PAs in their service wear to identify them to patients and staff. The significant themes are listed below.

PAs in primary care listed:

- uniforms with name and role: PAs wear uniforms, scrubs, or fleece jackets with their name and role embroidered on them for identification
- door and desk signs: signs on doors and desks in consultation rooms display the PAs' name and role to inform patients and staff
- name badges and lanyards: PAs use name badges, tags, lanyards, and ID cards displaying their name and role for identification
- posters and informative displays: posters, signs, and television screens in reception and waiting areas provide information about the PAs' role
- verbal introduction: PAs introduce themselves verbally during consultations to clarify their role and ensure patients understand they are not doctors
- SMS and online confirmation: the role of the PA is communicated through SMS appointment confirmations and online records

Those that have recently worked with PAs in primary care listed:

- uniforms and scrubs: PAs wear specific uniforms or scrubs, sometimes with different colours or embroidered names, to distinguish themselves
- signage for identification: PAs are identified by signs on desks, doors, or consultation rooms indicating their name and role
- name badges and lanyards: PAs wear name badges and lanyards that clearly state their role and name
- clear identification methods: PAs use various clear identification methods, such as large print signs, name cards, and ID cards, to ensure they are easily recognisable
- misidentification as doctors: there are issues with patients misidentifying PAs as doctors due to their attire and the name 'PA'

PAs in secondary care listed:

- role-identified scrubs: PAs wear scrubs with their role or 'PA' embroidered on them, often in specific colours
- lanyards and badges: PAs use lanyards and various badges to display their name and role
- ID and staff cards: PAs use ID or staff cards with their photo and role for identification
- clinic room signage: PAs use signs or plaques on clinic room doors to identify their role
- no specific uniform: some PAs report the absence of a specific uniform for their role

Those that have recently worked with PAs in secondary care listed:

- varied uniform colours: PAs wear various uniform colours including dark green, purple, blue, and sometimes the same colours as consultants or nursing staff, leading to confusion
- lanyards and badges visibility: PAs use lanyards and badges for identification, but these are often not visible or clear, contributing to confusion
- uniforms with role display: PAs wear uniforms or scrubs with their role clearly displayed, often personalized with their name and role
- misleading appearance: PAs' attire and accessories can mislead patients into thinking they are doctors
- verbal role explanation: PAs introduce themselves verbally to patients and staff, explaining their role

4.3 Do you agree or disagree that patients in your service understand the role of PAs?

Figure 11: do you agree or disagree that patients in your service understand the role of PAs? Split by job role (PAs and those that have recently worked with PAs)

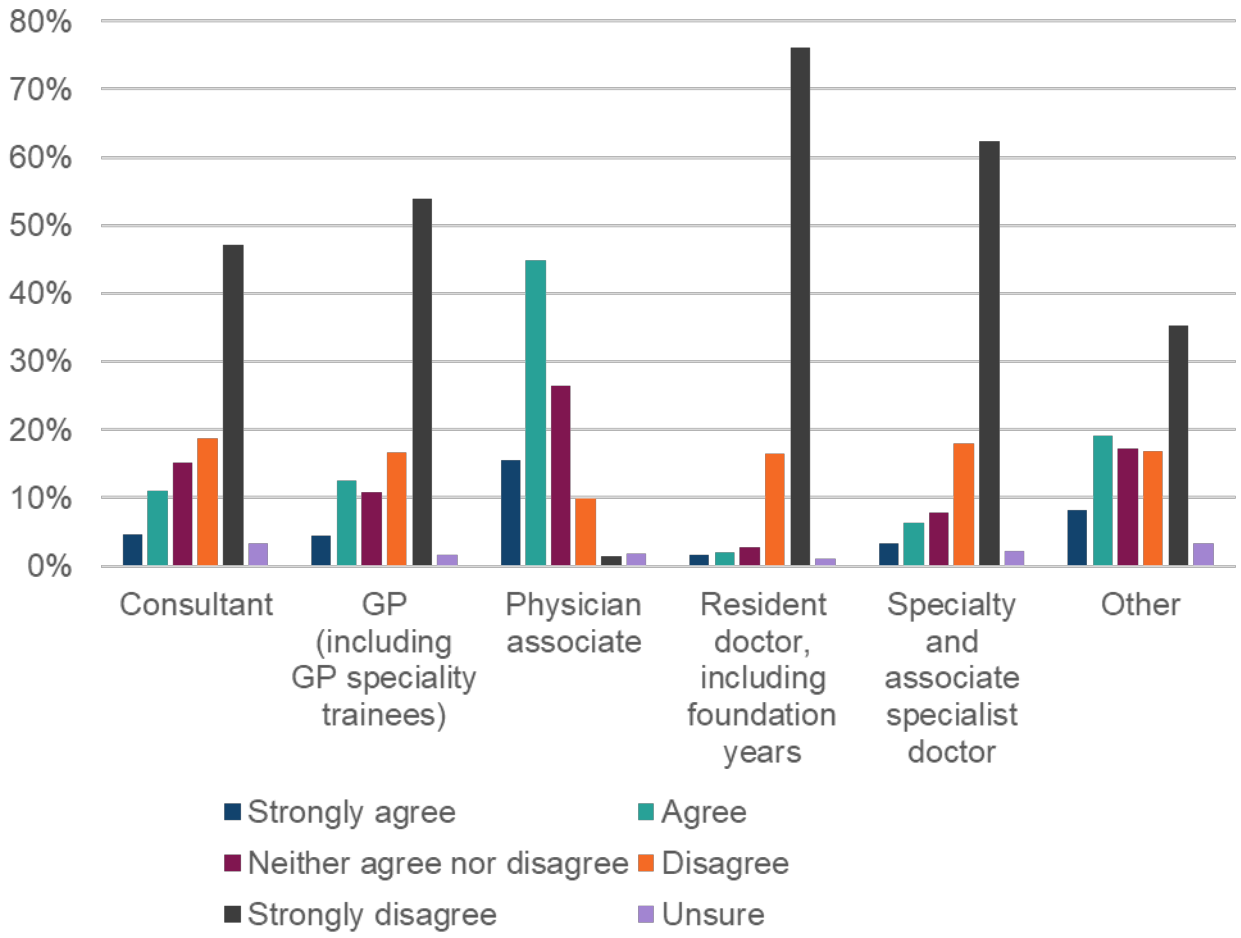

Table 27: do you agree or disagree that patients in your service understand the role of PAs? Split by job role (PAs and those that have recently worked with PAs)

Job role	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Unsure
Consultant	5%	11%	15%	19%	47%	3%
GP (including GP	4%	13%	11%	17%	54%	2%

Job role	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Unsure
speciality trainees)						
PA	16%	45%	26%	10%	1%	2%
Resident doctor, including foundation years	2%	2%	3%	16%	76%	1%
Specialty and associate specialist doctor	3%	6%	8%	18%	62%	2%
Other	8%	19%	17%	17%	35%	3%
All respondents	6%	14%	12%	16%	51%	2%

Figure 12: do you agree or disagree that patients in your service understand the role of PAs? Split by setting (PAs and those that have recently worked with PAs)

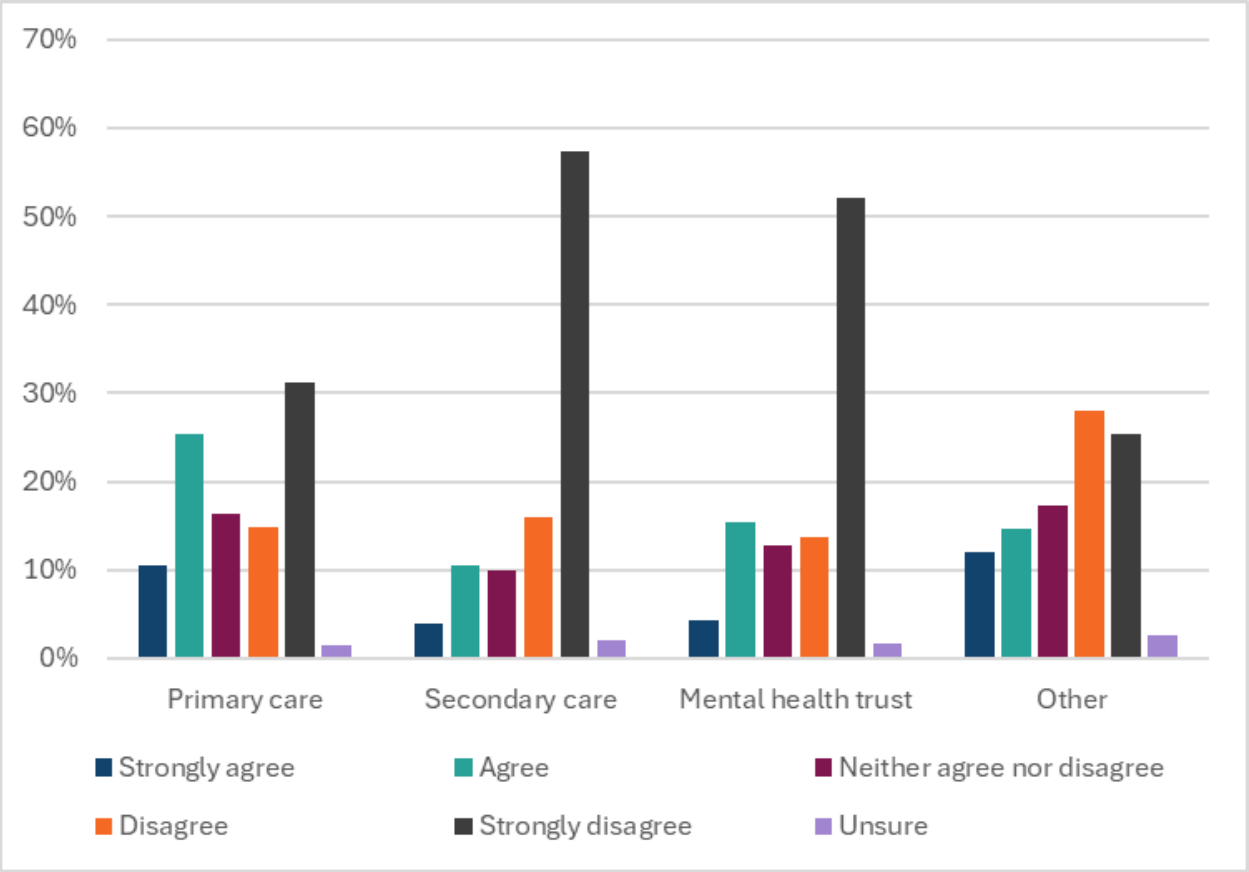

Table 28: do you agree or disagree that patients in your service understand the role of PAs? Split by setting (PAs and those that have recently worked with PAs)

Healthcare setting	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Unsure
Primary care	11%	25%	16%	15%	31%	2%
Secondary care	4%	11%	10%	16%	57%	2%
Mental health trust	4%	15%	13%	14%	52%	2%
Other	12%	15%	17%	28%	25%	3%

Healthcare setting	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Unsure
Total	6%	14%	12%	16%	51%	2%

The survey asked respondents to provide more detail to support their answer regarding patient understanding of the PA role, including suggestions for how this may be improved. The significant themes identified are listed below.

PAs in primary care listed:

- patient education efforts: patients understand the PA role through explanations during consultations, educational materials, and continuous efforts by healthcare staff
- role confusion among patients: patients often confuse PAs with doctors or nurses, indicating a lack of understanding of the PA role, especially among older patients
- need for public awareness: there is a need for national-level awareness campaigns and positive media representation to educate the public about the PA role
- patient satisfaction with care: despite misunderstandings about the PA role, patients are generally satisfied with the care they receive
- information at booking and reception: patients are informed about the PA role during the booking stage and by reception staff, which helps in understanding the role

Those that have recently worked with PAs in primary care listed:

- need for better public awareness: there is a significant need for better public education and communication about the role, qualifications, and responsibilities of PAs to reduce confusion and improve understanding
- misleading title causes confusion: the title 'PA' is misleading and causes confusion among patients and healthcare staff, leading to misunderstandings about the PA's qualifications and role
- distinct uniforms for PAs: distinct uniforms and clear identification for PAs are necessary to help patients distinguish them from doctors and understand their role
- patient satisfaction with PAs: patients generally receive good care from PAs, appreciate longer consultations, and are given the option to reschedule if they prefer to see a doctor

- PAs in multidisciplinary teams: PAs work within a multidisciplinary team, contributing to patient care and often introducing themselves and their supervising GP during consultations

PAs in secondary care listed:

- role clarification during consultations: PAs take time during consultations to explain their role and answer any questions patients may have
- need for public awareness: there is a need for broader public awareness and education about the PA role, including national campaigns and informational materials
- confusion due to role name: the term 'PA' can be confusing for patients, leading to misunderstandings and often being mistaken for doctors or nurses
- role clarity challenges: patients with cognitive impairments or under stress may struggle to understand the PA role despite explanations
- organisational efforts to inform: healthcare organisations use information boards, leaflets, and specific uniforms to raise the profile of the PA role and ensure patients are well-informed

Those that have recently worked with PAs in secondary care listed:

- patient confusion and misidentification: patients often confuse PAs with doctors due to similar roles, attire, and unclear introductions, leading to issues with informed consent and patient safety
- need for clear role explanation: better communication, education, and clear explanations about the PA role are needed to prevent confusion and improve understanding among patients and healthcare staff
- distinct uniforms and identification: PAs should wear distinct uniforms and use clear identification to differentiate themselves from doctors, addressing patient confusion
- role complexity and clarity: the PA role is complex and not always clearly explained, necessitating clear role definitions within clinical teams to avoid confusion among healthcare professionals and patients
- impact of cognitive and language barriers: patients with cognitive or sensory impairments, as well as those who do not speak English, are particularly likely to mistake PAs for doctors if the distinction is not made clear

4.4 What changes do you think healthcare services could make to improve how the PA role is implemented?

This was an open question, and the significant themes identified in the responses are listed below.

PAs in primary care listed:

- increasing PA awareness: increasing awareness and understanding of the PA role among the public and healthcare professionals through media campaigns, educational materials, and training programs
- structured training programs: implementing structured training programs, clear career pathways, and continuous professional development opportunities for PAs
- support systems for PAs: providing structured support systems, including designated supervisors, preceptorship programs, and regular debriefing sessions to ensure PAs feel supported and can work safely
- addressing bullying and discrimination: tackling bullying and discrimination against PAs by promoting teamwork, respect, and addressing misinformation campaigns
- standardised role definitions: creating clear and standardised role definitions, scopes of practice, and practice guidelines for PAs to reduce confusion and improve integration into healthcare teams

Those that have recently worked with PAs in primary care listed:

- ensure patient safety: addressing patient safety concerns through structured supervision, clear accountability, and regular reviews are essential for PAs
- clear scope of practice: there should be clear definitions and standardised scope of practice for PAs to ensure patient safety and avoid overlap with doctors
- promote PA role awareness: national advertising and public education campaigns are needed to promote the PA role, clarify their responsibilities, and enhance public identification
- structured training programs: providing structured training programs, ongoing support, and development opportunities is essential for PAs' effective role implementation
- focus on administrative tasks: PAs should handle administrative and supportive roles to free up doctors for patient care and reduce non-clinical duties

PAs in secondary care listed:

- positive role promotion: national advertising and public education campaigns to enhance understanding of the PA role
- role clarity: clear boundaries, guidelines, and standardised information about PA roles and responsibilities
- career progression: clear career pathways for PAs, including specialisation, regulation, and professional development
- supervisor training and support: comprehensive training for supervisors and support structures for PAs to enhance integration and effectiveness
- uniform and identification: specific uniforms and visual aids to help patients and staff recognise PAs and understand their roles

Those that have recently worked with PAs in secondary care listed:

- PAs in administrative roles: PAs should focus on administrative and clerical tasks to support doctors, freeing them up for more complex clinical work
- national PA scope of practice: a nationally defined and clearly defined scope of practice for PAs is needed to ensure consistency, safety, and clarity about their role and limitations
- strict supervision for PAs: PAs should have strictly monitored and defined roles, work under close supervision, and have a clear support structure to prevent patient harm
- standardised PA identification: there is a consensus on the need for a standardised uniform and clear identification badges to differentiate PAs from doctors and other healthcare professionals
- clear PA role name: the role should be renamed to 'physician assistant' or 'clinical assistant' to better reflect its intended function and reduce confusion

5 Defining the PA role

5.1 Do you agree or disagree that the role and responsibilities of PAs are clearly defined?

The survey asked responds 2 questions regarding the definition of the roles and responsibilities of PAs:

- do you agree or disagree that the role and responsibilities of PAs are clearly defined within your organisation?

- do you agree or disagree that the role and responsibilities of PAs are clearly defined at a national level?

The tables and graphs below present the responses to these 2 questions.

Figure 13: do you agree or disagree that the role and responsibilities of PAs are clearly defined within your organisation and at national level? Split to show PA and all other job roles (those that have recently worked with PAs)

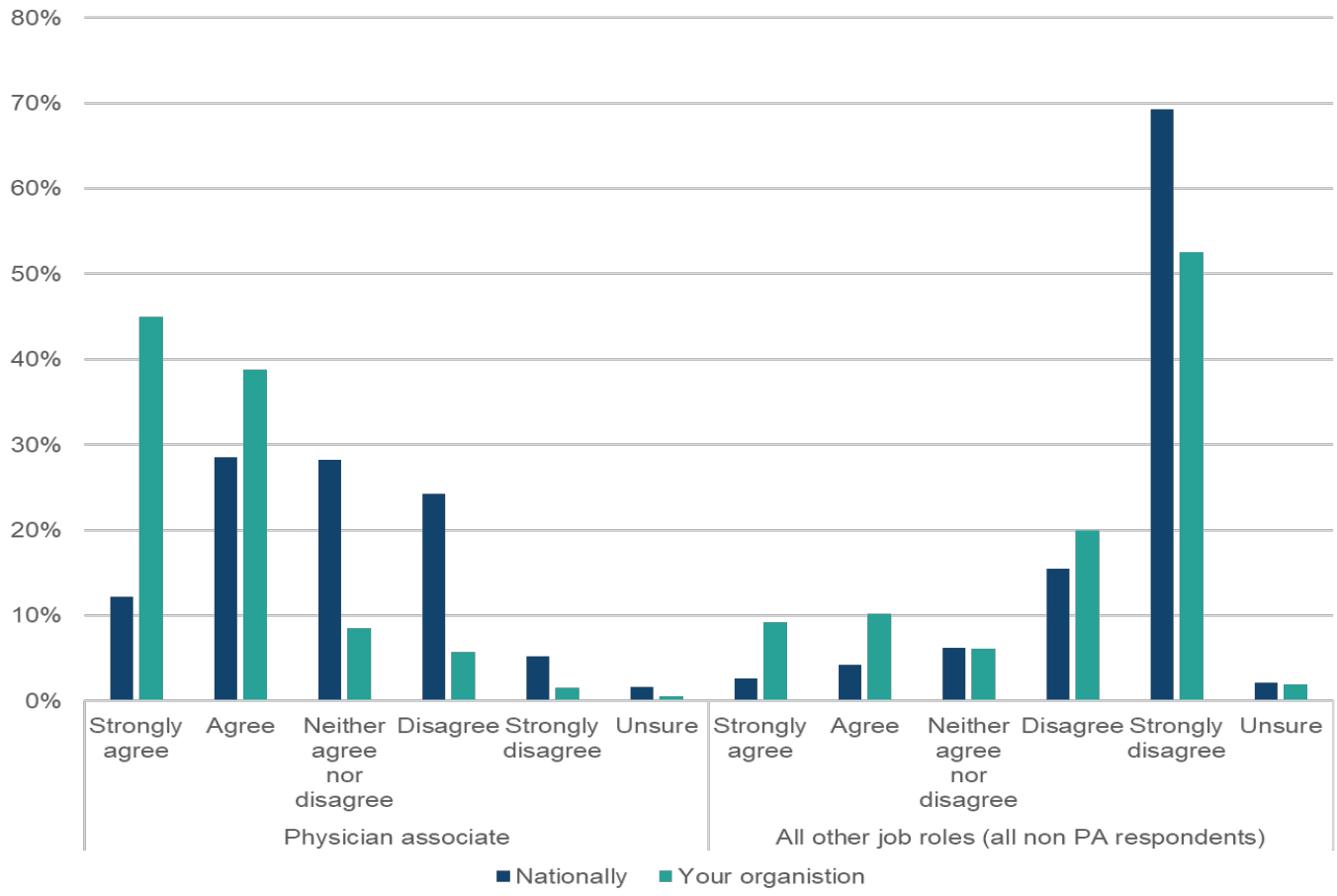

Table 29: do you agree or disagree that the role and responsibilities of PAs are clearly defined within your organisation? Split to show PA with detailed job role breakdown (PAs and those that have recently worked with PAs)

	Strongly agree	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**	**Unsure**
PA	45%	39%	9%	6%	1%	1%

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Unsure
All other job roles (all non-PA respondents)	9%	10%	6%	20%	53%	2%
Consultant	13%	17%	9%	21%	37%	2%
GP (including GP speciality trainees)	16%	15%	7%	21%	39%	3%
Resident doctor, including foundation years	2%	3%	3%	20%	71%	1%
Specialty and associate specialist doctor	6%	9%	6%	23%	54%	2%
Other	21%	22%	12%	15%	28%	2%

Table 30: do you agree or disagree that the role and responsibilities of PAs are clearly defined at national level? Split to show PA with detailed job role breakdown (PAs and those that have recently worked with PAs)

