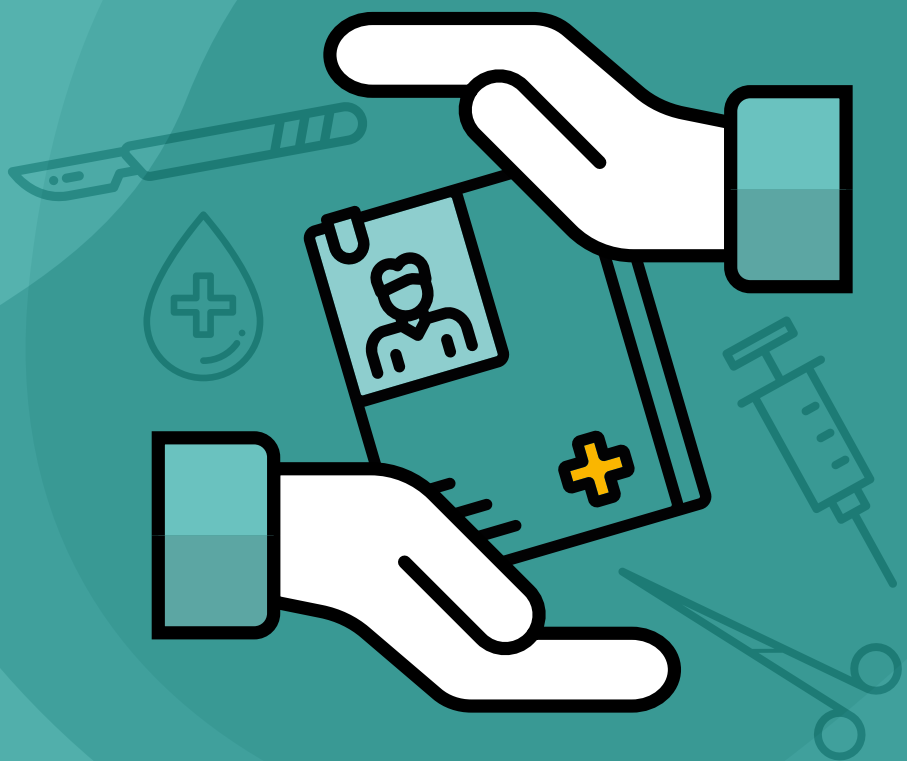
Royal College of Surgeons
ADVANCING SURGICAL CARE

Surgical Care Team

GUIDANCE FRAMEWORK



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1. Introduction to the surgical care team guidance

A significant contribution to patient care has been achieved through the development of the roles of non-medical practitioners who undertake a series of duties traditionally carried out by medical staff. These roles within the surgical team have become critical to the delivery of surgical services in many specialties.

For the most part, such roles perform activities that support the day-to-day care of the surgical patient at a competence level that lies from foundation to core training stages, with a few taking on responsibilities that would normally be carried out in the first specialty training years. The RCS *A Question of Balance* report (2016) suggests that the adoption of extended roles in medical services has been largely beneficial for patient care, training quality and the efficiency of the surgical team.

Benefits of the surgical care team can include:

- improving continuity of care and patient experience;
- improving service efficiency through better coordination of patient flow and the reduction of waiting times;
- increasing productivity and staff capacity by spreading the service workload across more members of the surgical team;
- improving the quality of training by allowing trainees to focus on activities with the greatest training benefit;
- supporting trainees to settle into their posts and providing them with informal training; and
- reducing locum costs.

Effective use of the surgical care team can also help tackle the challenges and pressures currently faced by those delivering surgical services and surgical training, including:

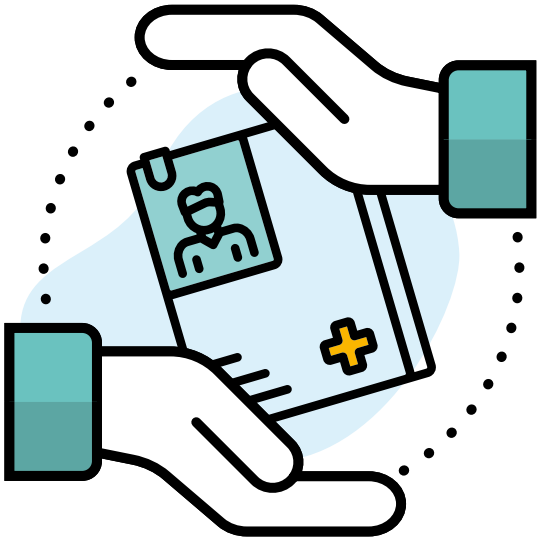
- the increase in service workload and complexity of cases due to an ageing population with increasing comorbidities;
- the reduction of trainee numbers, especially in foundation surgical posts, alongside changes to working hours;
- the concentration of complex services to fewer specialist centres;
- the reduced exposure of trainees to common surgical conditions; and
- the use of trainees to fill gaps in frontline services such as night rotas and provision of ward or theatre cover.