Job role	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Unsure
PA	12%	29%	28%	24%	5%	2%
All other job roles (all non-PA respondents)	3%	4%	6%	16%	69%	2%

Job role	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Unsure
Consultant	3%	6%	11%	22%	57%	2%
GP (including GP speciality trainees)	2%	6%	7%	19%	63%	2%
Resident doctor, including foundation years	2%	1%	2%	9%	86%	1%
Specialty and associate specialist doctor	4%	4%	3%	18%	66%	4%
Other	6%	12%	16%	23%	37%	7%

Figure 14: do you agree or disagree that the role and responsibilities of PAs are clearly defined within your organisation and at national level? Split by setting (PAs and those that have recently worked with PAs)

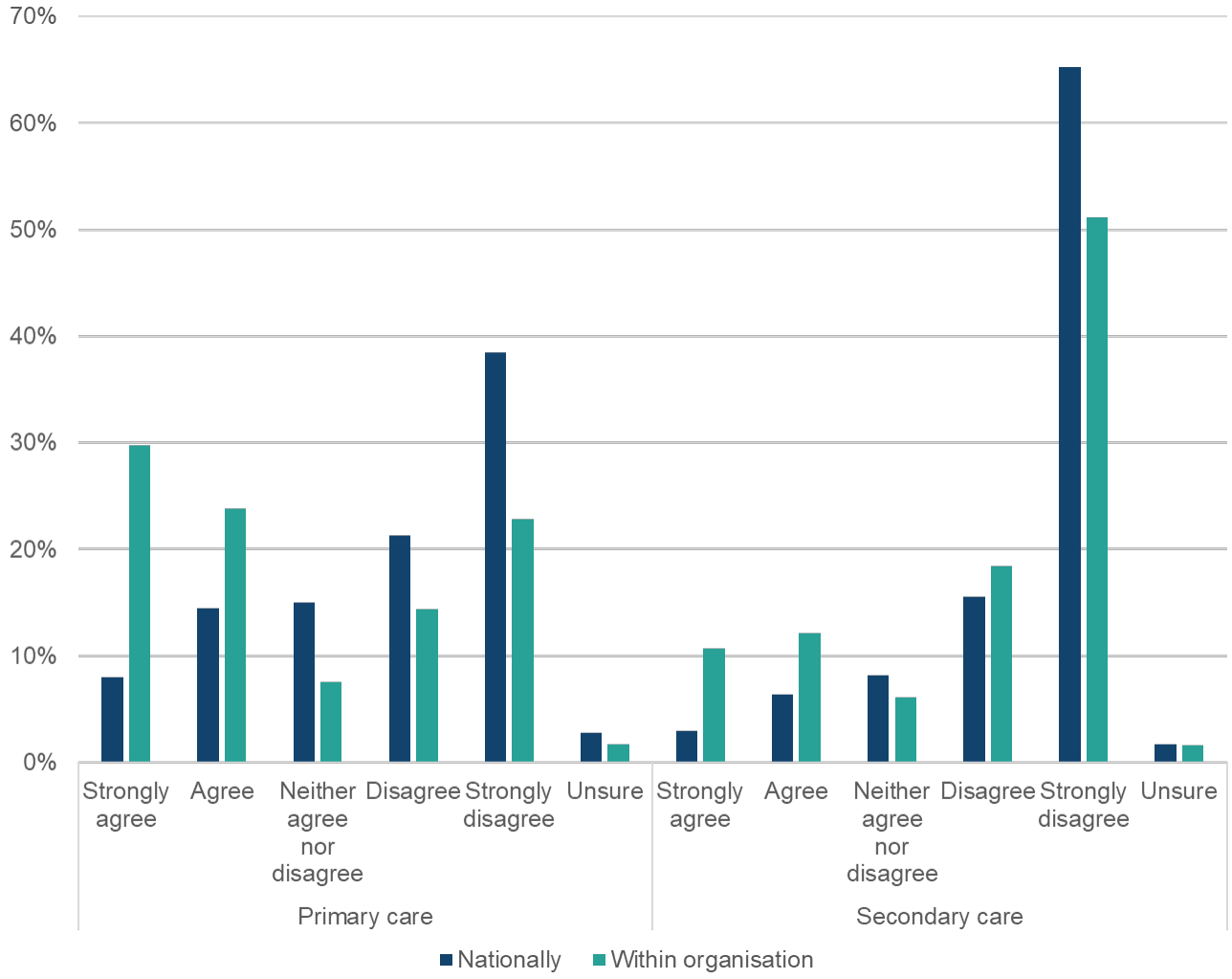

Table 31: do you agree or disagree that the role and responsibilities of PAs are clearly defined within your organisation? Split by setting (PAs and those that have recently worked with PAs)

Setting	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Unsure
Primary care	30%	24%	8%	14%	23%	2%

Setting	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Unsure
Secondary care	11%	12%	6%	18%	51%	2%
Mental health trust	13%	17%	7%	19%	42%	3%
Other	15%	25%	13%	20%	23%	4%

Table 32: do you agree or disagree that the role and responsibilities of PAs are clearly defined at national level? Split by setting (PAs and those that have recently worked with PAs)

Setting	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Unsure
Primary care	8%	14%	15%	21%	38%	3%
Secondary care	3%	6%	8%	15%	65%	2%
Mental health trust	3%	9%	15%	15%	55%	3%
Other	8%	11%	13%	25%	35%	8%

5.2 Do you agree or disagree that a defined scope of practice for PAs would be helpful?

Figure 15: do you agree or disagree that a defined scope of practice for PAs would be helpful? By job role (PAs and those that have recently worked with PAs)

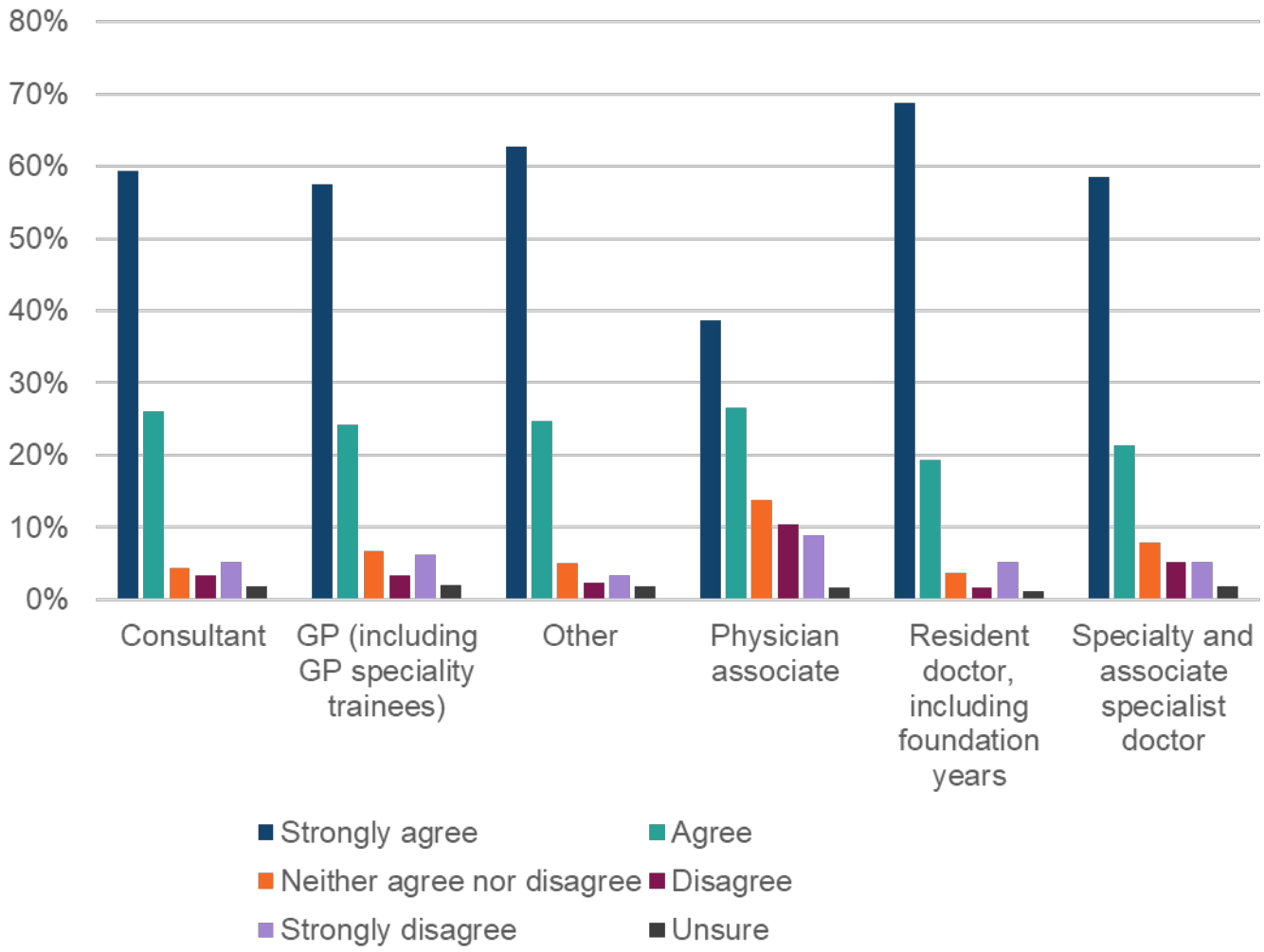

Table 33: do you agree or disagree that a defined scope of practice for PAs would be helpful? By job role (PAs and those that have recently worked with PAs)

Job role	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Unsure
Consultant	59%	26%	4%	3%	5%	2%

Job role	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Unsure
GP (including GP speciality trainees)	58%	24%	7%	3%	6%	2%
PA	39%	27%	14%	10%	9%	2%
Resident doctor, including foundation years	69%	19%	4%	2%	5%	1%
Specialty and associate specialist doctor	59%	21%	8%	5%	5%	2%
Other	63%	25%	5%	2%	3%	2%
All job roles	60%	23%	6%	4%	6%	2%

Additional analysis below compares responses from non-PA respondents according to how recently they last worked in a setting where PAs were part of the multidisciplinary team.

Figure 16: do you agree or disagree that a defined scope of practice for PAs would be helpful? By length of time since last worked with PAs (non-PA respondents only)

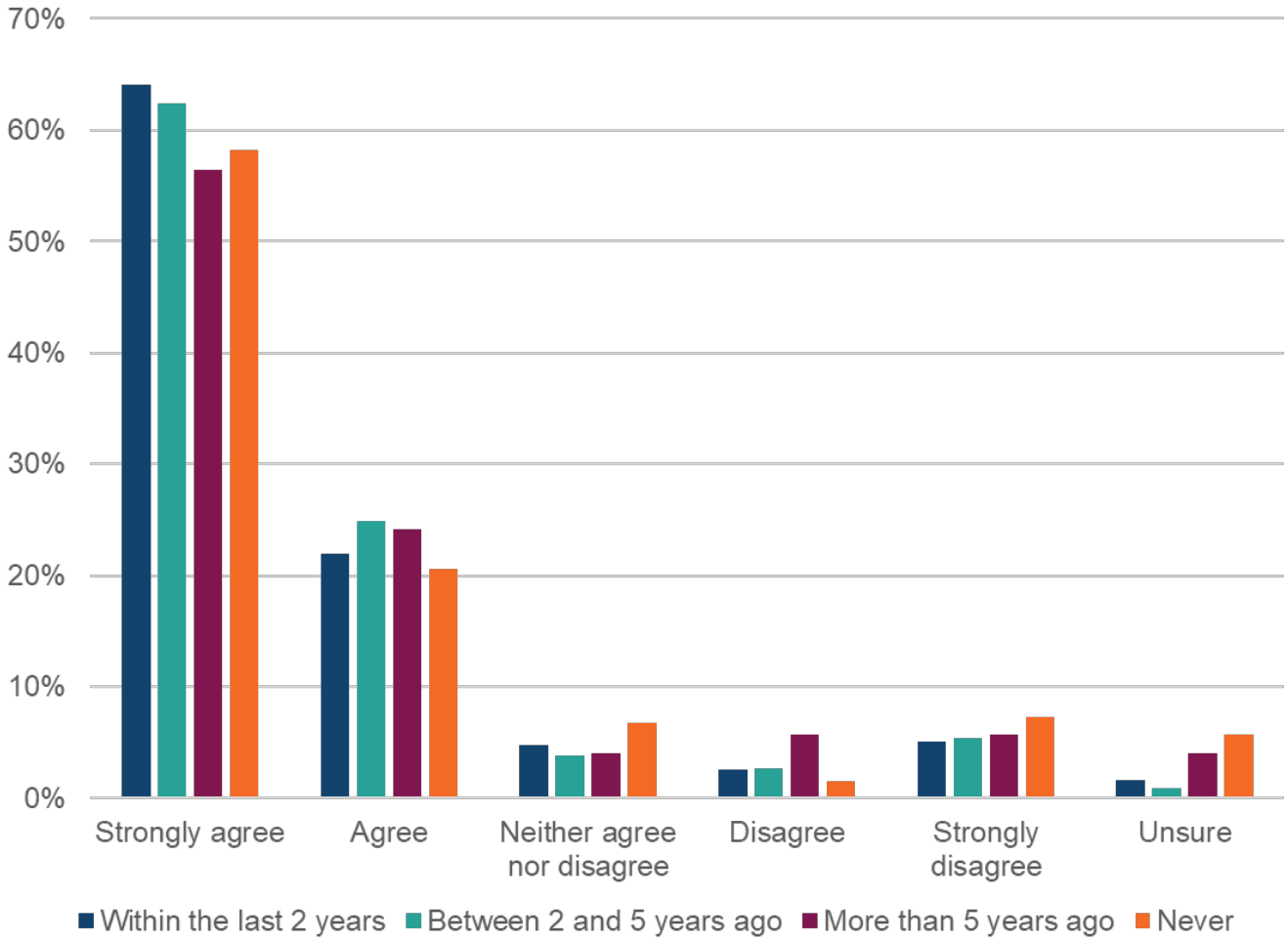

Table 34: do you agree or disagree that a defined scope of practice for PAs would be helpful? By length of time since last worked with PAs (non-PA respondents only - those that have recently worked with PAs)

Time since last worked with PAs	**Strongly agree**	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**	**Unsure**
Within the last 2 years	64%	22%	5%	3%	5%	2%
Between 2 and 5 years ago	62%	25%	4%	3%	5%	1%

Time since last worked with PAs	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Unsure
More than 5 years ago	56%	24%	4%	6%	6%	4%
Never	58%	21%	7%	2%	7%	6%

Figure 17: do you agree or disagree that a defined scope of practice for PAs would be helpful? By length of time since last worked with PAs. Split by healthcare setting (PAs and those that have recently worked with PAs)

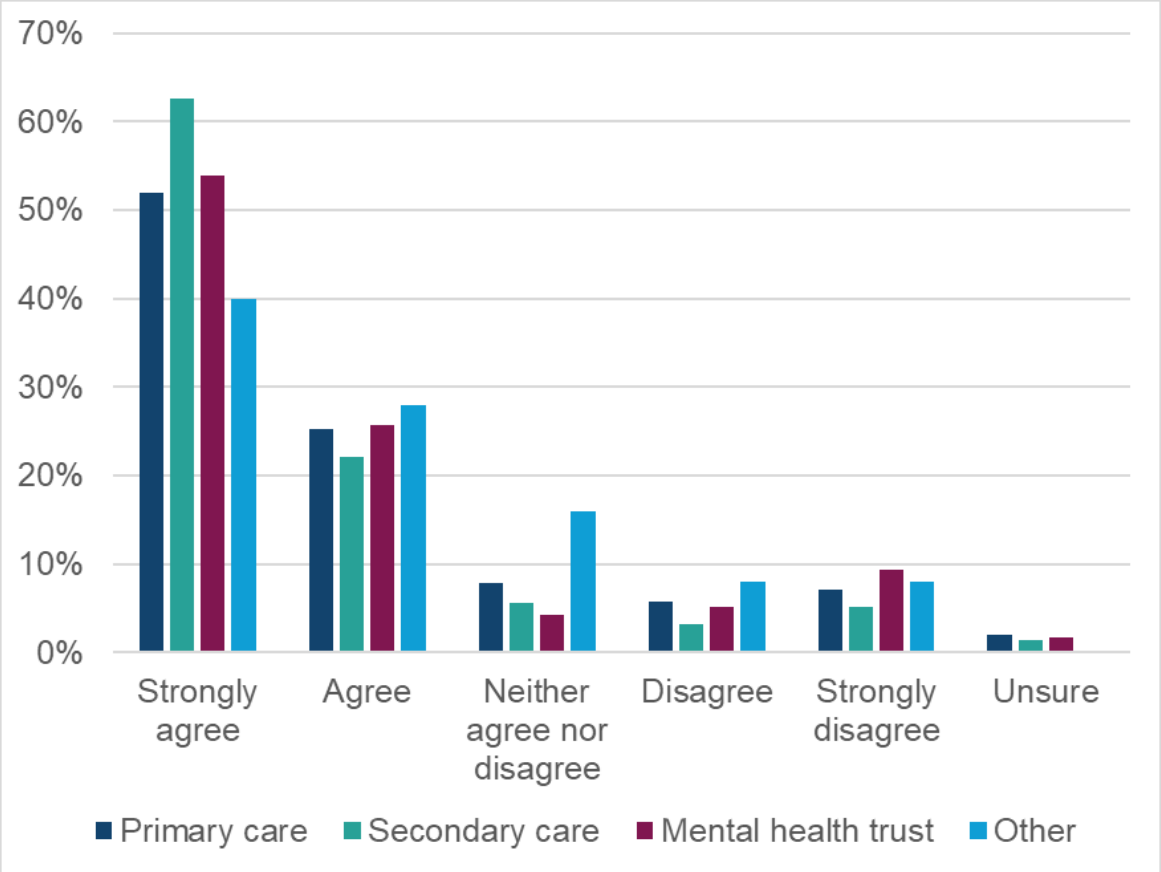

Table 35: do you agree or disagree that a defined scope of practice for PAs would be helpful? By length of time since last worked with PAs. Split by healthcare setting (PAs and those that have recently worked with PAs)

Healthcare setting	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Unsure
Primary care	52%	25%	8%	6%	7%	2%
Secondary care	63%	22%	6%	3%	5%	1%
Mental health trust	54%	26%	4%	5%	9%	2%
Other	40%	28%	16%	8%	8%	0%
All settings	60%	23%	6%	4%	6%	2%

Respondents were also asked to provide any detail to support their answer regarding a scope of practice for PAs. The significant themes identified in the responses are listed below.

PAs in primary care listed:

- experience-based scope: the scope of practice should be tiered based on the PA's experience, training, and career progression, allowing for growth and specialisation
- national scope with local adaptation: a national scope of practice is necessary for consistency and safety but should allow for local adaptation to reflect specific healthcare settings and needs
- impact of restrictive guidelines: overly restrictive guidelines could hinder the PA profession, reducing employability and the ability to provide effective patient care
- specialty and sector-based scope: scope of practice should be tailored to individual specialties and sectors, reflecting the diverse roles and specialised training of PAs

- awareness and education: greater awareness and education about the PA role among healthcare professionals, employers, and patients is needed, supported by professional bodies

Those that have recently worked with PAs in primary care listed:

- training and competency alignment: the scope of practice should align with the training PAs have received, ensuring competency and patient safety, with opportunities for further training and professional growth
- national scope of practice: a nationally recognised and consistent scope of practice is needed to ensure patient safety, prevent misuse, and provide clear guidance for PAs
- strict supervision and regulation: strict supervision and regulation by professional bodies are necessary to ensure PAs practice within safe and defined limits, preventing misdiagnosis and patient harm
- administrative focus: PAs should focus on administrative and repetitive tasks rather than clinical decision-making
- role clarification: a defined scope of practice is needed to clarify the role of PAs and prevent ongoing debate, ensuring clear communication to the public

PAs in secondary care listed:

- individualised scope based on experience: the scope of practice should be tailored to each PA's experience, skills, and training
- local and specialty-specific scope: the scope of practice for PAs should be defined locally and within each specialty, considering specific training and service needs. The defined scope of practice for PAs should be flexible to accommodate various departments and additional training
- national standardisation with flexibility: a national scope of practice should ensure consistency and standardisation while allowing for local adaptation
- limitations and role clarity: there should be clear limitations on PA roles to prevent confusion with doctors' training and expectations. A clear scope of practice is needed to avoid confusion among the public and the multidisciplinary team
- competency-based approach: the scope of practice should be competence-based, similar to other healthcare roles

Those that have recently worked with PAs in secondary care listed:

- nationally consistent scope of practice: a clearly defined, nationally consistent scope of practice is essential to ensure patient safety, prevent PAs from performing tasks beyond their training, and provide clarity for staff and patients
- supervised roles and training: PAs should work under direct supervision with clearly defined roles and responsibilities, and have access to training, competency documentation, and career development opportunities
- limited clinical and administrative tasks: PAs should be limited to basic, non-invasive clinical tasks and administrative support roles, avoiding advanced medical procedures and ensuring they do not take away training opportunities from resident doctors
- role appropriateness and public awareness: there are concerns about the appropriateness of using PAs to bridge the shortfall of doctors, and the public needs to be informed about the role and limitations of PAs
- local scope flexibility: the scope of practice for PAs should allow for local variability and flexibility to accommodate specific needs of different trusts and departments

5.3 What do you think could improve the effectiveness of PAs working in multidisciplinary teams? (Effectiveness can relate to any aspect of how these roles contribute to service quality and patient safety and quality as part of the multidisciplinary team)

This was an open question, and the significant themes identified in the responses are listed below.

PAs in primary care listed:

- clearly defined roles and responsibilities: clearly defining the roles and responsibilities of PAs within the multidisciplinary team to avoid misunderstandings and ensure effective collaboration
- professional development and training: providing ongoing training, professional development opportunities, and defined career pathways for PAs to enhance their skills and career progression
- respect and team integration: promoting respect, acceptance, and effective integration of PAs within multidisciplinary teams to foster collaboration and a positive working environment
- support and supervision: ensuring PAs receive adequate support and supervision from senior clinicians to build confidence and improve performance

- safe and trusting environment: creating a safe environment with mutual trust and respect, addressing bullying, and fostering a supportive culture to improve PA effectiveness

Those that have recently worked with PAs in primary care listed:

- role clarity and scope of practice: clearly defining the roles, responsibilities, and scope of practice for PAs, including regulatory clarity and national guidelines, is crucial for their effectiveness
- need for enhanced training: comprehensive training programs, including post-PA school training, competency training, postgraduate training, and specialisation opportunities, are essential for PAs' effectiveness
- importance of support and supervision: ensuring ongoing supervision, support, and access to experienced oversight is necessary for PAs to perform their roles effectively
- criticism and calls for role abolition: some believe that PAs do not add value, are unsafe, and should be abolished or retrained as doctors or nurses
- focus on administrative and supportive roles: PAs should focus on administrative tasks, assisting doctors, and supporting chronic disease management to improve team efficiency

PAs in secondary care listed:

- prescribing rights: granting PAs the ability to prescribe medications and request imaging would enhance their contribution and efficiency in patient care
- defined scope of practice: establishing a clear and standardised scope of practice for PAs would help in defining their roles and responsibilities within the multidisciplinary team
- bullying and harassment prevention: addressing and preventing bullying and harassment of PAs by medical groups would create a more supportive and effective working environment
- credentialing and career progression: establishing clear credentialing and career progression pathways for PAs would enable them to develop specialist skills and train other team members
- improved education and interprofessional training: encouraging interdisciplinary training and better education about the PA role among healthcare professionals would improve team collaboration and effectiveness

Those that have recently worked with PAs in secondary care listed:

- need for role clarity: clearer definitions and restrictions on the roles and responsibilities of PAs within multidisciplinary teams
- focus on administrative support: PAs should focus on administrative tasks to reduce the burden on doctors
- mandating training and development: requiring formal portfolios and providing training opportunities for PAs
- expanded scope of practice: allowing PAs to prescribe medications and perform certain tasks to improve efficiency and patient care
- adequate supervision and accountability: ensuring proper supervision and clear accountability structures for PAs

5.4 What do you think would reduce the effectiveness of PAs in multidisciplinary teams? (This can include factors you think already reduce the effectiveness)

This was an open question, and the significant themes identified in the responses are listed below.

PAs in primary care listed:

- restricted scope of practice: limiting the ability of PAs to prescribe medications or order diagnostic tests reduces their effectiveness
- negative attitudes and bullying: hostility and bullying from other healthcare professionals, especially doctors, hinder the effectiveness of PAs
- insufficient support and supervision: lack of adequate support, supervision, and training from senior colleagues diminishes the effectiveness of PAs
- unclear role definition: the absence of a clearly defined role for PAs within teams leads to confusion and reduced effectiveness
- negative media and public perception: misconceptions and negative media coverage about PAs undermine their effectiveness

Those that have recently worked with PAs in primary care listed:

- ambiguity in role: lack of a clearly defined role or scope of practice for PAs leads to confusion and reduced effectiveness

- negative attitudes: misunderstandings and negative perceptions undermine the acceptance of PAs
- insufficient training: inadequate training for PAs results in poor decision-making and unsafe practices
- limited autonomy: heavy supervision requirements for PAs reduce their effectiveness and team efficiency
- political and media influence: political interference and negative media coverage reduce the effectiveness of PAs

PAs in secondary care listed:

- negative perceptions and hostility: negative opinions, prejudice, and hostility from colleagues, media, and organisations undermine the effectiveness and morale of PAs
- restrictive scope of practice: limiting the tasks and responsibilities of PAs, including prescribing and ordering ionising radiation, reduces their effectiveness in multidisciplinary teams
- lack of understanding and respect: other healthcare professionals and the public not appreciating or understanding the role and input of PAs can reduce their effectiveness
- lack of career progression: insufficient guidance on career progression, continuing professional development (CPD), and training opportunities post-qualification can hinder the effectiveness of PAs
- negative media and misinformation: misleading broadcasting, negative media coverage, and misinformation about PAs create an environment of distrust and hostility, reducing their effectiveness

Those that have recently worked with PAs in secondary care listed:

- role clarity issues: lack of clear roles, boundaries, and scope of practice for PAs leads to confusion, inefficiency, and increased workload for doctors
- training and supervision deficiencies: insufficient training, lack of supervision, and inadequate management for PAs lead to safety concerns and reduced effectiveness
- interpersonal dynamics challenges: stigma, discrimination, and negative rhetoric from junior doctors can reduce the effectiveness of PAs in multidisciplinary teams
- prescribing limitations: the inability of PAs to prescribe medications and work autonomously limits their effectiveness in patient care

- impact on morale: the presence of PAs can negatively affect the morale of other medical professionals and create hierarchical barriers

5.5 What changes in your service (if any) have you experienced as a result of the introduction or expansion of PAs? (For example, changes to workload, skills mix or capacity)

This was an open question, which only those working with PAs were asked. The significant themes identified in the responses are listed below.

Those that have recently worked with PAs in primary care listed:

- increased capacity and patient access: the introduction or expansion of PAs has increased available appointments, improved access to services, and reduced waiting times

- increased workload for doctors: the introduction or expansion of PAs has led to an increased workload for doctors due to the need for supervision, correcting PA work, and additional responsibilities

- reduced GP workload: GPs are able to focus on more complex cases as PAs handle less complex and routine cases, thereby reducing the overall workload for GPs

- negative impact on patient care: the presence of PAs has led to poorer patient care, including misdiagnoses, increased follow-up appointments, and inappropriate referrals

- enhanced skill mix and team dynamics: the inclusion of PAs has diversified the skill set within the team, fostering better team dynamics and collaboration

Those that have recently worked with PAs in secondary care listed:

- increased supervision and workload: doctors report an increased workload due to the need to supervise, double-check, and perform tasks that PAs are not qualified to do

- negative impact on patient safety: concerns about patient safety due to misdiagnoses, inappropriate investigations, and poor quality referrals by PAs

- reduced training opportunities for doctors: the presence of PAs has led to fewer training opportunities for resident doctors, impacting their professional development and skill acquisition

- negative impact on doctor morale: the introduction of PAs has negatively impacted the morale of doctors, leading to frustration, demoralisation, and some doctors leaving the profession or country

- increased administrative burden: doctors report an increased administrative burden due to the need for increased documentation, oversight, and duplication of work done by PAs

6 Supervision

6.1 Who most commonly acts as your day-to-day supervisor?

Table 36: who most commonly acts as your day-to-day supervisor?

Job role of supervisor	**Percentage of respondents**
Consultant	54%
General practitioner	44%
Other	2%

The survey asked respondents who selected 'other' to provide the name of their supervisor's role if not a consultant or a GP. Only 24 (2%) of respondents selected 'other'. The majority of these (22 of 24) said doctors supervised them. Of these 6 said consultants or GPs supervised them alongside other healthcare professionals.

Table 37: specified job role of PA's supervisors for those that selected 'other' to the question 'who most commonly acts as your day-to-day supervisor?'

Job role of supervisor	**Number of respondents**
Other doctors	7
Mix of roles, including consultant and/or GP	6
Not applicable (for example, if the respondent is in training)	5

Job role of supervisor	Number of respondents
Registrar	4
Nurse	1
Senior PA	1

6.2 Do you provide, or have you previously provided, day-to-day supervision for any PAs?

Table 38: do you provide, or have you previously provided, day-to-day supervision for any PAs? (Those that have recently worked with PAs)

Do you provide, or have you previously provided, day-to-day supervision for any PAs?	Percentage of respondents
Yes, currently	25%
Yes, previously	30%
No	45%

6.3 What other relationships, if any, do you hold with PAs in your service?

As a multiple choice question, the total of the percentage is greater than 100% due to some respondents selecting multiple options.

Table 39: what other relationships, if any do you hold with PAs in your service? (Those that have recently worked with PAs)

Relationship with PAs	Percentage of respondents
Training lead or trainer	38%
Employer	27%
Governance lead	12%
Other	39%

6.4 How confident do you feel that there is enough supervision and support for you in your PA role?

Table 40: how confident do you feel that there is enough supervision and support for you in your PA role? Breakdown by setting

Setting	Extremely confident	Very confident	Moderately confident	Slightly confident	Not at all confident	Unsure
Primary care	71%	21%	4%	2%	2%	0%
Secondary care	62%	26%	8%	2%	2%	0%
Mental health trust	65%	26%	0%	9%	0%	0%
Other	42%	33%	17%	0%	4%	4%
All PA respondents	66%	24%	6%	2%	2%	0%

Respondents were also asked to provide more detail regarding their confidence in supervisory support. The significant themes identified in the responses are listed below.

PAs in primary care listed:

- flexible and accessible supervision: supervisors have flexible schedules and are readily available to provide support when needed, including for urgent concerns and acute services
- inconsistent supervision quality: the quality and availability of supervision vary greatly, impacting the ability to get timely advice and support
- targeted supervision support: supervisors provide targeted support for newly qualified PAs, triage-based clinics, complex cases, and clinical uncertainty
- need for better supervision guidance: there is a need for better guidance, structured protocols, and official training for supervisors to ensure consistent and effective supervision
- structured and regular supervision: supervision is well-structured with dedicated time for discussions, regular debriefs, and monthly sessions to ensure continuous support

PAs in secondary care listed:

- structured and regular supervision: clear structures and policies for supervision, including designated supervisors and regular meetings, ensure consistent support
- consultant availability and approachability: consultants need to be contactable and approachable to provide effective support
- inadequate supervision and support: respondents feel unsupported due to lack of consultant availability, delayed supervision, and systemic issues
- supervision in various clinical settings: supervision is available in different clinical settings, including wards, clinics, emergency departments, and specialised clinics
- team based and multidisciplinary support: support is provided by a team of consultants, registrars, and other senior staff, ensuring comprehensive supervision and collaborative patient care

6.5 How confident do you feel that PAs deployed in your service receive enough supervision and support?

Table 41: how confident do you feel that PAs deployed in your service receive enough supervision and support? Split by job role (those that have recently worked with PAs)

Role	Extremely confident	Very confident	Moderately confident	Slightly confident	Not at all confident	Unsure
Consultant	16%	17%	14%	8%	35%	9%
GP (including GP speciality trainees)	18%	14%	11%	10%	42%	5%
Resident doctor, including foundation years	3%	3%	7%	13%	61%	13%
Specialty and associate specialist doctor	6%	9%	15%	12%	46%	12%
Other	19%	22%	15%	7%	27%	10%

Table 42: how confident do you feel that PAs deployed in your service receive enough supervision and support? Split by setting (those that have recently worked with PAs)

Setting	Extremely confident	Very confident	Moderately confident	Slightly confident	Not at all confident	Unsure
Primary care	20%	17%	13%	9%	35%	6%
Secondary care	8%	9%	10%	11%	51%	12%

Mental health trust	5%	11%	13%	11%	50%	11%
Other	18%	12%	14%	14%	37%	6%

Respondents were also asked to provide more detail regarding their confidence in supervisory support for PAs in their service. The significant themes identified in the responses are listed below.

Those that have recently worked with PAs in primary care listed:

- increased risk due to inadequate supervision: PAs handling high-risk tasks without adequate supervision leads to increased risk of errors
- structured supervision with named supervisors: each PA has a named supervisor with allocated time for debriefs, tutorials, and case discussions
- increased GP workload due to supervision: supervising PAs adds to GPs' workload, making it difficult to manage their own patient load
- variability in supervision quality: supervision quality for PAs varies significantly across practices and depends on clinician availability
- continuous supervision availability: supervisors are available throughout the day for immediate queries and support

Those that have recently worked with PAs in secondary care listed:

- inconsistent supervision risks: inconsistent and inadequate supervision of PAs leads to potential risks in patient care
- structured supervision benefits: regular, structured supervision and training programs enhance PAs' skills and performance
- patient safety risks: inadequate supervision of PAs poses significant risks to patient safety
- specialised department supervision: PAs in specialised and emergency departments often lack adequate supervision, raising patient care concerns
- consultant availability issues: busy consultants often fail to provide adequate supervision to PAs, leading to gaps in oversight

6.6 What ratio of supervisor to PA do you work to in your setting?

This question was only answered by those working with PAs.

Table 43: what ratio of supervisor to PA do you work to in your setting? (Those that have recently worked with PAs)

Supervision ratio	**Percentage of respondents**
1 to 1	16%
1 to 2	7%
Between 1 to 3 and 1 to 4	11%
Between 1 to 5 and 1 to 6	5%
1 to 7 or more	5%
Other	3%
Unsure	52%

7 Continuing professional development

Questions in this section were only answered by PAs.

7.1 Does your work schedule allow time for continuing professional development?

Table 44: does your work schedule allow time for continuing professional development?

Answer	Percentage of respondents
Yes	85%
No	15%

7.2 Would you like more opportunities for career progression?

Table 45: would you like more opportunities for career progression?

Answer	Percentage of respondents
Yes	93%
No	3%
Unsure	4%

Respondents were asked to provide details of the opportunities for career development they would like. The significant themes identified in the responses are listed below.

PAs in primary care listed:

- advanced clinical skills: interest in advanced training and specialisation in areas such as minor surgery, dermatology, chronic disease management, and other medical specialties.
- career progression path: need for a clear and structured career progression path with defined stages, responsibilities, pay scales, and national guidelines

- prescribing rights: desire for prescribing rights, ability to order ionizing radiation, and perform specific medical procedures independently
- funded training programs: interest in funded training programs, conferences, CPD opportunities, and allocated time for professional development
- managerial and leadership roles: desire for progression to managerial, supervisory, and leadership positions within and outside the NHS

PAs in secondary care listed:

- clear career pathways: desire for clear and defined career pathways, including criteria for progression, seniority titles, and structured frameworks within specialties
- recognition and pay progression: desire for recognition of experience, appropriate banding, and clear pathways for salary increases based on competencies
- specialist training and advanced skills: interest in developing specialist roles, advanced clinical skills, and undertaking specialty-specific training and fellowships
- service development and leadership: opportunities for service development, leadership roles, and involvement in project management
- advanced clinical skills and prescribing: respondents want to develop advanced clinical skills, perform more complex procedures, and have the ability to prescribe medications and order investigations

8 Patient safety

The patient safety questions were optional. Some respondents therefore did not complete some or all of the question in this section.

The percentages quoted in the tables, charts and commentary below refer to the proportion of respondents who answered each question, not to the total number of respondents to the survey.

8.1 How confident would you feel reporting a patient safety incident?

This question was for PAs only.

Table 46: how confident would you feel reporting a patient safety incident? Split by setting (Question for PAs only)

Confidence level	Primary care	Secondary care	Mental health trust	Other	All PA respondents
Extremely confident	65%	62%	70%	71%	64%
Very confident	26%	27%	26%	25%	26%
Moderately confident	7%	7%	0%	4%	7%
Slightly confident	1%	2%	4%	0%	1%
Not at all confident	1%	2%	0%	0%	1%
Unsure	0%	1%	0%	0%	1%

8.2 How confident do you feel that you would be supported by your service following a patient safety incident?

This question was for PAs only.

Table 47: how confident do you feel that you would be supported by your service following a patient safety incident? Split by setting (Question for PAs only)

Confidence	Primary care	Secondary care	Mental health trust	Other	All PA respondents
Extremely confident	57%	41%	48%	33%	48%

Confidence	Primary care	Secondary care	Mental health trust	Other	All PA respondents
Very confident	25%	30%	39%	29%	28%
Moderately confident	12%	15%	9%	17%	14%
Slightly confident	3%	5%	4%	8%	4%
Not at all confident	2%	5%	0%	8%	4%
Unsure	2%	4%	0%	4%	3%

The survey asked respondents to explain their answer. The significant themes identified in the responses are listed below.

PAs in primary care listed:

- supportive reporting environment: supervisors and management provide support in reporting patient safety incidents, focusing on learning and improvement
- open reporting culture: incidents are reported openly without blaming individuals, emphasising learning and patient safety improvement
- reflective learning practices: encouragement of reflective practice, further training, and structured learning sessions to prevent future incidents
- regular safety reviews: regular meetings and reviews are held to discuss significant events and patient safety incidents for continuous improvement
- clear reporting protocols: familiarity with reporting protocols and the importance of clear communication and timely action

PAs in secondary care listed:

- unfair treatment of PAs: PAs are unfairly blamed for incidents, face double standards, and lack management support

- supportive team environment: a supportive team environment boosts confidence in reporting patient safety incidents and receiving senior staff support
- clear reporting systems: clear and accessible reporting systems, including IT systems like Datix, facilitate incident reporting
- confidence in incident management: confidence exists that patient safety incidents are investigated and managed appropriately with rigorous protocols and training
- effective incident review: reported incidents are reviewed effectively, with feedback leading to changes in practice or training

8.3 Have you ever been involved in a patient safety incident?

This question was for PAs only.

Table 48: have you ever been involved in a patient safety incident? Split by setting (Question for PAs only)

Answer selected	Primary care	Secondary care	Mental health trust	Other	All PA respondents
No	91%	92%	96%	78%	92%
Yes	9%	8%	4%	22%	8%

The survey asked respondents to provide any details about how the patient safety incident might have been prevented. The significant themes identified in the responses are listed below.

PAs in primary care listed:

- timely review of test results: ensuring timely review of blood and microbiology results to prevent missed diagnoses and overlooked important results
- proper supervision and collaboration: ensuring adequate supervision and involving multiple staff members to spot and correct mistakes
- adequate patient interaction time: ensuring sufficient time with patients to prevent safety incidents

- early discharge and follow-up care: preventing complications by ensuring proper follow-up for patients discharged early, especially those with low renal function
- effective debriefing and management plans: implementing proper debriefing and management plans to prevent patient safety incidents

PAs in secondary care listed:

- adequate staffing levels: ensuring sufficient staffing levels, reducing patient load, and providing better staff-to-patient ratios to prevent incidents
- improved documentation and communication: enhancing clarity and accuracy in documentation and ensuring clear communication during handovers to prevent patient safety incidents
- known complications and care: recognising that some incidents may involve known surgical complications or be deemed unpreventable due to specific pathology, with appropriate care provided
- team collaboration and review: promoting a team approach, collaborative effort, and thorough review of drug charts by the entire medical team to spot and prevent errors
- training and support for staff: providing appropriate support and training for doctors and PAs (PAs) to prevent incidents

8.4 Have any PAs in your team been involved in a patient safety incident?

This question was for healthcare professionals who work with PAs only.

Table 49: have any PAs in your team been involved in a patient safety incident? Split by job role (those that have recently worked with PAs)

Job role	Yes	No	Unsure
Consultant	27%	35%	38%
GP (including GP speciality trainees)	36%	29%	35%
Resident doctor, including foundation years	37%	8%	54%

Job role	Yes	No	Unsure
Specialty and associate specialist doctor	33%	15%	52%
Other	21%	35%	43%
All job roles (non-PA respondents)	33%	20%	47%

Table 50: have any PAs in your team been involved in a patient safety incident? Split by setting – includes those that have recently worked with PAs

Job role	Yes	No	Unsure
Primary care	34%	31%	35%
Secondary care	33%	17%	50%
Mental health trust	25%	23%	52%
Other	22%	33%	45%
All settings (non-PA respondents)	33%	20%	47%

The survey asked respondents to provide any details about how the patient safety incident might have been prevented. The significant themes identified in the responses are listed below.

Those that have recently worked with PAs in primary care listed:

- frequent diagnostic errors: frequent diagnostic errors, including missed critical diagnoses and misinterpretation of test results, leading to patient harm

- need for enhanced supervision: enhanced supervision and training for PAs are necessary to prevent errors in diagnosis, prescribing, and patient management
- defined scope of practice: PAs should work within a clearly defined scope of practice and avoid complex cases to ensure patient safety
- inappropriate prescribing issues: issues with inappropriate prescribing patterns, incorrect medication doses, and lack of supervision in medication management
- doctor employment for safety: employing doctors or ensuring GP review of cases seen by PAs could prevent patient safety incidents

Those that have recently worked with PAs in secondary care listed:

- need for clear role definitions: clearer role definitions and better supervision of PAs are needed to prevent incidents, ensuring they do not work independently in critical situations
- prescription and medication errors: errors in prescribing and medication management, including unauthorised prescriptions, highlight the need for electronic prescribing to reduce incidents
- misdiagnosis and delayed treatment: instances of misdiagnosis and delayed treatment, including serious conditions like cancer and myocardial infarction, lead to significant harm
- higher educational standards for PAs: higher educational standards and proper training for PAs are needed to ensure they have adequate medical knowledge and understanding of medical procedures
- communication and handover failures: poor communication and failure to properly hand over patient information lead to delays in care and missed critical information

8.5 Reporting of patient safety incidents

Table 51: have you ever reported any patient safety incidents, including incidents that did not involve PAs? (PAs and those that have recently worked with PAs)

Job role	**Yes**	**No**
Consultant	60%	40%

Job role	Yes	No
GP (including GP speciality trainees)	50%	50%
PA	43%	57%
Resident doctor, including foundation years	43%	57%
Specialty and associate specialist doctor	42%	58%
Other	39%	61%
All respondents	46%	54%

Respondents were able to select multiple options for the questions below. The ‘percentage of respondents’ columns in these tables indicate how many respondents selected each job role – therefore the total percentage for each table totals more than 100%.