However, the development of such roles has emerged as an ad hoc way to address gaps and shortages in local services. This has led to variation around the training, scope of practice, autonomy and integration into robust governance structures of surgical care team members.

Such inconsistency can undermine the advantages of these roles. For example, uncertainty over the training and scope of practice of non-medical team members can create confusion as to what tasks and activities can be delegated to them and present potential risks for patient safety. The lack of strategic vision and planning of how these roles can fit into the wider service can also create resistance against their full integration into the team and cause unnecessary competition with trainees for training opportunities. Lastly, insufficient governance arrangements can undermine the long-term sustainability of extended roles and have significant impact on their retention and development.

It is crucial that there is a strategic, whole-system approach to planning and modelling the surgical care team if its full benefits for patients, training and the service are to be realised. This should include:

- Clarity about the nature of extended surgical care team roles, and the scope and limitations of their practice.
- Standardisation of training and competencies in a way that does not compromise flexibility of implementation at a local level.
- Consultant engagement and leadership of the development of surgical care team roles, in a way that considers how they are integrated within other roles within the team.
- Robust governance structures that include systematic recruitment and planning for these roles within the service, with provisions around accountability, management, assessment, development and career progression. The consultant responsible for the extended role (the clinical supervisor) is therefore ideally suited to line manage these roles.



AIMS OF THIS GUIDANCE

The surgical care team guidance aims to help employers, surgeons and other healthcare professionals develop models of care that utilise the surgical care team in a consistent manner. It sets out distinct extended roles within the surgical team, and outlines competencies, training and clear routes of entry into these roles. It provides guidance on how to lead a surgical care team as well as recommendations and resources for the clinical governance arrangements that can support a flexible modelling of the surgical care team that meets local needs. The ultimate aim of this work is to enhance the quality of patient care, patient experience and patient safety, to improve the effectiveness and efficiency of services, and to support the quality and experience of surgical training.

2. Key principles of the surgical care team

The following principles support the RCS' vision for developing the surgical care team:

1. There is a need for change to traditional workforce models of healthcare delivery.
2. Well-managed use of the surgical care team can improve patient experience, service delivery and quality of training.
3. Healthcare providers should develop a strategic plan for developing and recruiting these roles.
4. When modelling the surgical care team, one size does not fit all, and any recommendations have to be adjusted to meet local need.
5. The structure of the surgical care team should be determined with the intent to meet the needs of patients by improving patient care and promoting prompt access to safe services.
6. The definition of extended roles and proposed scope of practice is not aimed at fixing and restricting the remit of these roles, but rather at promoting clarity of competencies. It also facilitates delegation and limits risks to patient safety.
7. The introduction of extended roles into the service can be flexible and varied. Job plans and descriptions can be adapted within the broader scope and competencies of each defined role to meet the demands of the service.
8. Extended practitioner roles complement, but do not replace, surgeons or medical staff. They enhance the capability of the surgical team and should evolve together within the team. Their educational development should not compromise the training of future surgeons.
9. The implementation of these roles should cover the whole surgical pathway for surgical patients, from admission to discharge, and in both the operating and non-operating environment.
10. Extended roles should be fully integrated into the surgical team with dedicated job plans, rather than simply 'fill gaps' in the service in an ad hoc manner. The model for developing extended surgical roles should be team-based rather than task-based.
11. Extended roles in the surgical team should be able to carry out medical work within defined boundaries. It is acknowledged that there will be some overlap of competencies and activities between extended roles, trainees and non-training grade surgeons who make up the surgical team. Consultant leadership is crucial to ensure well-managed use of each practitioner's different skillsets and a balanced allocation of activities and opportunities between trainees, extended roles and other professional staff.
12. Due care should be given to ensure that the training of extended roles does must not come at the expense of surgical trainees' access to training opportunities. The primary driver for service design must be developing the best model for delivering high-quality patient care.
13. Extended roles should undertake both clinical and administrative work.
14. Extended roles should work within a medical management model in which they are clinically responsible to a consultant.

15. The split between service and training is not sharply defined. The educational value of tasks will vary based on experience and level of training so the aim is to create a closer link between the two through an intelligent allocation of tasks and a balanced share of the workload.
16. There should be clarity and consistency of roles and titles, educational requirements and scope of practice. Training and assessment of these roles should be standardised and eventually lead to admission onto a national register.
17. Consultant leadership and robust clinical governance frameworks alongside a culture that supports training and professional development are crucial for the sustainability and success of the surgical care team.
18. It is accepted that practitioners who trained prior to the current regulations regarding training, or in other parts of the world, may have equivalent skills and capabilities to current members of the surgical care team. Further work will be needed to determine the right processes for assessing equivalence.
19. The practice of extended roles should be monitored and regulated. The consultant surgeon remains responsible for the overall management of the patient's care.