Table 52: who was involved in the patient safety incidents that you reported? (Follow up question to PAs only – could select more than one response)

Job role	Percentage of respondents
Resident doctors	62%
Nurses	47%
Speciality and associate specialist doctors, registrars or other doctors	38%

Job role	Percentage of respondents
Consultants	22%
Other	18%
Yourself (PA completing the survey)	6%
Other PAs	2%

Table 53: who was involved in the patient safety incidents that you reported? (Follow up question, those that work with PAs included – those that have recently worked with PAs – can select more than one response)

Job role	Percentage of respondents
Nurses	57%
Resident doctors	51%
PAs	42%
Yourself (the healthcare professional completing the survey)	35%
Consultants	33%
Speciality and associate specialist doctors, registrars or other doctors	32%

Job role	Percentage of respondents
Other	10%

Table 54: who have you reported patient safety incidents to? All respondents (PAs and those that have recently worked with PAs) who have reported a patient safety incident (Select all that apply)

Job role	Percentage of respondents
Organisation leadership	56%
Consultant	45%
Other	16%
General practitioner	14%
Freedom to Speak Up Guardian or other whistleblowing support role	10%
Datix	6%

8.6 Describe any changes to the PA role – or the way this role is integrated into multidisciplinary teams – that you feel would help increase patient safety.

This was an open question, and the significant themes identified in the responses are listed below.

PAs in primary care listed:

- support for newly qualified PAs: providing adequate support, supervision, and compulsory preceptorship training for newly qualified PAs
- enhanced training and education: improving training, education, and continuous development opportunities for PAs to enhance their skills and knowledge

- clear role definition: clearly defining the PA role and scope of practice to ensure effective contribution to patient care
- increased autonomy with safeguards: granting PAs more autonomy in prescribing medications and ordering diagnostic tests within a regulated framework
- public and patient awareness: increasing awareness about the PA role among the public and patients

Those that have recently worked with PAs in primary care listed:

- concerns about PA role: there are significant concerns that the PA role increases risk, does not add unique value, and should be limited to assistant duties or removed from the healthcare system
- close supervision of PAs: PAs should work under close and structured supervision by senior doctors, including dedicated supervision time and regular debriefs, to ensure patient safety
- PAs in administrative roles: PAs should focus on administrative and supportive tasks to allow doctors to concentrate on clinical duties and improve overall patient safety
- clear role parameters for PAs: there should be clear, nationally enforced role parameters and limitations for PAs based on their training and qualifications, ensuring they do not see undifferentiated patients
- enhanced training for PAs: PAs should receive more extensive and ongoing training, including postgraduate training and specialised training within specific roles, to ensure they are adequately prepared for their tasks

PAs in secondary care listed:

- national regulation for PAs: defining a clear scope of practice and ensuring national regulation for PAs to promote accountability and protect patients
- prescribing and imaging rights for PAs: granting PAs the ability to prescribe medications and request imaging tests to improve efficiency and reduce delays in patient care
- improving PA role awareness: enhancing awareness and education about the PA role within multidisciplinary teams to improve communication and task delegation
- uniform and role differentiation: implementing changes to uniform and clear role differentiation to help staff and patients distinguish between PAs and doctors

- structured onboarding for PAs: implementing structured onboarding and team integration processes to support safe and efficient collaboration

Those that have recently worked with PAs in secondary care listed:

- limit scope of practice: PAs should have a limited scope of practice, focusing on administrative tasks, scribing, and basic procedures, without engaging in clinical decision-making or independent patient assessments
- abolish PA role: the PA role should be completely abolished due to concerns about inadequate training, patient safety, and redundancy
- defined scope of practice: a clearly defined and limited scope of practice for PAs is essential, focusing on specific tasks and avoiding complex procedures or undifferentiated patient care
- national standardisation and regulation: there should be national standardisation of the PA course, strict guidelines, and a clearly defined scope of practice to ensure PAs do not perform tasks beyond their training
- adequate supervision: PAs should work under close supervision by senior doctors or consultants to ensure patient safety and proper oversight

9 Regulation

9.1 What impact do you expect the General Medical Council's regulation of PAs to have on the safety of the PA role?

Table 55: what impact do you expect the General Medical Council's regulation of PAs to have on the safety of the PA role? (PAs and those that have recently worked with PAs)

Impact of regulation	PA	Consultant	GP (including GP speciality trainees)	Resident doctor, including foundation years	Specialty and associate specialist doctor	Other	All roles
Very positive impact	61%	13%	9%	4%	9%	37%	20%
Some positive impact	31%	23%	18%	10%	13%	21%	18%

Impact of regulation	PA	Consultant	GP (including GP speciality trainees)	Resident doctor, including foundation years	Specialty and associate specialist doctor	Other	All roles
Neither positive nor negative impact	5%	21%	23%	24%	22%	15%	19%
Some negative impact	1%	9%	11%	14%	14%	6%	10%
Very negative impact	1%	25%	29%	38%	32%	14%	26%
Unsure	2%	9%	10%	9%	10%	7%	8%

9.2 What impact do you expect the General Medical Council's regulation of PAs to have on the support that PAs receive in their roles?

Table 56: what impact do you expect the General Medical Council's regulation of PAs to have on the support that PAs receive in their roles? (PAs and those that have recently worked with PAs)

Impact of regulation	PA	Consultant	GP (including GP speciality trainees)	Resident doctor, including foundation years	Specialty and associate specialist doctor	Other	All roles
Very positive impact	38%	11%	8%	4%	9%	28%	14%

Impact of regulation	PA	Consultant	GP (including GP speciality trainees)	Resident doctor, including foundation years	Specialty and associate specialist doctor	Other	All roles
Some positive impact	38%	23%	19%	12%	20%	27%	21%
Neither positive nor negative impact	18%	31%	31%	34%	30%	20%	29%
Some negative impact	2%	7%	7%	9%	9%	4%	7%
Very negative impact	1%	15%	17%	20%	16%	8%	14%
Unsure	3%	13%	18%	21%	16%	13%	15%

9.3 What impact do you expect the General Medical Council's regulation of PAs to have on the perception of PAs within the medical profession?

Table 57: what impact do you expect the General Medical Council's regulation of PAs to have on the perception of PAs within the medical profession? (PAs and those that have recently worked with PAs)

Impact of regulation	PA	Consultant	GP (including GP speciality trainees)	Resident doctor, including foundation years	Specialty and associate specialist doctor	Other	All job roles
Very positive impact	32%	7%	6%	3%	6%	24%	12%
Some positive impact	34%	19%	13%	6%	11%	21%	16%
Neither positive nor negative impact	16%	17%	18%	15%	16%	13%	16%
Some negative impact	8%	13%	15%	16%	17%	13%	14%
Very negative impact	6%	38%	41%	51%	45%	22%	36%
Unsure	4%	6%	8%	9%	4%	7%	7%

9.4 What impact do you expect the General Medical Council's regulation of PAs to have on the public perception of the PA role?

Table 58: what impact do you expect the General Medical Council's regulation of PAs to have on the public perception of the PA role? (PAs and those that have recently worked with PAs)

Impact of regulation	PA	Consultant	GP (including GP speciality trainees)	Resident doctor, including foundation years	Specialty and associate specialist doctor	Other	All job roles
Very positive impact	35%	8%	7%	4%	7%	21%	12%
Some positive impact	39%	22%	18%	13%	13%	24%	21%
Neither positive nor negative impact	16%	26%	28%	28%	27%	20%	25%
Some negative impact	4%	11%	11%	12%	11%	11%	10%
Very negative impact	2%	20%	23%	28%	30%	14%	20%
Unsure	4%	13%	13%	16%	13%	10%	12%

9.5 Impact of regulation - collated results by setting

Results broken down by healthcare setting showing those who believe there will be at least some positive impact (selected 'very positive impact' or 'some positive impact') are shown below.

Table 59: respondents expecting at least some positive impact from the General Medical Council's regulation of PAs to have on the public perception of the PA role? By setting (PAs and those that have recently worked with PAs)

Setting	Safety of the role	The support that physician associates receive in the role	Perception of the role within the medical profession	Public perception of the role
Primary care	55%	50%	41%	45%
Secondary care	33%	30%	22%	29%
Mental health trust	32%	35%	26%	25%
Other	61%	43%	41%	47%
All settings	38%	35%	27%	33%

9.6 Impact of regulation - by length of time since last worked with PAs

As additional analysis of the above questions regarding the impact of GMC regulation the report also provides data breaking down responses based on the length of time since respondents last worked in a service where PAs were part of the multidisciplinary team.

This table only includes non-PA respondents, who answered that there would be 'some' or 'very' positive impact from GMC regulation on each of the identified factors.

Figure 18: do respondents expect GMC regulation on defined factors (only non-PA respondents answering at least 'some' positive impact)

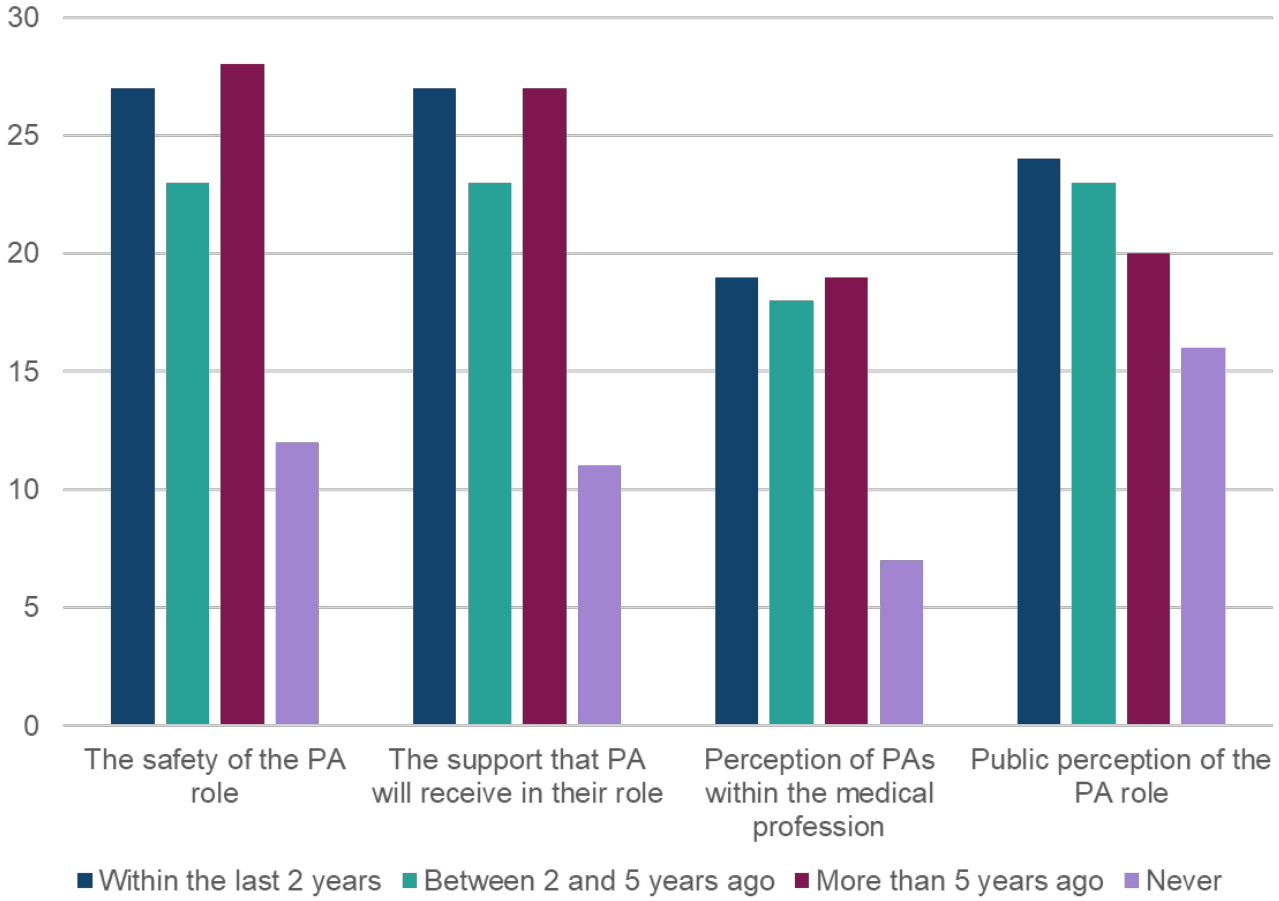

Table 60: do respondents expect GMC regulation on defined factors (only non-PA respondents answering at least 'some' positive impact)

	Between 2 and 5 years ago	**More than 5 years ago**	**Never**	**Within the last 2 years**	**All Respondents**
The safety of the PA role	23%	28%	12%	27%	27%
The support that PA will receive in their role	23%	27%	11%	27%	26%

	Between 2 and 5 years ago	More than 5 years ago	Never	Within the last 2 years	All Respondents
Perception of PAs within the medical profession	18%	19%	7%	19%	19%
Public perception of the PA role	23%	20%	16%	24%	24%

9.7 Please provide any detail regarding your expectations on the General Medical Council's regulation

This was an open question, and the significant themes identified in the responses are listed below.

PAs in primary care listed:

- increased public confidence: GMC regulation will enhance public confidence in PAs by ensuring they meet specific standards, thereby improving patient safety
- professional accountability: regulation provides professional accountability, legitimacy, and standardised competency for the PA role
- impact on PA role safety: concerns about how GMC regulation will affect the safety, support, and scope of the PA role
- improving perceptions: GMC regulation is expected to improve public and professional perception of PAs, countering negative narratives and stigma
- career advancement: regulation will offer PAs clearer career pathways, job security, and opportunities for advancement within the healthcare system

Those that have recently worked with PAs in primary care listed:

- public and professional perception: GMC regulation may mislead the public into thinking PAs are equivalent to doctors, causing confusion and potentially compromising patient safety

- concerns about GMC's effectiveness: scepticism exists about the GMC's ability to effectively regulate PAs, with concerns about its independence, potential government influence, and trustworthiness
- alternative regulatory body: PAs should be regulated by a different body, such as the Health and Care Professions Council rather than the GMC
- clear scope of practice needed: a clearly defined and robust scope of practice for PAs is essential for safe and effective regulation and practice
- negative impact on patient safety: concerns that GMC regulation of PAs could negatively impact patient safety due to perceived equivalence with doctors and lack of clear guidelines

PAs in secondary care listed:

- enhanced public perception: regulation aims to improve the perception of PAs among the public and medical community, despite concerns about media influence
- improved accountability and safety: regulation ensures PAs are held accountable for their actions, enhancing patient safety and public assurance
- improved workplace relationships: regulation is expected to enhance relationships between PAs and doctors, ensuring adequate training and support, though concerns about bullying remain
- defined scope and standards: regulation provides clear guidelines for the scope of practice, prescribing rights, and ensures consistent national standards
- mixed support among doctors: support for PAs varies across trusts, with concerns about professional protectionism and resentment from doctors

Those that have recently worked with PAs in secondary care listed:

- inappropriate regulatory body: the GMC is not the appropriate body to regulate PAs and should focus solely on doctors, with the HCPC being a preferred alternative
- GMC ineffectiveness and trust issues: there is a lack of trust in the GMC's ability to effectively regulate PAs, with concerns about corruption, racism, government influence, and overall inefficacy
- public perception and confusion: regulating PAs under the GMC will cause public confusion, making people think PAs are doctors and blurring professional boundaries. There is concern that GMC regulation will mislead the public into believing PAs have the same qualifications and responsibilities as doctors

- need for clear differentiation between doctors and PAs: there needs to be clear differentiation between doctors and PAs to avoid confusion and ensure patient safety, as current regulation blurs professional boundaries
- GMC's failure to define scope and practice: the GMC has failed to define the scope of practice for PAs, leading to confusion and ineffective regulation

10 Any other comments that respondents felt might be useful to the Leng review

This was an open question, and the significant themes identified in the responses are listed below.

PAs in primary care listed:

- support and empowerment for PAs: PAs need adequate supervision, support, and empowerment to function effectively, ensuring their mental health, team dynamics, and patient safety
- supportive work environment: ensure a supportive and safe work environment for PAs, free from toxicity, institutional bullying, and negative media coverage
- public and professional perception of PAs: improve public awareness and professional support for PAs to clarify their qualifications, scope of practice, and contributions to patient care
- positive impact of PAs: recognise that PAs provide safe, effective care and are valuable members of clinical teams, positively impacting patient care and reducing workload for doctors
- career progression for PAs: consider routes for experienced PAs to transition into medicine, including bridge programs, upskilling opportunities, and financial support for retraining

Those that have recently worked with PAs in primary care listed:

- support and respect: PAs should be supported and respected in their role, with clear guidance and regulation to address the anti-PA narrative
- need for regulation: structured governance, regulation, and oversight are needed to ensure patient safety and maintain professional standards for PAs
- supervision challenges: providing adequate supervision and integration for PAs, especially in primary care, is challenging and can lead to inefficiencies and safety concerns

- call for evidence-based review: there is a call for an evidence-based review of the PA role to assess its impact on patient care, healthcare quality, and the training of medical professionals
- economic considerations: concerns about the cost-effectiveness of employing PAs, with suggestions to redirect funds towards training and employing more doctors

PAs in secondary care listed:

- impact of negative media: negative media portrayal and bullying have significantly impacted the mental health and job security of PAs
- positive impact of PAs: PAs are valuable members of the healthcare team, providing continuity of care and improving patient outcomes
- proper implementation and support: effective utilisation of PAs requires proper implementation, support, and supervision
- mental health and wellbeing: negative press and hostile work environments have significantly impacted the mental health of PAs
- survey validity and integrity: concerns about the validity and integrity of the survey, including potential bias in data collection

Those that have recently worked with PAs in secondary care listed:

- concerns about PA training quality and patient safety: significant concerns exist about the quality of PA training and potential risks to patient safety due to their limited training compared to doctors
- need for role clarity and regulation: clear role definitions, regulatory bodies, and appropriate oversight for PAs are necessary to ensure accountability and proper integration into the healthcare system
- call for discontinuation of PA role: the PA role should be discontinued due to safety risks, negative impact on medical training, and perceived redundancy
- regulation and supervision: stricter regulation and supervision of PAs are demanded to ensure they work within their competence and training
- cost-effectiveness and resource allocation: doubts exist about the cost-effectiveness of employing PAs, with suggestions that resources could be better spent on training more doctors

Anaesthesia associate (AA) survey

1 Background questions

1.1 Job role of respondents

The table below shows the number of respondents selecting different job role.

As stated in the 'notes on the data section' at the start of this report, partway through data collection, the job role options were updated. The ‘anaesthetist’ option was replaced with ‘consultant’ because feedback was received that ‘anaesthetist’ was a confusing term that could apply to doctors at different career stages. It is not accurate to combine the responses from these 2 separate options, so they have been presented separately in the results. Readers of the report should note that the ‘anaesthetist’ category likely contains a mix of job roles, while the ‘consultant’ category does not.

Table 61: do you work (currently or previously) as one of the following? (Select the most relevant)

Job role	**Respondents**
AA	131
Anaesthetist	229
Consultant	726
Resident doctor, including foundation years	376
Specialty and associate specialist doctor	115
Other	117

The table below contains a breakdown of the 117 respondents who selected ‘other’ as their job roles.

Table 62: breakdown of those who selected 'other' for the question 'Do you work (currently or previously) as one of the following? (Select the most relevant)'

Role	**Count**
Operating department and other healthcare practitioners	51
Nursing	27
Medical student and trainees	6
Surgeon	5
Healthcare assistant	4
Others	24

1.2 Healthcare setting

Respondents were asked 2 questions about healthcare setting depending on the respondent's job role, which are considered together in the tables below. The questions were:

- AAs: In which healthcare setting do you work?
- Other healthcare professionals: In which healthcare setting did you most recently work in a team with AAs? (If not relevant, please enter your current setting)

Table 63: healthcare setting most relevant to respondents

Healthcare setting	Respondents
Secondary care	1,601
Other	93

1.3 Region (service)

Respondents were asked 2 questions about region depending on the respondent's job role, which are considered together in the table below. The questions were:

For AAs: In which region is the service where you most recently worked as a PA based? (Select all that apply)

For other healthcare professionals: In which region is the service where you most recently worked with AAs based? (Select all that apply)

Table 64: region of respondents to the AA survey

Region	% of respondents
East Midlands	6%
East of England	9%
London	15%
North East England	5%
North West England	12%

Region	% of respondents
South East England	8%
South West England	10%
West Midlands	12%
Yorkshire and the Humber	11%
Scotland	9%
Wales	3%

1.4 When did you last work in a healthcare setting where AAs were part of the multidisciplinary team?

Table 65: when did you last work in a healthcare setting where AAs were part of the multidisciplinary team?

Answer	Respondents
Within the last 2 years	72%
Between 2 and 5 years ago	7%
More than 5 years ago	6%
Never	15%

The tables in this background section include the numbers of all respondents, not just those who had only worked with an AA within the last 5 years.

2 Initial training and development

2.1 When did you qualify as an AA?

Table 66: when did you qualify as an AA?

Answer	Respondents
Within the last 2 years	42%
Between 2 and 5 years ago	8%
More than 5 years ago	50%

2.2 Before becoming an AA did you have any experience working in a health or care role or setting?

Table 67: before becoming an AA did you have any experience working in a health or care role or setting?

Answer	Respondents
Yes	89%
No	11%

2.3 What other roles in a health or care setting did you hold before training to become an AA?

Respondents who had stated they had previous experience in a health or care setting prior to training as an AA provided information on their previous roles. Of a total of 117 respondents who had previous experience, 113 provided details.

Responses have been combined into the groups in the table below. Duration of previous experience was not provided.

Table 68: what other roles in a health or care setting did you hold before training to become an AA? (only respondents with previous roles, excluding blank responses)

Role	Number of respondents
Operating department practitioner	72
Nursing	31
Paramedic	4
AA in other country	1
Theatre support worker	1
Other	4
Total	113

3 Day to day activities of AAs

3.1 How often do AAs in your service conduct these activities?

Respondents were asked how often AAs within their service conduct a list of defined activities. The table below compares the percentage of respondents who said ‘daily’ for each activity.

As flagged in the 'note on the data' section above, after initial launch of the survey the review updated the descriptive text in the ‘Day-to-day practice of PAs/AAs’ sections of the surveys to clarify that the questions applied to both frequency of current practice and

appropriateness for future practice. All responses were included for analysis and the impact of the changes has been considered when interpreting the results.

Table 69: percentage of respondents (AAs and those that have recently worked with AAs) that answered 'daily' to how often AAs in their service conduct these activities?[4]

Activity	All roles	AA	Anaesthetist	Consultant	Resident doctor	Specialty and associate specialist doctor	Other
Review patients prior to surgery and assess them for anaesthesia	82%	96%	84%	82%	77%	80%	83%
Take medical histories and clinical assessments, allowing for an anaesthesia plan to be created	82%	99%	83%	82%	76%	78%	83%
Induce, maintain and/or wake up patients	82%	99%	82%	80%	75%	78%	89%

[4] Each activity included a 'not applicable' option - examples of where this may have been selected may include where an activity was not relevant to the service or speciality relevant to the respondent. The 'not applicable' responses have been excluded when calculating these percentages. The calculation did include any respondents who selected 'not sure'.

Activity	All roles	AA	Anaesthetist	Consultant	Resident doctor	Specialty and associate specialist doctor	Other
from anaesthesia under appropriate supervision							
Initiate and manage medications, fluid and blood therapy during surgery under supervision	76%	98%	74%	72%	74%	67%	84%
Ensure there is a plan for patients following their operation and that it is carried out	65%	86%	69%	62%	61%	52%	72%
Support innovation, audit and research	13%	16%	9%	13%	9%	15%	26%

Activity	All roles	AA	Anaesthetist	Consultant	Resident doctor	Specialty and associate specialist doctor	Other
Teach, supervise and assess other team members	17%	16%	16%	14%	15%	20%	34%
Interpret and monitor clinical readings and patients' parameters and respond appropriatel y	81%	98%	80%	80%	74%	72%	91%
Identify potential issues during surgery and anaesthesia, take action and seek appropriate support when required	69%	93%	67%	70%	57%	57%	82%
Use anaesthesia	83%	98%	79%	82%	80%	77%	90%

Activity	All roles	AA	Anaesthetist	Consultant	Resident doctor	Specialty and associate specialist doctor	Other
techniques and agents, medications and specialist equipment							
Prescribe medications	21%	3%	22%	17%	33%	24%	20%
Order ionising radiation	2%	1%	4%	3%	2%	3%	2%

For additional analysis we have broken down the results of this question to show the breakdown of these results for AA respondents and those from all other roles.

Figure 19: percentage of respondents (AAs and those that have recently worked with AAs) that answered 'daily' to how often AAs in their service conduct specific activities

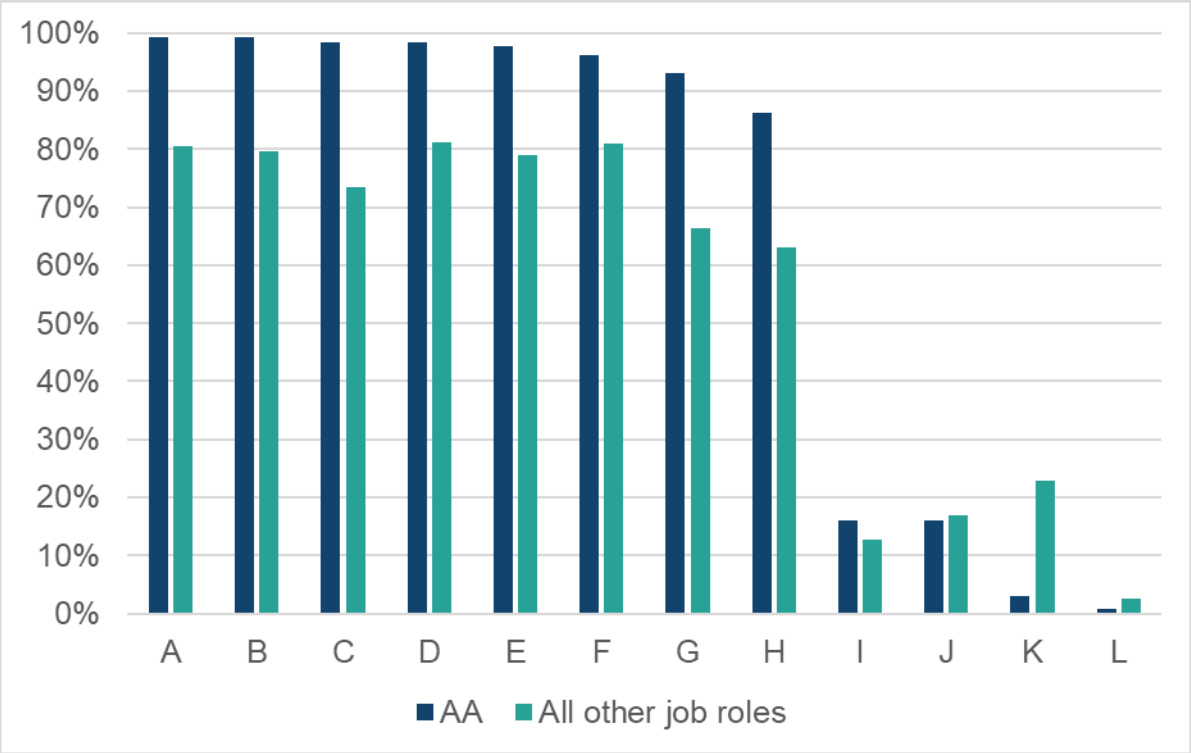

Table 70: percentage of respondents (AAs and those that have recently worked with AAs) that answered 'daily' to how often AAs in their service conduct specific activities

Activity	**Letter (in reference to figure 19)**	**AAs**	**Other**
Take medical histories and clinical assessments, allowing for an anaesthesia plan to be created	A	99%	80%
Induce, maintain and/or wake up patients from anaesthesia under appropriate supervision	B	99%	80%
Initiate and manage medications, fluid and blood therapy during surgery under supervision	C	98%	73%

Activity	Letter (in reference to figure 19)	AAs	Other
Use anaesthesia techniques and agents, medications and specialist equipment	D	98%	81%
Interpret and monitor clinical readings and patients' parameters and respond appropriately	E	98%	79%
Review patients prior to surgery and assess them for anaesthesia	F	96%	81%
Identify potential issues during surgery and anaesthesia, take action and seek appropriate support when required	G	93%	66%
Ensure there is a plan for patients following their operation and that it is carried out	H	86%	63%
Support innovation, audit and research	I	16%	13%
Teach, supervise and assess other team members	J	16%	17%
Prescribe medications	K	3%	23%
Order ionising radiation	L	1%	3%

3.2 Do you believe it is appropriate for AAs to conduct these activities?

Respondents were asked a follow up question about whether they believed the same activities were appropriate for AAs to conduct. The table below compares the percentage of respondents who said ‘yes’ for each activity.[5]

As flagged in the 'note on the data' section above, after initial launch of the survey the review updated the descriptive text in the ‘Day-to-day practice of PAs/AAs’ sections of the surveys to clarify that the questions applied to both frequency of current practice and appropriateness for future practice. All responses were included for analysis and the impact of the changes has been considered when interpreting the results.

Table 71: percentage of respondents (AAs and those that have recently worked with AAs) that answered 'yes' to whether they feel the following activities are appropriate for anaesthesia associates to conduct

Activity	All job roles	AA	Anaesthetist	Consultant	Resident doctor, including foundation years	Specialty and associate specialist doctor	Other
Review patients prior to surgery and assess them for anaesthesia	49%	97%	26%	62%	14%	35%	79%
Take medical histories and clinical assessments, allowing for an anaesthesia plan to be created	48%	98%	22%	60%	14%	36%	76%

[5] It is not assumed that all other respondents believed an activity was not appropriate for PAs to conduct. The answer options were: 'yes', 'no' and 'unsure'.

Activity	All job roles	AA	Anaesthetist	Consultant	Resident doctor, including foundation years	Specialty and associate specialist doctor	Other
Induce, maintain and/or wake up patients from anaesthesia under appropriate supervision	47%	98%	25%	59%	12%	29%	75%
Initiate and manage medications, fluid and blood therapy during surgery under supervision	42%	98%	19%	52%	9%	27%	70%
Ensure there is a plan for patients following their operation and that it is carried out	44%	90%	24%	52%	16%	28%	73%
Support innovation, audit and research	64%	98%	51%	70%	46%	48%	78%

Activity	All job roles	AA	Anaesthetist	Consultant	Resident doctor, including foundation years	Specialty and associate specialist doctor	Other
Teach, supervise and assess other team members	34%	94%	10%	40%	5%	23%	68%
Interpret and monitor clinical readings and patients' parameters and respond appropriately	51%	98%	29%	62%	19%	33%	82%
Identify potential issues during surgery and anaesthesia, take action and seek appropriate support when required	52%	98%	34%	64%	21%	34%	78%
Use anaesthesia techniques and agents, medications and specialist	45%	98%	22%	57%	10%	27%	76%

Activity	All job roles	AA	Anaesthetist	Consultant	Resident doctor, including foundation years	Specialty and associate specialist doctor	Other
equipment							
Prescribe medications	28%	73%	12%	33%	5%	20%	44%
Order ionising radiation	14%	46%	4%	17%	3%	10%	13%

As flagged in the 'note on the data' section above, after initial launch of the survey the review updated the descriptive text in the ‘Day-to-day practice of PAs/AAs’ sections of the surveys to clarify that the questions applied to both frequency of current practice and appropriateness for future practice. All responses were included for analysis and the impact of the changes has been considered when interpreting the results.

Figure 20: percentage of respondents (AAs and those that have recently worked with AAs) answering 'yes' to whether they believe activities are appropriate for AAs to conduct

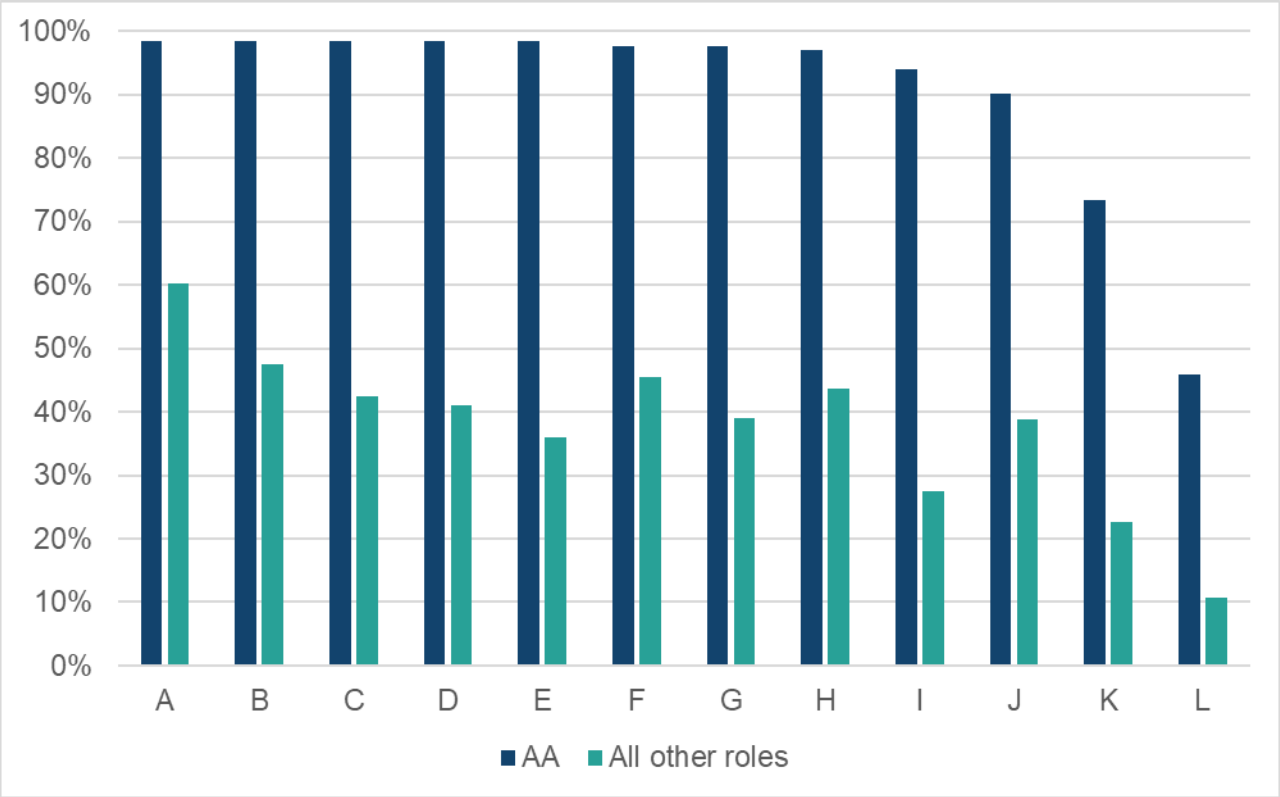

Table 72: percentage of respondents (AAs and those that have recently worked with AAs) answering 'yes' to whether they believe activities are appropriate for AAs to conduct

Activity	**Letter (in reference to figure 20)**	**AA**	**Other roles**
Support innovation, audit and research	A	98%	60%
Identify potential issues during surgery and anaesthesia, take action and seek appropriate support when required	B	98%	47%
Take medical histories and clinical assessments, allowing for an anaesthesia plan to be created	C	98%	42%

Activity	Letter (in reference to figure 20)	AA	Other roles
Induce, maintain and/or wake up patients from anaesthesia under appropriate supervision	D	98%	41%
Initiate and manage medications, fluid and blood therapy during surgery under supervision	E	98%	36%
Interpret and monitor clinical readings and patients' parameters and respond appropriately	F	98%	46%
Use anaesthesia techniques and agents, medications and specialist equipment	G	98%	39%
Review patients prior to surgery and assess them for anaesthesia	H	97%	44%
Teach, supervise and assess other team members	I	94%	27%
Ensure there is a plan for patients following their operation and that it is carried out	J	90%	39%
Prescribe medications	K	73%	23%
Order ionising radiation	L	46%	11%

3.3 Please describe any other activities that AAs in your service carry out

The significant themes identified in the qualitative answers to this question are listed below.

AAs listed:

- regional anaesthesia techniques: AAs perform various regional anaesthesia techniques, including spinal anaesthesia, peripheral nerve blocks, and sub-tenon blocks, though some practices have been recently restricted
- vascular access services: AAs support vascular access services by inserting PICC lines, midlines, and other invasive monitoring lines
- pre-operative assessments: AAs conduct pre-operative assessments, review patient notes, and formulate care plans under supervision
- sedation services: AAs provide sedation for various procedures, including TAVI implantation and burns patients, with deep sedation under consultant support
- training and education: AAs engage in simulation training, informal training of ODP/ODP students, teaching theatre team members, and providing ILS and ALS training

Those who have recently worked with AAs listed:

- specialised services: AAs provide specialised services such as eye blocks, lumbar punctures, Biers Block, and regional anaesthesia techniques including spinal anaesthesia and nerve blocks
- vascular access: AAs perform vascular access procedures, including PICC line insertion, advanced vascular access devices, and central venous catheter placement
- concerns about supervision: there are significant concerns about the level of supervision, scope of practice, and patient safety regarding AAs
- invasive procedures: AAs perform invasive procedures such as line insertion, regional anaesthesia, and intubation
- pre-operative assessment: AAs are involved in pre-operative assessments, including diagnostic procedures and preoperative IV iron therapy, providing comprehensive patient care under appropriate supervision

3.4 Are there other activities that could be assigned to AAs?

Table 73: are there additional activities that you feel your service could assign to AAs? (AAs and those that have recently worked with AAs)

Job role	Yes	No	Unsure
AA	63%	9%	27%
Anaesthetist	23%	71%	6%
Consultant	34%	49%	17%
Resident doctor, including foundation years	14%	78%	9%
Specialty and associate specialist doctor	20%	66%	14%
Other	22%	38%	40%
All job roles	29%	55%	16%

Respondents who answered 'yes' to this question were asked which additional activities could be assigned to PAs. The significant themes identified in the responses are listed below.

AAs listed:

- regional anaesthesia tasks: assigning AAs to perform regional anaesthesia tasks, including nerve blocks, limb blocks, and peripheral nerve blocks under supervision
- vascular access procedures: involving AAs in vascular access procedures, including PICC lines, midline/peripheral access, and difficult cannulation services
- preoperative assessment services: utilising AAs for preoperative assessment services and clinics to optimize surgery preparation and prevent cancellations

- prescribing rights for AAs: allowing AAs to prescribe medications through non-medical prescribing courses and authorise blood products
- on-call support by AAs: AAs assisting with the on-call rota, providing out-of-hours cover, and supporting resident anaesthetists

Those who have recently worked with AAs listed:

- regional anaesthesia techniques: providing regional anaesthesia techniques such as nerve blocks, spinals, chest wall analgesic blocks, and pain relief services under supervision
- vascular access procedures: performing vascular access procedures including cannulation, midlines, PICC lines, central access lines, and supporting vascular access teams
- pre-operative and post-operative care: conducting pre-operative assessments, clinics, post-operative follow-ups, and triage to ensure patient readiness and continuity of care
- non-clinical and administrative duties: performing non-clinical duties such as teaching, management, quality improvement projects, and handling administrative tasks
- research, audit, and teaching activities: participating in research, audit activities, data collection, service development, and teaching residents, consultants, and trainees

3.5 Are there any activities respondents are uncomfortable about AAs conducting?

AAs and those in other job roles were asked different versions of this question:

- AA question: Are there any activities that you currently conduct that you feel uncomfortable about carrying out? (This could include activities you think are potentially unsafe)
- Question for other job roles: Are there any elements of work that you feel uncomfortable about AAs carrying out? (This could include activities you think are potentially unsafe for AAs to conduct)

The answers to these questions have been combined in the analysis below.

Table 74: are respondents (AAs and those that have recently worked with AAs) uncomfortable about carrying out any tasks?

Job role	**Yes**	**No**	**Unsure**
AA	3%	93%	4%
Anaesthetist	88%	9%	4%
Consultant	67%	26%	7%
Resident doctor, including foundation years	95%	3%	2%
Specialty and associate specialist doctor	74%	19%	7%
Other	30%	67%	4%

Additional analysis below compares the responses from all non-AA respondents by how recently they last worked in a setting where AAs were part of the multidisciplinary team.