3. Extended roles and their scope of practice

This document describes in detail two distinct roles for the extended surgical care team, with defined clinical tasks and responsibilities:

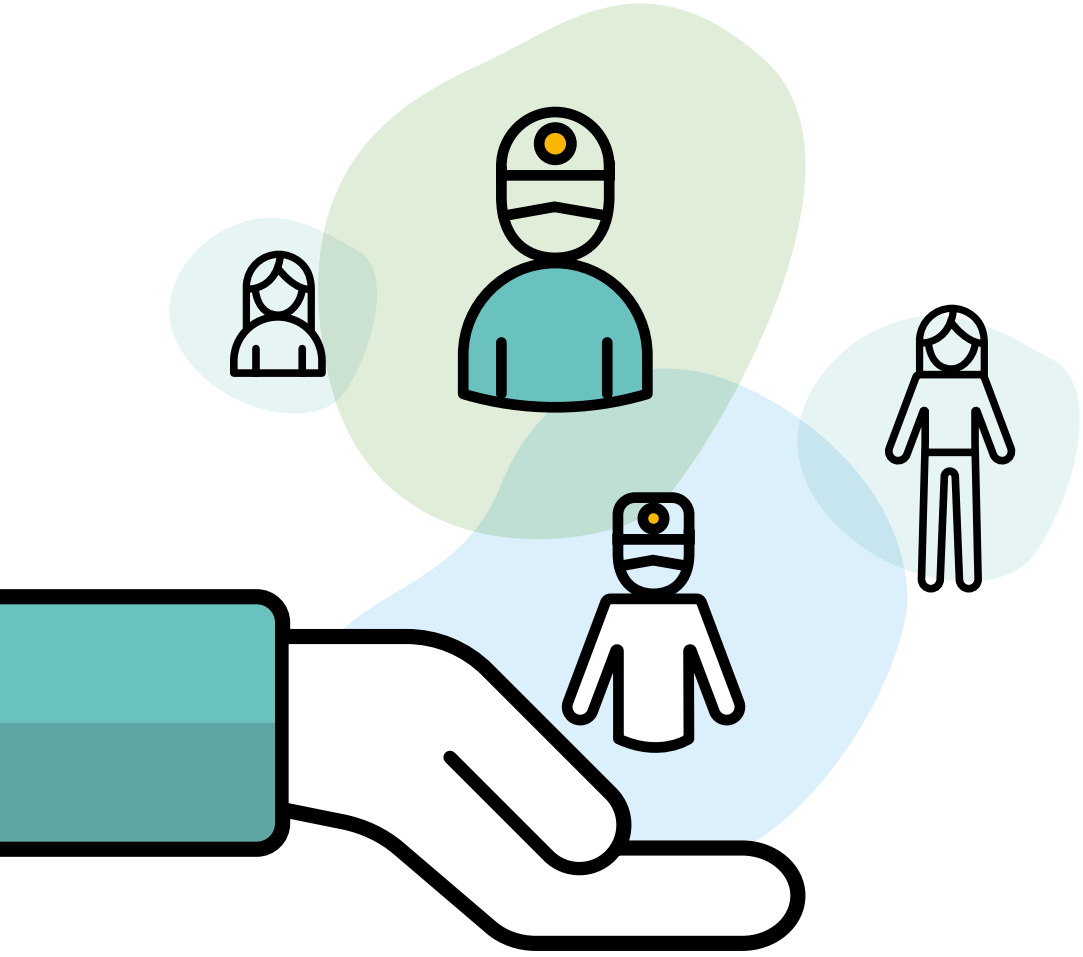
- Surgical care practitioner (SCP)
- Surgical first assistant (SFA).

Both roles support the routine care of the surgical patient and increase the capacity of the surgical team. They work under the supervision of a consultant surgeon and support continuity of care in areas that can be delegated to non-medically qualified staff, while allowing surgeons to focus on more complex patient pathways and specialised care.

In addition, there are other allied roles that contribute to the work of various medical teams within a hospital. These include:

- Physician associates (PAs)
- Advanced clinical practitioners (ACPs).

Although the clinical tasks and responsibilities of these roles vary according to the specialty in which they work, when they practise in surgery they can also support the routine care of the surgical patient and increase the capacity of the surgical team. Typically, such practitioners would support the surgical care team outside the operating theatre environment. These roles are described in broader terms, given the potential of these roles to work across medicine.