Figure 21: are there any elements of work that you feel uncomfortable about AAs carrying out? (This could include activities you think are potentially unsafe for AAs to conduct) - split by length of time since last worked in a setting where AAs were part of the multidisciplinary team

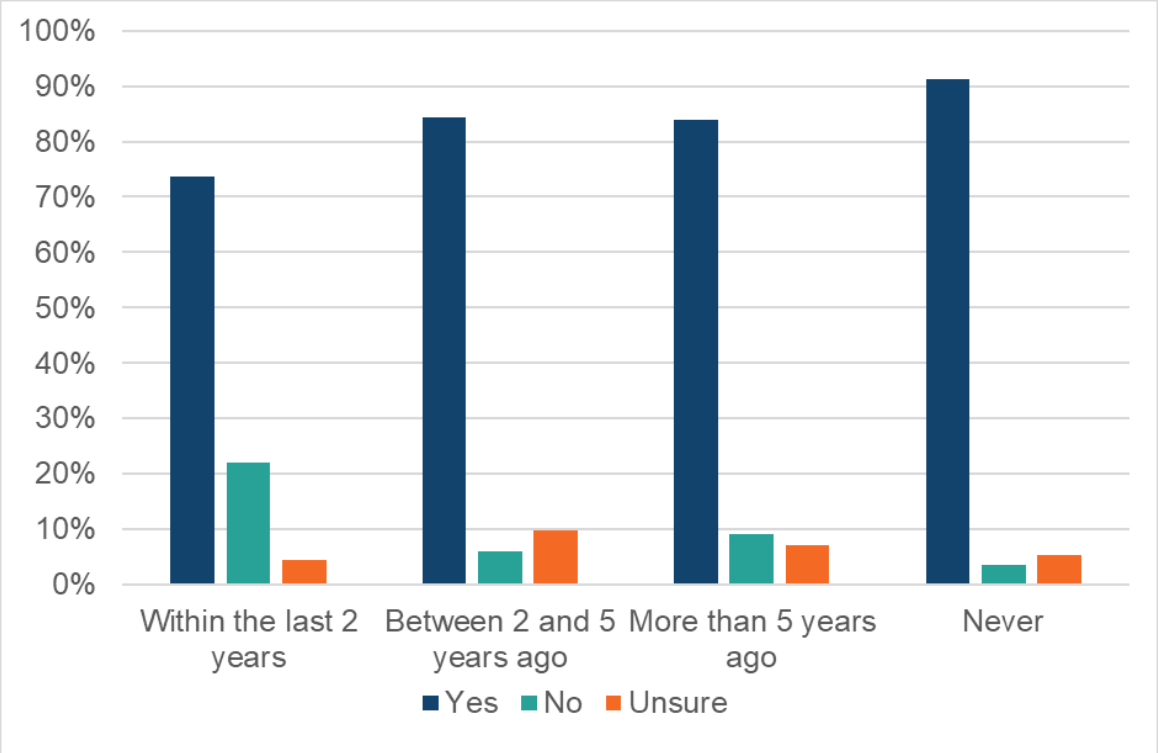

Table 75: are there any elements of work that you feel uncomfortable about AAs carrying out? (This could include activities you think are potentially unsafe for AAs to conduct) - split by length of time since last worked in a setting where AAs were part of the multidisciplinary team

Time since last worked with AAs	**Yes**	**No**	**Unsure**
Within the last 2 years	74%	22%	4%
Between 2 and 5 years ago	84%	6%	10%
More than 5 years ago	84%	9%	7%

Time since last worked with AAs	Yes	No	Unsure
Never	91%	3%	5%
All respondents	78%	17%	5%

Respondents who answered 'yes' were asked which activities they were uncomfortable with AAs conducting. The significant themes identified in the responses are listed below.

AAs listed:

- lack of support and relationship issues: concerns about unsupportive colleagues and anaesthetists negatively impacting job performance and satisfaction
- career progression and pay: discomfort due to lack of career advancement and meaningful pay progression for AAs within the Trust
- lack of supervision and support: concerns about insufficient supervision and support, especially for new AAs with limited healthcare experience
- safety concerns with specific procedures: discomfort with performing eye blocks due to a past incident where a patient died

Those that have recently worked with AAs listed:

- inadequate training and regulation: AAs lack adequate training, regulation, and necessary medical knowledge to safely perform their duties
- need for direct supervision: AAs should not work independently and require direct supervision by consultants, especially for complex and high-risk patients
- patient safety and legal issues: patient safety and legal defensibility of AA practices are concerns without proper oversight and training
- impact on trainee opportunities: AAs performing advanced procedures take away valuable training opportunities from anaesthesia residents
- defined role for AAs: the role of AAs should be clearly defined, focusing on tasks that do not require the extensive training of a doctor

4 Identifying AAs

4.1 At your service, are patients told when they are seeing an AA?

Figure 22: are patients told when they are seeing an AA? (AAs and those that have recently worked with AAs)

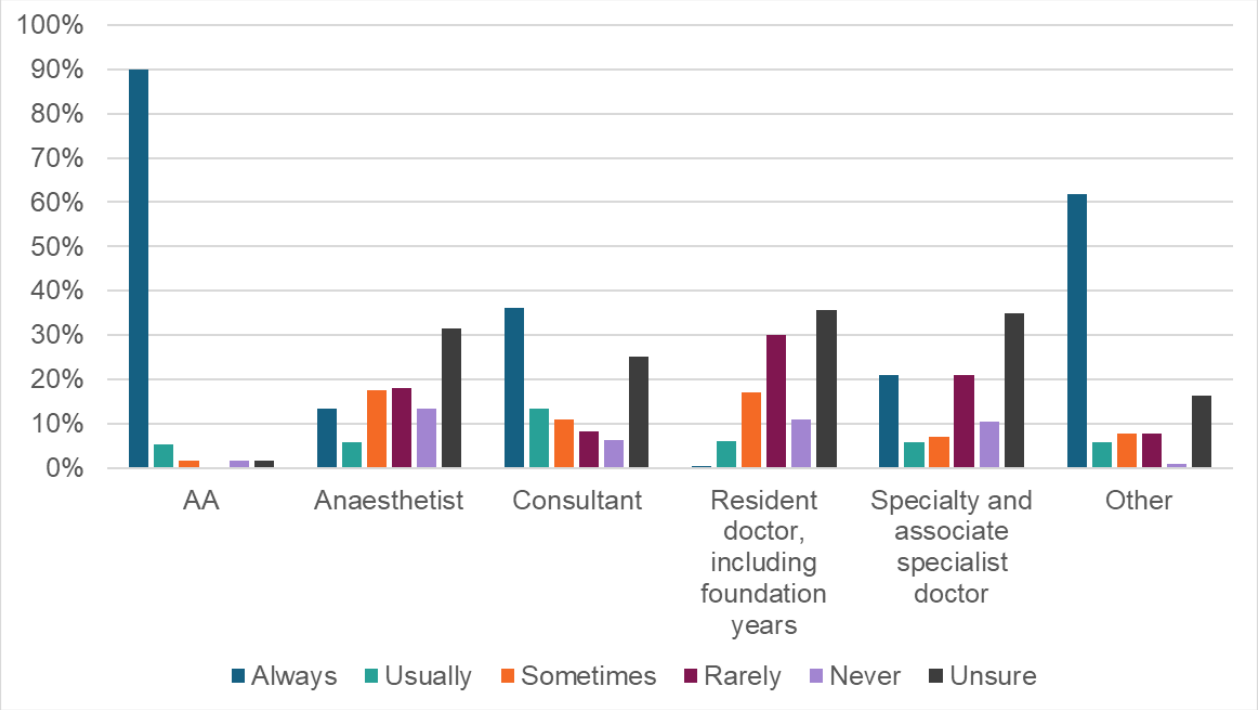

Table 76: at your service, are patients told when they are seeing an AA? (AAs and those that have recently worked with AAs)

Job role	Always	Usually	Sometimes	Rarely	Never	Unsure
AA	90%	5%	2%	0%	2%	2%
Anaesthetist	13%	6%	18%	18%	13%	32%
Consultant	36%	13%	11%	8%	6%	25%
Resident doctor, including foundation	0%	6%	17%	30%	11%	36%

Job role	Always	Usually	Sometimes	Rarely	Never	Unsure
years						
Specialty and associate specialist doctor	21%	6%	7%	21%	10%	35%
Other	62%	6%	8%	8%	1%	16%
All job roles	31%	9%	12%	15%	8%	26%

4.2 How often do AAs in your service wear the following items and/or clothing to identify their role to patients and staff?

To show the overall trend for this question, analysis is presented without breakdown by job role.

Figure 23: how often do AAs in your service wear the following items and/or clothing to identify their role to patients and staff? All respondents (AAs and those that have recently worked with AAs)

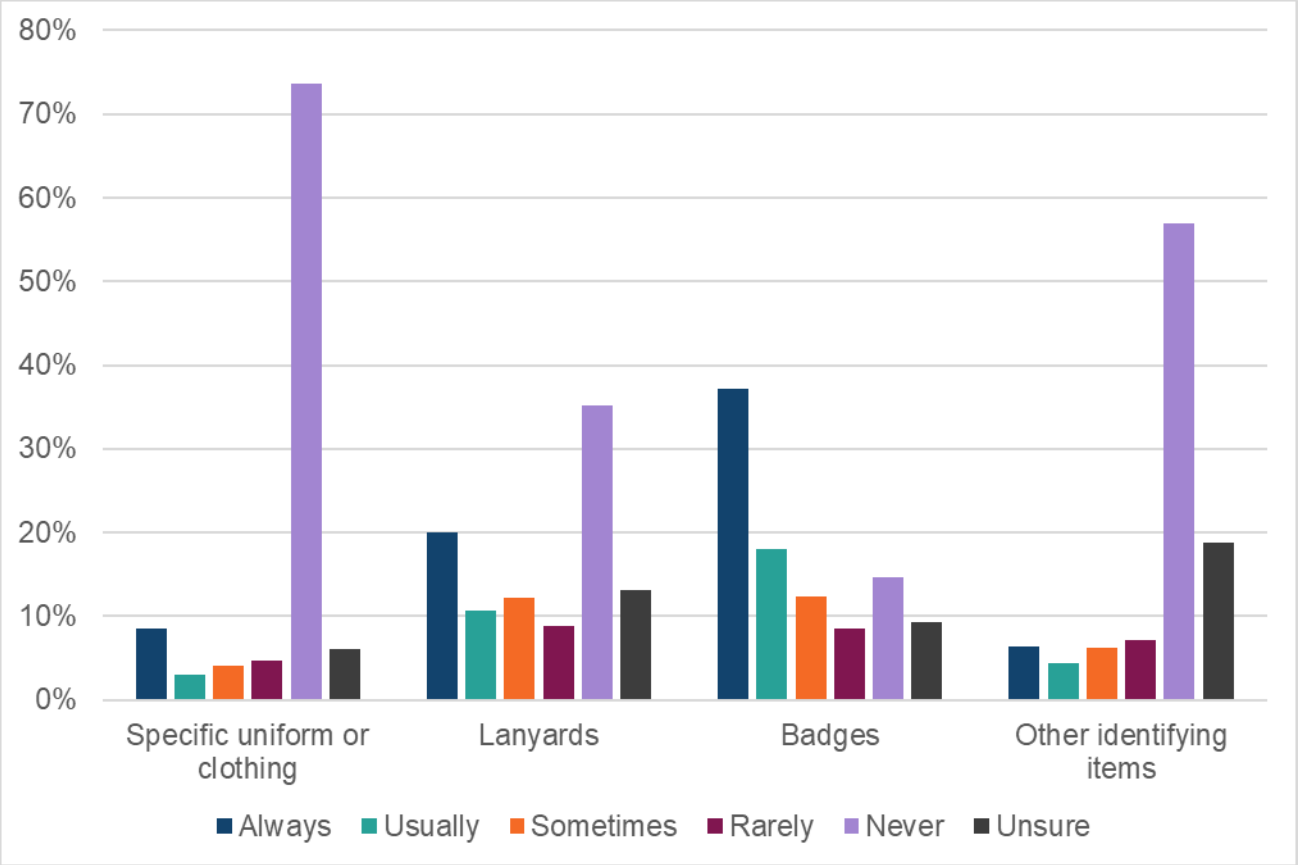

Table 77: how often do AAs in your service wear the following items and/or clothing to identify their role to patients and staff? All respondents (AAs and those that have recently worked with AAs)

Identification method	Always	Usually	Sometimes	Rarely	Never	Unsure
Specific uniform or clothing	9%	3%	4%	5%	74%	6%
Lanyards	20%	11%	12%	9%	35%	13%
Badges	37%	18%	12%	9%	15%	9%

Identification method	Always	Usually	Sometimes	Rarely	Never	Unsure
Other identifying items	6%	4%	6%	7%	57%	19%

Analysis below shows the responses from AAs selecting the 'always' option compared to other healthcare professionals.

Figure 24: respondents (those that have recently worked with AAs) who answered 'always' to the question, 'how often do AAs in your service wear the following items and/or clothing to identify their role to patients and staff?' (AAs and those that have recently worked with AAs)

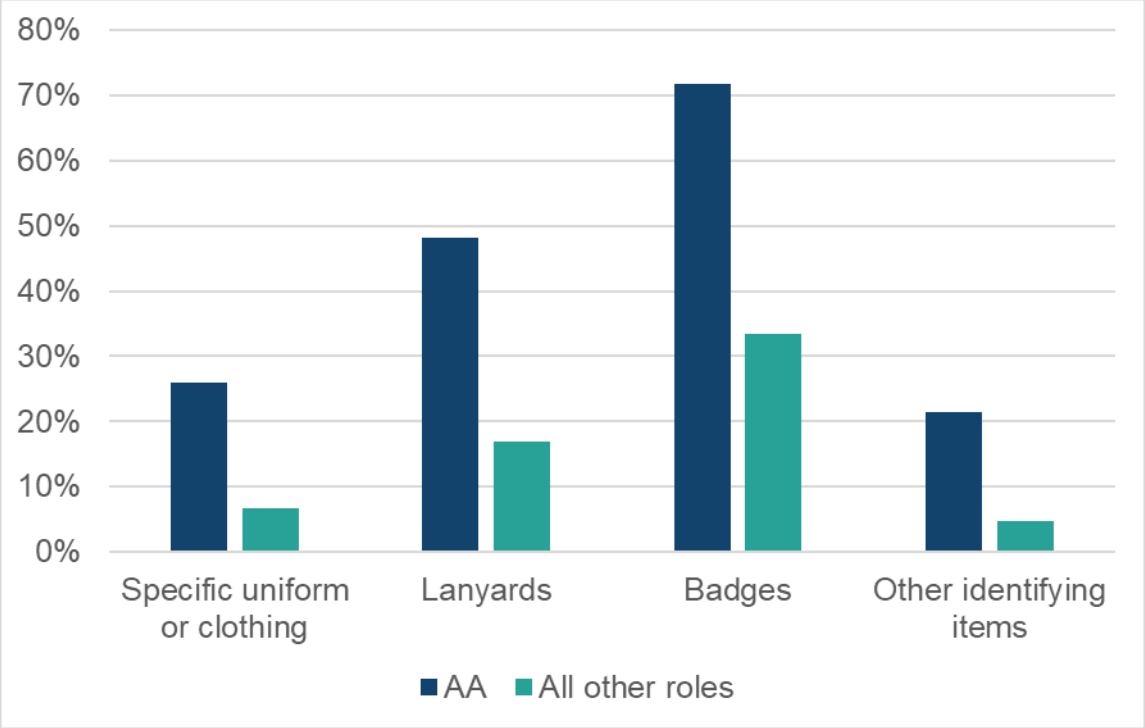

Table 78: respondents (those that have recently worked with AAs) who answered 'always' to the question, 'how often do AAs in your service wear the following items and/or clothing to identify their role to patients and staff?' (AAs and those that have recently worked with AAs)

Identification method	**AA**	**All other roles**
Specific uniform or clothing	26%	7%
Lanyards	48%	17%
Badges	72%	33%
Other identifying items	21%	5%

Respondents who answered 'always', ‘usually’, ‘sometimes’ or ‘rarely’, to the question, 'how often do AA in your service wear the following items and/or clothing to identify their role to patients and staff?' The significant themes identified in the responses are listed below.

AAs listed:

- named and color-coded hats: AAs wear hats that display their name and role, often color-coded to identify different roles
- lanyards and badges: AAs use lanyards and badges that display their name and role for identification
- no specific uniform: due to the requirement to wear scrubs in the theatre, no specific uniform is used

Those that have recently worked with AAs listed:

- name badges and lanyards: AAs use name badges and lanyards to identify themselves, though these are often not easily distinguishable from those of doctors

- patient confusion about roles: patients often do not understand the role of AAs, leading to confusion about whether they are doctors
- indistinguishable from doctors: AAs' identification methods do not sufficiently distinguish them from doctors, causing potential misidentification
- theatre hats with names: AAs wear theatre hats with their name and role clearly visible to identify themselves to patients and staff
- scrubs with names: AAs wear scrubs, sometimes with embroidered names and roles, to be easily identifiable

4.3 Do you agree or disagree that patients in your service understand the role of AAs?

Figure 25: do you agree or disagree that patients in your service understand the role of AAs? All respondents (AAs and those that have recently worked with AAs)

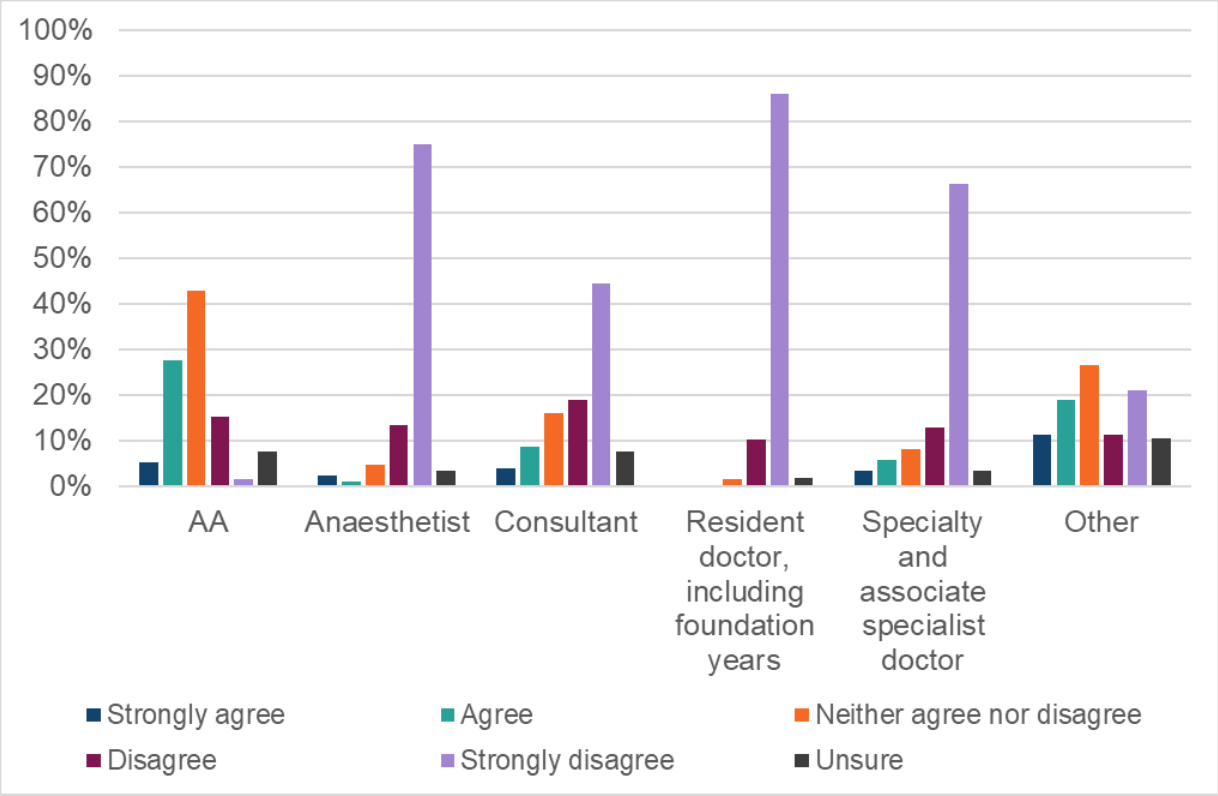

Table 79: do you agree or disagree that patients in your service understand the role of AAs? All respondents (AAs and those that have recently worked with AAs)

Job role	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Unsure
AA	5%	27%	43%	15%	2%	8%
Anaesthetist	2%	1%	5%	13%	75%	4%
Consultant	4%	9%	16%	19%	45%	8%
Resident doctor, including foundation years	0%	0%	2%	10%	86%	2%
Specialty and associate specialist doctor	3%	6%	8%	13%	66%	3%
Other	11%	19%	27%	11%	21%	10%
All job roles	4%	8%	14%	15%	54%	6%

Respondents were asked to provide more detail to support their answer regarding patient understanding of the AA role, including suggestions for how this may be improved. The significant themes are listed below.

AAs listed:

- patient information materials: patients understand the AA role through information leaflets, posters, and banners provided at pre-assessment and around the hospital

- supervised care and consultant collaboration: patients are informed that AAs work under the supervision of a consultant anaesthetist, ensuring quality and safety
- introduction and explanation: AAs introduce themselves and explain their role, including the presence of a supervising consultant, to every patient
- need for better introduction and national awareness campaigns: there is a need for better introduction and explanation of the AA role to patients, including national campaigns to raise public awareness
- qualified and experienced AAs: patients are reassured that AAs are qualified, skilled, experienced, and capable of delivering high-quality anaesthesia care

Those that have recently worked with AAs listed:

- patient confusion about roles: patients often confuse anaesthetic associates with anaesthetists and do not understand the differences in their training and qualifications
- need for clear role explanation: AAs should clearly introduce themselves and explain their role, including their supervision by a consultant anaesthetist, to ensure patients are informed
- public education on AA roles to increase public awareness: there is a general lack of public awareness and information about the role and qualifications of anaesthetic associates. Better public education and explicit communication about the role of anaesthetic associates would help patient understanding
- misleading terminology: the term 'AA' is confusing and misleading, suggesting a higher level of expertise than accurate, and alternative titles like 'anaesthetic assistant' might be clearer
- uniforms and identification: different uniforms or identification methods (such as badges, coloured scrubs) could help patients distinguish between AAs and other medical staff

4.4 What changes do you think healthcare services could make to improve how the AA role is implemented?

This was an open question, and the significant themes identified in the responses are listed below.

AAs listed:

- improved visibility and education: enhancing awareness and understanding of the AA role among staff, patients, and the public through advertising, leaflets, and educational programs

- positive public perception: promoting a positive image of the AA role through advertising, combating misinformation, and emphasising its supportive role to doctors
- increased national support: increasing national support from NHS England, Royal College of Anaesthetists, and other institutions, including funding, regulation, and addressing negative behaviour and misinformation
- enhanced support and guidelines: providing better support for AAs, establishing proper guidelines and SOPs, and ensuring appropriate supervision and collaboration with other healthcare professionals
- expanded scope of practice: allowing AAs to have a less restrictive scope of practice, including prescribing rights, and granting more autonomy to experienced AAs

Those that have recently worked with AAs listed:

- clear role definition: providing a clearly defined scope of practice with strict boundaries and guidelines for AA, ensuring they practice within safe, supervised limits
- effective supervision and training: ensuring effective supervision, clear training standards, and maintaining a logbook to prepare AAs well for integration into services
- public and patient education: increasing public education and patient information about the AA role, including clear communication during the consent process
- specific procedure roles: utilising AA in specific roles such as day case anaesthesia, vascular access, and low-risk procedures under appropriate supervision
- distinct uniforms for identification: using distinct uniforms, such as embroidered scrubs, for AAs to help with role identification and reduce confusion

5 Defining the AA role

5.1 Do you agree or disagree that the role and responsibilities of AAs are clearly defined?

Respondents were asked 2 questions regarding the definition of the roles and responsibilities of AAs:

- Do you agree or disagree that the role and responsibilities of AAs are clearly defined within your organisation?
- Do you agree or disagree that the role and responsibilities of AAs are clearly defined at a national level?

The analysis below presents the responses to these 2 questions.

Figure 26: do you agree or disagree that the role and responsibilities of PAs are clearly defined within your organisation and at national level? Split to show AA and all other job roles (AAs and those that have recently worked with AAs)

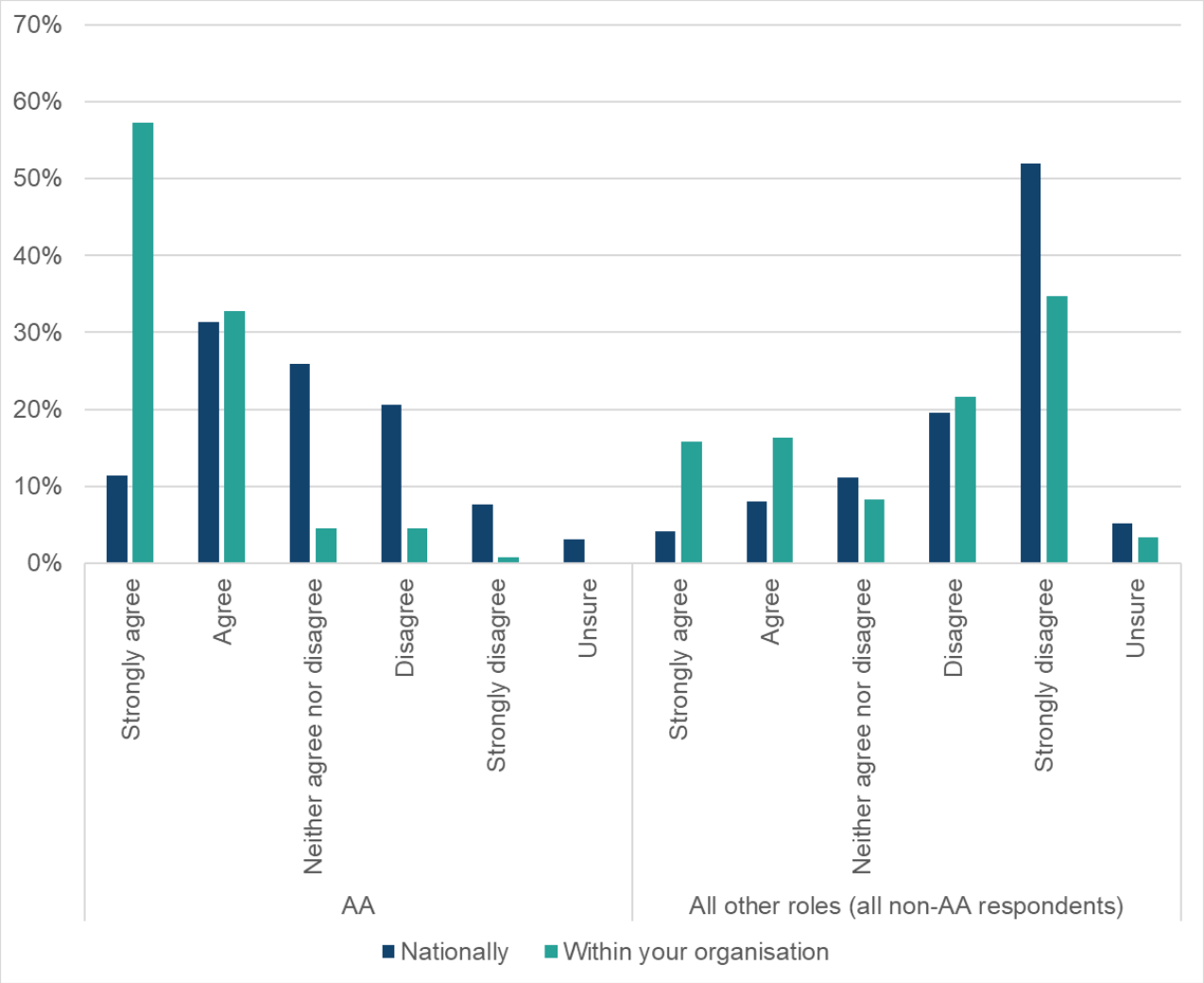

Table 80: do you agree or disagree that the role and responsibilities of AAs are clearly defined within your organisation? Split to show AA and all other job roles (AAs and those that have recently worked with AAs)

Job role	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Unsure
AA	57%	33%	5%	5%	1%	0%

Job role	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Unsure
All other roles (all non-AA respondents)	16%	16%	8%	22%	35%	3%
Anaesthetist	9%	13%	10%	22%	43%	4%
Consultant	24%	25%	7%	18%	24%	2%
Resident doctor, including foundation years	0%	4%	7%	31%	54%	4%
Specialty and associate specialist doctor	8%	15%	12%	19%	41%	6%
Other	38%	19%	11%	14%	11%	6%

Table 81: do you agree or disagree that the role and responsibilities of AAs are clearly defined at a national level? Split to show AA and all other job roles (AAs and those that have recently worked with AAs)

Job role	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Unsure
AA	11%	31%	26%	21%	8%	3%

Job role	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Unsure
All other roles (all non-AA respondents)	4%	8%	11%	20%	52%	5%
Anaesthetist	4%	8%	10%	13%	63%	2%
Consultant	5%	10%	13%	25%	40%	6%
Resident doctor, including foundation years	1%	3%	5%	14%	76%	1%
Specialty and associate specialist doctor	2%	3%	12%	24%	50%	8%
Other	10%	18%	20%	15%	22%	15%

5.2 Do you agree or disagree that a defined scope of practice for AAs would be helpful?

Figure 27: do you agree or disagree that a defined scope of practice for AAs would be helpful? All respondents (AAs and those that have recently worked with AAs)

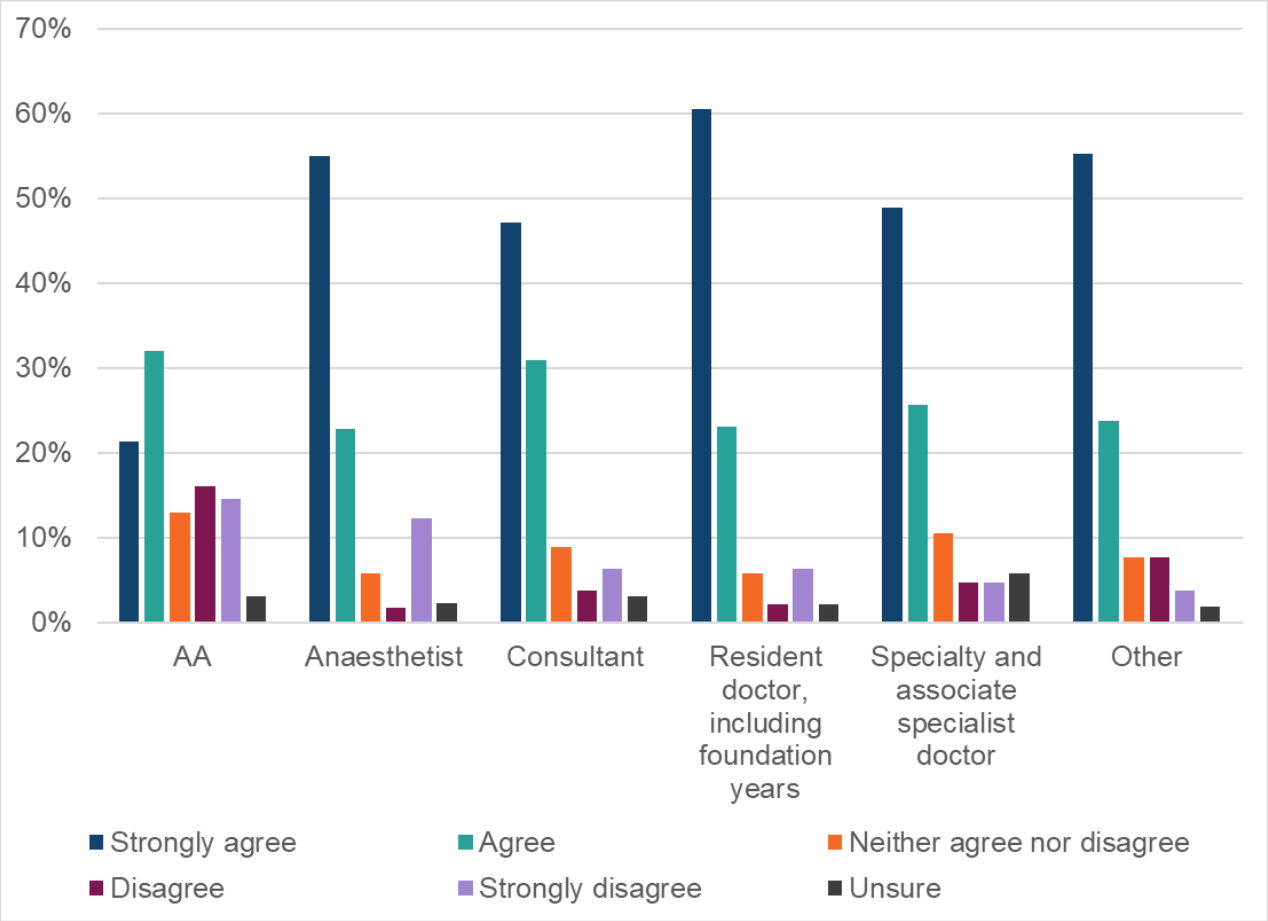

Table 82: do you agree or disagree that a defined scope of practice for AAs would be helpful? All respondents (those that have recently worked with AAs)

Job role	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Unsure
AA	21%	32%	13%	16%	15%	3%
Anaesthetist	55%	23%	6%	2%	12%	2%
Consultant	47%	31%	9%	4%	6%	3%
Resident doctor,	60%	23%	6%	2%	6%	2%

Job role	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Unsure
including foundation years						
Specialty and associate specialist doctor	49%	26%	10%	5%	5%	6%
Other	55%	24%	8%	8%	4%	2%
All job roles	50%	27%	8%	5%	8%	3%

Additional analysis compared the responses from all non-PA respondents by how recently they last worked in a setting where AAs were part of the multidisciplinary team.

Figure 28: do you agree or disagree that a defined scope of practice for AAs would be helpful? Split by length of time since last worked with AAs

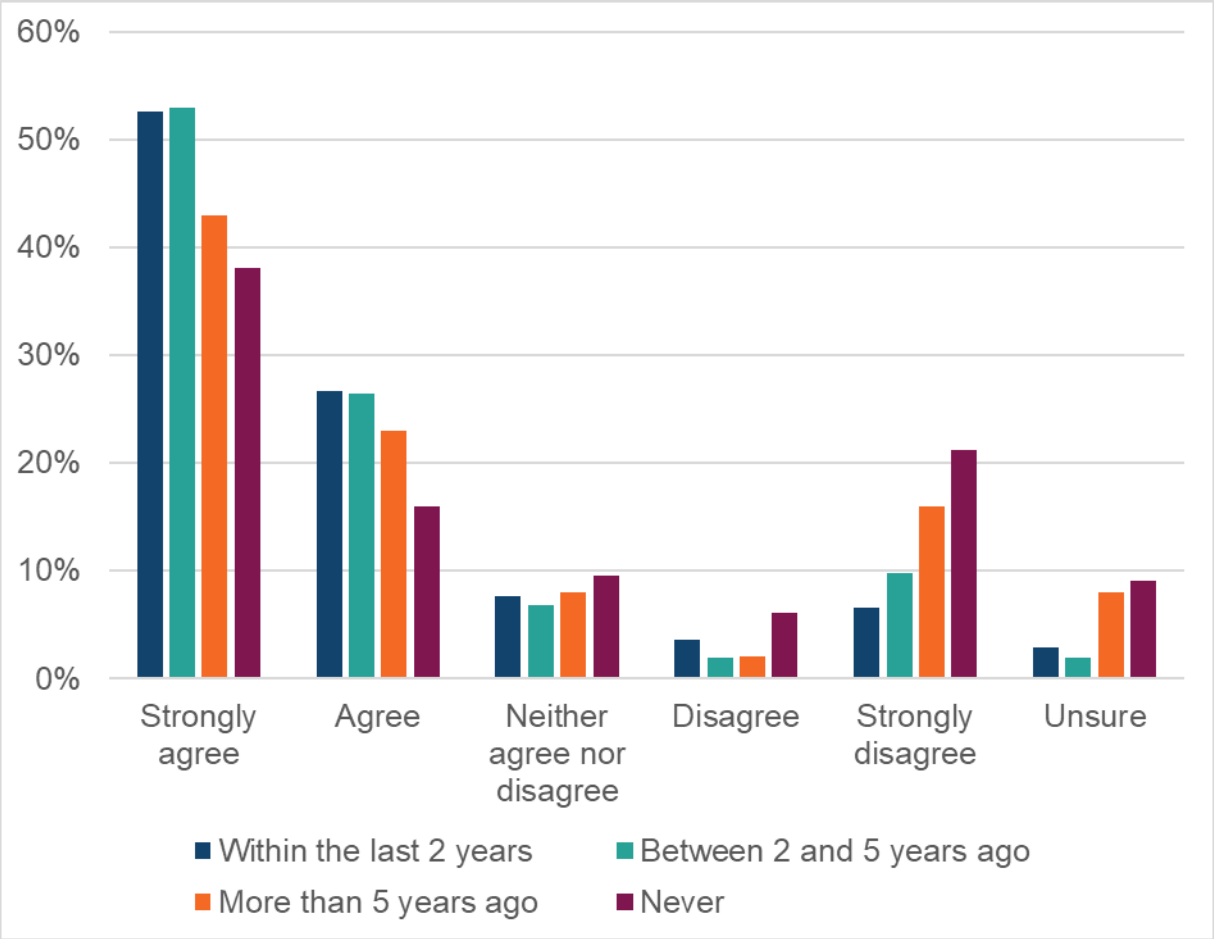

Table 83: do you agree or disagree that a defined scope of practice for AAs would be helpful? Split by length of time since last worked with AAs - only includes non-AA respondents

Time since worked with PAs	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Unsure
Within the last 2 years	53%	27%	8%	4%	7%	3%
Between 2 and 5 years ago	53%	26%	7%	2%	10%	2%

Time since worked with PAs	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Unsure
More than 5 years ago	43%	23%	8%	2%	16%	8%
Never	38%	16%	10%	6%	21%	9%
Total	50%	25%	8%	4%	10%	4%

Respondents were also asked to provide any detail to support their answer regarding a scope of practice for AAs. The significant themes identified in the responses are listed below.

AAs listed:

- flexible scope of practice: the scope of practice should be flexible and adaptable, allowing for local needs, individual development, and role diversification with appropriate training
- national scope with local adaptations: a national scope of practice is beneficial but should allow for local adaptations to meet the specific needs of individual healthcare trusts
- advanced roles with training: advanced roles should be available to AAs within the scope of practice, provided there is appropriate training, experience, and supervision
- competency based progression: progression should be based on competency and skills rather than years of experience, ensuring safety and competence without being overly restrictive
- governance and safety: a strong governance structure is essential to support AA practice and ensure safety and supervision

Those that have recently worked with PAs:

- strict supervision needed: strict supervision is necessary to ensure safe practice, with significant concerns about the safety of AAs practicing without constant supervision

- national vs local scope: debate exists on whether the scope of practice should be defined nationally or locally, with concerns about local disregard for national frameworks and the need for local discretion

- defined role to address misconceptions: a clearly defined role will address misconceptions, allay fears among doctors, and ensure appropriate use of AAs within the healthcare team

- role abolition and redundancy: the role of AAs is seen by some as unsafe, unnecessary, and redundant compared to hiring and training more anaesthetic doctors and nurses / operating department practitioners

- restrictive scope concerns: the current scope of practice is seen as too restrictive, limiting the effectiveness and development of AAs

5.3 What do you think could improve the effectiveness of AAs working in multidisciplinary teams? (Effectiveness can relate to any aspect of how these roles contribute to service quality and patient safety and quality as part of the multidisciplinary team)

This was an open question, and the significant themes identified in the responses are listed below.

AAs listed:

- flexible practice scope: allowing flexible practice scope for AAs with supervision based on competency

- role awareness: increasing awareness and understanding of the AA role through education campaigns

- team integration: better embedding the AA role within the team and ensuring clear communication

- professional recognition: recognition of AAs' skills and professional status by all healthcare groups

- clinical audit participation: conducting clinical audits and contributing to quality improvement initiatives for safe care

Those that have recently worked with AAs listed:

- role clarity for AAs: clearly defining roles, scope of practice, and boundaries for AAs is crucial for their effectiveness in multidisciplinary teams

- national standards for AAs: implementing nationally defined standards, a formal training program, and consistent national regulation for AAs to ensure consistency and effectiveness
- supervision and support for AAs: providing appropriate supervision, leadership, and mentorship from anaesthetic doctors and consultants to enhance AAs' effectiveness
- training and development for AAs: providing extensive training, including primary FRCA exams, and opportunities for progression are necessary for AAs' preparedness and respect
- role redundancy of AAs: many believe that the role of AAs is redundant and should be phased out or abolished

5.4 What do you think would reduce the effectiveness of AAs in multidisciplinary teams? (This can include factors you think already reduce the effectiveness)

This was an open question and the significant themes identified in the responses are listed below.

AAs listed:

- restrictive practice guidelines: a limited or overly restrictive scope of practice, including rigid national guidelines and lack of flexibility, hinders the effectiveness and development of AAs
- lack of support: insufficient support from colleagues, organisations, and professional disrespect from medical doctors undermine the effectiveness of AAs
- negative impact of media: public and social media campaigns, including toxic online debates and disinformation, negatively impact the effectiveness and morale of AAs
- excessive supervision: requiring constant or unnecessary supervision and enforcing an unworkable scope of practice reduce the efficiency and effectiveness of AAs
- hostile work environment: hostility, bullying, and a toxic working environment from other healthcare professionals reduce the effectiveness of AAs

Those that have recently worked with AAs listed:

- scope of practice issues: an undefined, overly restrictive, or inappropriate scope of practice reduces the effectiveness and job satisfaction of AAs
- supervision challenges: the need for 1 to 1 supervision and the associated workload for supervisors reduce the effectiveness of AAs

- training and qualification issues: AAs lack the core knowledge, training, and qualifications required for effective team contribution, leading to higher workloads for anaesthetists and safety concerns

- workplace culture and resistance: bullying, exclusion, resistance to integrating AAs, and negative attitudes from colleagues reduce their effectiveness

- role ambiguity: ambiguity and lack of clarity around the roles and responsibilities of AAs can reduce their effectiveness and harm professional working relationships

5.5 What changes in your service (if any) have you experienced as a result of the introduction or expansion of AAs? (For example, changes to workload, skills mix or capacity)

This was an open question, which only those working with AAs were asked. The significant themes identified in the responses are listed below.

Those that have recently worked with AAs listed:

- decline in training opportunities: the introduction or expansion of AAs has led to a decline in training opportunities for anaesthetists, causing delays in gaining experience and increased competition for training lists

- improved service quality and efficiency: the introduction or expansion of AAs has led to significant improvements in service quality, efficiency, patient throughput, and theatre usage

- increased stress and workload: the introduction or expansion of AAs has increased stress and workload for consultant anaesthetists and resident doctors, leading to demotivation and reduced morale

- positive impact on training and teaching: AAs have created better environments for trainees, offering more flexibility for training opportunities and providing excellent teaching for junior medical staff

- concerns about patient safety: there are concerns about reduced patient safety and high-risk situations due to inadequate supervision and the replacement of doctors with AAs

6 Supervision

6.1 Who most commonly acts as your day-to-day supervisor?

Table 84: who most commonly acts as your day-to-day supervisor?

Role supervising	Number of responses
Consultant	98%
Other	2%

There were only 2 respondents who selected ‘other’ for this question - one said a lead AA acted as supervisor, while another suggested supervision was minimal.

6.2 Do you provide, or have you previously provided, day-to-day supervision for any AAs?

Table 85: do you provide, or have you previously provided, day-to-day supervision for any AAs? (Those that have recently worked with AAs)

Answer option	Percentage of respondents
Yes, currently	36%
Yes, previously	22%
No	42%

6.3 What other relationships, if any, do you hold with AAs in your service?

As a multiple choice question the total of the percentage is greater than 100% due to some respondents selecting multiple options.

Table 86: other relationships with AAs in the service (those that have recently worked with AAs)

Relationship with AAs	Percentage of respondents
Employer	10%
Training lead or trainer	49%
Governance lead	14%
Other (Please specify)	37%

6.4 How confident do you feel that there is enough supervision and support for you in your AA role?

Table 87: how confident do you feel that there is enough supervision and support for you in your AA role?

Level of confidence in supervision and support	Percentage of respondents
Extremely confident	76%
Very confident	15%
Moderately confident	5%

Level of confidence in supervision and support	Percentage of respondents
Slightly confident	2%
Not at all confident	2%

Respondents were also asked to provide more detail regarding their confidence in supervisory support. The significant themes are listed below.

AAs listed:

- immediate emergency support: consultants are always available immediately if needed, ensuring prompt support in emergencies or complications
- regular supervision: there is regular and consistent support from consultants, with clear communication and established protocols
- pre-assessment case discussion: every case is discussed with consultants during pre-assessment to develop safe and appropriate care plans
- supportive team environment: the team is very supportive, fostering a positive and collaborative work environment
- regular check-ins: consultants check in regularly and are available for immediate contact if needed

6.5 How confident do you feel that PAs deployed in your service receive enough supervision and support?

Table 88: how confident do you feel that AAs deployed in your service receive enough supervision and support? Split by job role (those that have recently worked with AAs)

Job role	Extremely confident	Very confident	Moderately confident	Slightly confident	Not at all confident	Unsure
Anaesthetist	10%	12%	16%	12%	42%	9%

Job role	Extremely confident	Very confident	Moderately confident	Slightly confident	Not at all confident	Unsure
Consultant	30%	24%	13%	8%	19%	6%
Resident doctor, including foundation years	1%	2%	11%	13%	48%	25%
Specialty and associate specialist doctor	8%	19%	14%	10%	40%	9%
Other	39%	24%	10%	6%	12%	10%
All job roles (non-AA respondents)	18%	16%	13%	10%	31%	12%

Respondents were also asked to provide more detail regarding their confidence in supervisory support for PAs in their service. The significant themes are listed below.

Those that have recently worked with AAs listed:

- continuous supervision for patient safety: AAs receive continuous supervision with immediate consultant availability, ensuring patient safety and seamless service
- adherence to standard operating practices (SOPs) and guidelines: AAs adhere to thorough SOPs, national guidelines, and maintain clear lines of communication, ensuring high standards and positive feedback
- lack of supervision: AAs are often left unsupervised or with inadequate supervision, posing a risk to patient safety

- need for clear supervision guidelines: there is a need for clearer national guidelines on the scope of practice and supervision requirements for AAs, with well-defined roles and limitations
- supervision burden on consultants: supervising AAs creates additional workload for consultants, impacting service efficiency and raising concerns about future supervision structures

6.6 What ratio of supervisor to AA do you work to in your setting?

This question was answered by all respondents, including AAs, due to an error in the survey skip logic. In the PA survey only those working with PAs were asked the equivalent question. To ensure consistency with the PA survey results responses from those working with AAs are presented separately to those from AAs themselves.

Table 89: what ratio of supervisor to AA do you work to in your setting? (Those that have recently worked with AAs)

Supervision ratio	**Percentage of respondents**
1 to 1	39%
1 to 2	32%
Unsure	21%
Other	7%

Table 90: what ratio of supervisor to AA do you work to in your setting? (AA respondents only)

Supervision ratio	**Percentage of respondents**
1 to 1	45%

Supervision ratio	Percentage of respondents
1 to 2	40%
Unsure	1%
Other	14%

7 Continuing professional development

Question in this section were only answered by AAs.

7.1 Does your work schedule allow time for continuing professional development?

Table 91: does your work schedule allow time for continuing professional development?

Time for development	Percentage of respondents
Yes	76%
No	24%

7.2 Would you like more opportunities for career progression?

Table 92: would you like more opportunities for career progression?

Would you like more opportunities for career progression?	Percentage of respondents
Yes	86%
No	5%

Would you like more opportunities for career progression?	Percentage of respondents
Unsure	9%

Respondents were asked to provide details of the opportunities for career development they would like. The significant themes are listed below.

AAs listed:

- expansion of clinical roles: interest in expanding clinical roles and skills, including regional anaesthesia, prescribing rights, and independent practice
- career progression in management: desire for career progression through management and leadership roles, including lead AA positions and involvement in service development
- need for professional development: desire for opportunities to continue professional development, including accredited training programs, CPD funding, and advanced practice modules
- opportunities in research and education: interest in more opportunities for research, teaching, and educational roles
- challenges in scope of practice: challenges related to scope of practice restrictions and interest in varying levels of supervision for different procedures

8 Patient safety

The patient safety questions were optional, therefore some respondents did not complete some or all of the question in this section.

8.1 How confident would you feel reporting a patient safety incident?

This question was for AAs only.

Table 93: how confident would you feel reporting a patient safety incident? (Question for AAs only)

Confidence in reporting a patient safety incident	Percentage of respondents
Extremely confident	69%
Very confident	23%
Moderately confident	5%
Slightly confident	1%
Not at all confident	2%

8.2 How confident do you feel that you would be supported by your service following a patient safety incident?

This question was for AAs only.

Table 94: how confident do you feel that you would be supported by your service following a patient safety incident? (Question for AAs only)

Confidence in being supported following a patient safety incident	Percentage of respondents
Extremely confident	49%
Very confident	29%
Moderately confident	15%

Confidence in being supported following a patient safety incident	Percentage of respondents
Slightly confident	3%
Not at all confident	4%
Unsure	1%

Respondents were asked to explain their answer. The significant themes identified are listed below.

AAs listed:

- supportive and open culture: the department fosters a supportive and open culture where staff feel confident to report incidents and are supported, with a no blame attitude
- proactive learning environment: regular governance meetings and case reviews are held to discuss and learn from incidents, promoting a proactive learning environment
- established reporting systems: there are established policies, procedures, and systems like Datix in place for dealing with and reporting incidents
- bias against AAs: there is a perception that AAs are not supported and are often unfairly blamed for mistakes, with concerns about bias and scapegoating
- patient safety emphasis: patient safety is a top priority, with a strong emphasis on maintaining a no blame culture and equal treatment for all staff

8.3 Have you ever been involved in a patient safety incident?

This question was for AAs only.

Table 95: have you ever been involved in a patient safety incident? (AAs only)

Answer selected	Percentage of respondents
Yes	22%
No	78%

8.4 Have any AAs in your team been involved in a patient safety incident?

This question was just for those working with AAs.

Table 96: have any AAs in your team been involved in a patient safety incident? (Those that have recently worked with AAs)

Job role	Yes	No	Unsure
Anaesthetist	41%	9%	50%
Consultant	25%	27%	48%
Resident doctor, including foundation years	19%	4%	77%
Specialty and associate specialist doctor	20%	23%	57%
Other	10%	38%	52%
Total	24%	19%	57%

Respondents were asked to provide any details about how the patient safety incident might have been prevented. The significant themes identified are listed below.

Those that have recently worked with AAs listed:

- need for qualified supervision: direct 1 to 1 supervision by a qualified anaesthetist or consultant could prevent patient safety incidents
- inadequate training and experience: AAs lack necessary training and experience, leading to poor decision-making and patient safety incidents
- drug errors: incidents involving drug errors highlight the need for better oversight
- employment of qualified anaesthetists: medically qualified anaesthetists instead of AAs would prevent incidents
- scope of practice issues: AAs working beyond their scope of practice have led to patient safety incidents

8.5 Reporting of patient safety incidents

Table 97: have you ever reported any patient safety incidents, including incidents that did not involve AAs? (AAs and those that have recently worked with AAs)

Job role	Yes	No
AA	55%	45%
Anaesthetist	56%	44%
Consultant	59%	41%
Resident doctor, including foundation years	37%	63%
Specialty and associate specialist doctor	46%	54%
Other	35%	65%

Job role	Yes	No
All job roles	50%	50%

Respondents were able to select multiple options for the questions below. The 'percentage of respondents' columns in these tables indicate how many respondents selected each job role - therefore the total % for each table totals more than 100%.

Table 98: who was involved in the patient safety incidents that you reported? (Follow up question to AAs only - can select more than one response)

Job roles selected as involved	Percentage of respondents
Consultants	68%
Nurses	59%
Other AAs	2%
Resident doctors	37%
Speciality and associate specialist doctors, registrars or other doctors	27%
Yourself (the AA completing the survey)	33%
Others	21%

Table 99: who was involved in the patient safety incidents that you reported? (Follow up question, includes those that have recently worked with AAs - can select more than one response)

Who incidents involved	**Percentage of respondents**
Yourself	67%
Nurses	59%
Consultants	58%
Resident doctors	55%
Speciality and associate specialist doctors, registrars or other doctors	39%
Other	34%

Table 100: who have you reported patient safety incidents to? All respondents (AAs and those that have recently worked with AAs) who have reported a patient safety incident (Select all that apply)

Who incidents were reported to	**Percentage of respondents**
Consultant	41%
Datix	6%

Who incidents were reported to	Percentage of respondents
Freedom to Speak Up Guardian or other whistleblowing support role	4%
General practitioner	1%
Organisation leadership	71%
Other	20%

8.6 Describe any changes to the AA role - or the way this role is integrated into multidisciplinary teams - that you feel would help increase patient safety.

This was an open question, and the significant themes identified in the responses are listed below.

AAs listed:

- training and development: providing increased training, continued professional development, and a recognised national curriculum for AAs
- role integration and acceptance: improving acceptance and integration of the AA role within multidisciplinary teams and ensuring it is officially recognised
- multidisciplinary team collaboration: continuing to provide multidisciplinary team training opportunities and fostering collaboration between AAs, consultants, and senior registrars to enhance role awareness and integration
- national acceptance and transparency: achieving wider national acceptance of the AA role and ensuring transparency to boost patient confidence and counter false information
- regulation and oversight: introducing regulation and oversight by bodies such as the GMC to ensure patient safety and proper protocols

Those that have recently worked with AAs listed:

- national training program: implementing a national training program and syllabus with a clearly defined and limited scope of practice for AAs
- consultant supervision: AAs should be supervised by consultants at all times and should not substitute trained physician anaesthetists
- professional regulation: AAs should be regulated by a professional body, such as the GMC, with clear definitions of supervision and robust governance
- role identification: AAs should have clear identification within the team such as uniforms, badges, and lanyards to distinguish them from other medical staff
- patient consent and awareness: ensuring patients are fully informed about the AA role and obtaining their consent for procedures is crucial for transparency and safety

9 Regulation

9.1 What impact do you expect the General Medical Council's regulation of AAs to have on the safety of the AA role?

Table 101: what impact do you expect the General Medical Council's regulation of AAs to have on the safety of the AA role? (AAs and those that have recently worked with AAs)

Job role	Very positive impact	Some positive impact	Neither positive nor negative impact	Some negative impact	Very negative impact	Unsure
AA	48%	33%	14%	2%	1%	3%
Anaesthetist	4%	15%	25%	13%	37%	7%
Consultant	12%	23%	28%	9%	17%	11%
Resident doctor, including foundation years	1%	11%	25%	14%	41%	8%

Job role	Very positive impact	Some positive impact	Neither positive nor negative impact	Some negative impact	Very negative impact	Unsure
Specialty and associate specialist doctor	6%	16%	30%	16%	21%	10%
Other	42%	20%	14%	7%	10%	8%
All job roles	14%	19%	25%	10%	23%	9%

9.2 What impact do you expect the General Medical Council's regulation of AAs to have on the support that AAs receive in their roles?

Table 102: what impact do you expect the General Medical Council's regulation of AAs to have on the support that AAs receive in their roles? (AAs and those that have recently worked with AAs)

Job role	Very positive impact	Some positive impact	Neither positive nor negative impact	Some negative impact	Very negative impact	Unsure
AA	34%	33%	21%	5%	2%	6%
Anaesthetist	5%	10%	36%	9%	24%	16%
Consultant	10%	21%	34%	9%	10%	16%
Specialty and associate	6%	16%	35%	8%	13%	22%

Job role	Very positive impact	Some positive impact	Neither positive nor negative impact	Some negative impact	Very negative impact	Unsure
specialist doctor						
Other	35%	26%	15%	6%	5%	13%
All job roles	11%	18%	33%	9%	12%	17%

9.3 What impact do you expect the General Medical Council's regulation of AAs to have on the perception of AAs within the medical profession?

Table 103: what impact do you expect the General Medical Council's regulation of AAs to have on the perception of AAs within the medical profession? (AAs and those that have recently worked with AAs)

Job role	Very positive impact	Some positive impact	Neither positive nor negative impact	Some negative impact	Very negative impact	Unsure
AA	22%	37%	15%	15%	5%	6%
Anaesthetist	4%	5%	16%	21%	50%	5%
Consultant	6%	16%	21%	17%	30%	10%
Resident doctor, including	1%	4%	20%	16%	51%	8%

Job role	Very positive impact	Some positive impact	Neither positive nor negative impact	Some negative impact	Very negative impact	Unsure
foundation years						
Specialty and associate specialist doctor	3%	12%	20%	20%	33%	13%
Other	28%	26%	10%	14%	14%	8%
All job roles	7%	14%	19%	17%	34%	8%

9.4 What impact do you expect the General Medical Council's regulation of AAs to have on the public perception of the AA role?

Table 104: what impact do you expect the General Medical Council's regulation of AAs to have on the public perception of the AA role? (AAs and those that have recently worked with AAs)

Job role	Very positive impact	Some positive impact	Neither positive nor negative impact	Some negative impact	Very negative impact	Unsure
AA	31%	37%	17%	4%	3%	9%
Anaesthetist	5%	8%	27%	12%	33%	16%

Job role	Very positive impact	Some positive impact	Neither positive nor negative impact	Some negative impact	Very negative impact	Unsure
Consultant	6%	18%	31%	10%	17%	18%
Resident doctor, including foundation years	2%	9%	34%	12%	25%	18%
Specialty and associate specialist doctor	6%	12%	33%	6%	20%	24%
Other	20%	25%	20%	10%	8%	18%
Total	8%	16%	29%	10%	19%	17%

9.5 Impact of regulation - by length of time since last worked with AAs

As additional analysis of the above questions regarding the impact of GMC regulation, the report also provides data breaking down responses based on the length of time since respondents last worked in a service where AAs were part of the multidisciplinary team.

This table only includes non-AA respondents, who answered that there would be 'some' or 'significant' positive impact from GMC regulation on each of the identified factors.

Figure 29: do respondents expect GMC regulation on defined factors (only non-AA respondents answering at least 'some' positive impact)

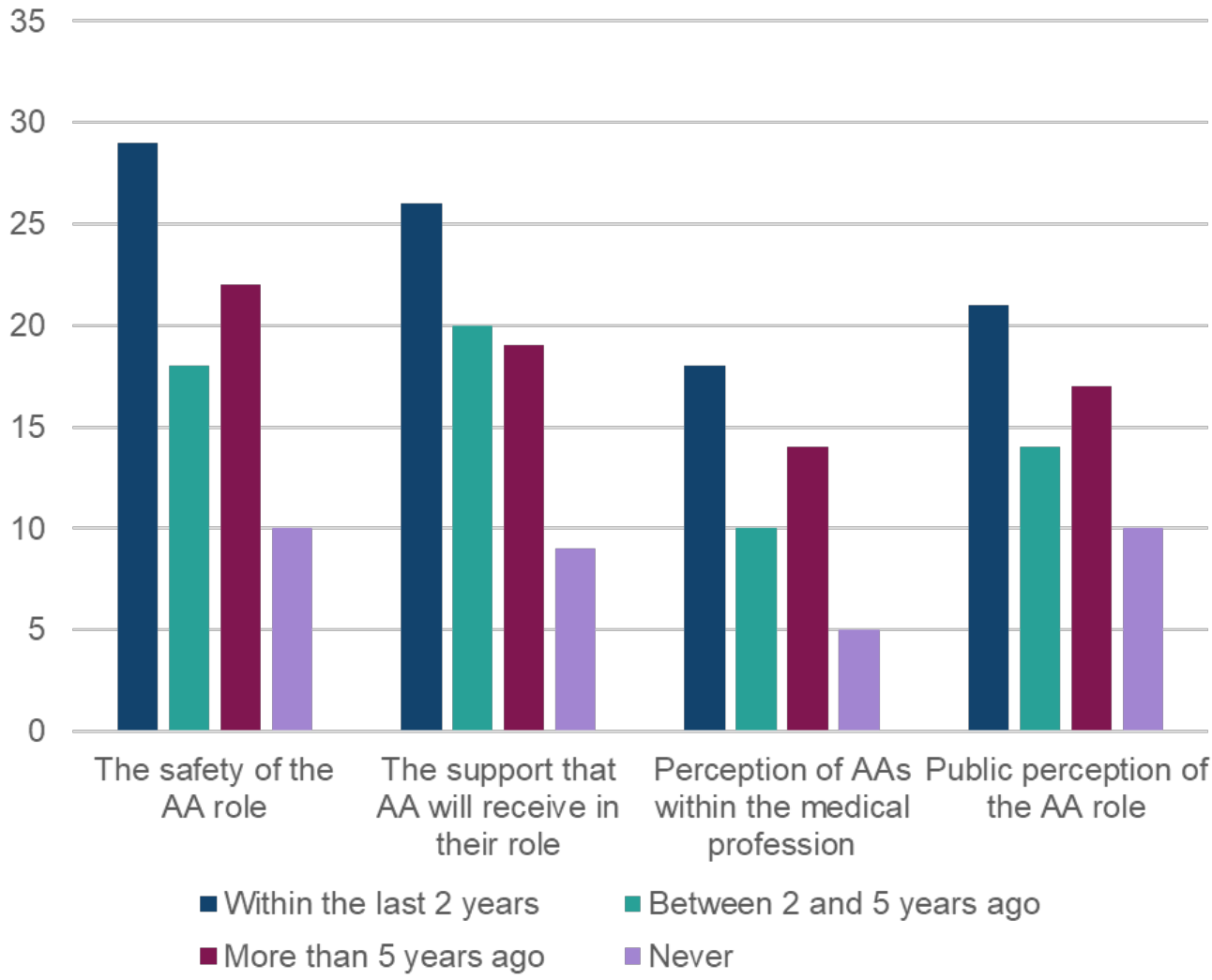

Table 105: do respondents expect GMC regulation on defined factors (only non-AA respondents answering at least 'some' positive impact)

Factor	Within the last 2 years	Between 2 and 5 years ago	More than 5 years ago	Never
The safety of the AA role	29%	18%	22%	10%

Factor	Within the last 2 years	Between 2 and 5 years ago	More than 5 years ago	Never
The support that AA will receive in their role	26%	20%	19%	9%
Perception of AAs within the medical profession	18%	10%	14%	5%
Public perception of the AA role	21%	14%	17%	10%

9.6 Please provide any detail regarding your expectations on the General Medical Council's regulation

This was an open question, and the significant themes identified in the responses are listed below.

AAs listed:

- maintaining high standards: GMC regulation will help maintain high standards of practice, improve trust in the role, and increase public confidence
- validation and professional status: regulation provides validation and trust in the competency of AAs, enhancing their professional status within the healthcare system
- patient reassurance: patients may feel comforted knowing AAs are now a regulated profession, providing reassurance and peace of mind
- supportive GMC development: the GMC is supportive of developing the AA role for the future of healthcare, ensuring safe practice and setting standards
- negative perception and identity: doctors feel GMC regulation puts them in a negative light, blurring professional lines and impacting the professional identity of AAs

Those that have recently worked with AAs listed:

- separate regulatory body for AAs: AAs should have their own regulatory body to avoid confusion and ensure proper oversight

- public perception and awareness: clear communication is needed to address public confusion and lack of awareness regarding the role and qualifications of AAs
- negative impact on patient safety: GMC regulation may negatively impact patient safety due to inadequate supervision and blurred boundaries
- financial concerns: GMC regulation may impose financial burdens on AAs and the healthcare system
- role legitimacy and training: GMC regulation may legitimise roles that are not appropriately trained, leading to potential safety issues

10 Any other comments that respondents felt might be useful to the Leng review

This was an open question, and the significant themes identified in the responses are listed below.

AAs listed:

- distress due to current climate: the current climate around AA and PA roles has caused distress among professionals due to job protectionism and negative media portrayal
- positive addition to anaesthesia departments: AAs are seen as valuable members of the anaesthetic team, contributing positively to patient care under consultant supervision
- high standards and patient safety: AAs are trained to high standards, adhere to patient safety protocols, and have a strong safety record with no critical incidents reported
- negative online influence: negative views from individuals who don't work with AAs can create a toxic online environment, leading to professional bullying and abuse
- impact on mental health: the negative climate around the AA role has significantly impacted the mental health of professionals, causing distress and uncertainty

Those that have recently worked with AAs listed:

- need for regulation and scope: AAs require a clearly defined national scope of practice with tight regulation to ensure patient safety and proper role definitions
- economic and productivity concerns: AAs can improve NHS productivity, but there are concerns about their cost-effectiveness

- negative impact on healthcare teams: the introduction of AAs disrupts team dynamics and reduces professional morale, leading to potential conflicts and dissatisfaction
- patient safety concerns: many respondents believe that the introduction of AAs compromises patient safety due to their limited training and experience compared to fully qualified anaesthetists
- impact on medical training: concerns that the presence of AAs reduces training opportunities for resident doctors, potentially leading to a generation of less competent healthcare professionals