SURGICAL CARE PRACTITIONER

ROLE DEFINITION

Surgical care practitioners are registered healthcare professionals who have extended the scope of their practice by completing an RCS-accredited training programme (or other programme in the case of those practitioners who have been practising since before the establishment of the RCS-accredited training). They work as members of the surgical team and their main responsibilities are to support surgeons and other professionals before, during and after surgical procedures. They can perform some surgical interventions and carry out preoperative and postoperative care under the supervision of a senior surgeon.

AREA OF PRACTICE

Intra- and perioperative environment – including theatre, wards and clinics – usually within a specific surgical specialty. This can include both elective and emergency work within the practitioner's scope of practice.

OVERVIEW OF TASKS AND ACTIVITIES

- Clinics – seeing specific preoperative patients and listing them for surgical procedures, as well as seeing postoperative patients for follow-up.
- Preoperative assessment processes including clinical examination and enhanced recovery education as directed by the surgical team.
- Arrangement of pre- and postoperative investigations as part of the MDT.
- Participation in the consent process in their areas of practice.
- Liaison with surgical staff – as well as theatre, ward and clerical staff – on relevant issues (including theatre lists) to support coherent service provision.
- Participation in the WHO safe surgery checklist.
- Preparation of patients for surgery including venepuncture, male and female catheterisation, patient positioning and preparation.
- Undertaking of surgical procedures as part of the MDT for the respective surgical specialty under the supervision and direction of the operating surgeon.
- Acting as first or second assistant as directed by the supervising surgeon.
- Facilitation of continuity of care.
- Daily ward rounds, making assessments and formulating plans for postoperative care.
- Writing of operation notes and ward round note taking.
- Postoperative care, including wound assessment, initial treatment and identification of surgical problems and complications.
- Identification of acute deterioration of patients with knowledge of early warning scores.
- Provision of support to on-call and emergency services.
- Evaluation and documentation of care, including the discharge process and follow-up care arrangements, including writing discharge summaries and liaising with primary care.
- Facilitation of the training by supporting a training session or providing delegated care to a patient while the supervising surgeon is conducting a training session.
- Research, development, education and audit within the surgical department.
- Prescription of medications relevant to their individual specialty following appropriate training for non-medically qualified prescribers.

SUPERVISION AND MANAGEMENT

- Clinical responsibility to the consultant surgeon.
- Day-to-day work under the direction of the operating surgeon and as a member of the surgical care team.
- Line management as part of the surgical team and under the direction of the responsible consultant.

During the two-year training, the SCP will be assigned a named responsible consultant who will serve as clinical supervisor and mentor for the duration of the training programme.

AUTONOMY AND INDEPENDENT WORK

- Pre-determined level of autonomy and supervision, agreed on a case-by-case basis with the responsible consultant surgeon.
- Once the surgeon is satisfied the SCP works safely and competently within his or her role, the surgeon can arrange for proximal supervision (where the consultant surgeon is not in theatre but his or her location is within the hospital, and can be easily contactable).

TRAINING

- Two-year programme at Master's level, accredited by the RCS and comprising both a theoretical and a practical element.
- In the second year there is specialisation in a chosen surgical specialty.
- All competencies should be assessed and signed off by the responsible consultant. These should be documented in the SCP training portfolio.

ELIGIBILITY FOR ENTRY INTO THE TRAINING

- Registration as a healthcare professional (eg nurse, operating department practitioner or physiotherapist).
- 18 months of post-registration experience.
- Evidence of ability to study at Master's degree level.
- Aptitude for clinical and operative practice.

PROFESSIONAL ACCOUNTABILITY

- Nursing and Midwifery Council, or Health and Care Professions Council, for their original, non-extended roles.
- It is recommended that SCPs follow the Association for Perioperative Practice voluntary code of conduct for registered practitioners working in advanced surgical roles, as well as the codes of conduct and performance of their regulatory bodies.

NB. At the time of writing of this document, the UK health departments were consulting on further options for professional assurance and appropriate regulation for medical associate professions, including SCPs.

BANDING

Between 7 – 8b
Trained SCP: Band 7
Senior SCP: Band 8a
Lead SCP: Band 8b

FURTHER INFORMATION

The Curriculum Framework for the Surgical Care Practitioner, RCS, 2014

SURGICAL FIRST ASSISTANT

ROLE DEFINITION

Surgical first assistants are registered healthcare professionals who provide continuous competent and dedicated assistance under the direct supervision of the operating surgeon throughout the procedure, while not performing any form of surgical intervention.

AREA OF PRACTICE

Primarily intraoperative work, although pre- and postoperative visits may also be part of the role.

OVERVIEW OF TASKS AND ACTIVITIES

- Improving communication between theatre, patient and ward.
- Involvement in the team completion of the WHO surgical safety checklist for all surgical interventions.
- Male and female urethral catheterisation.
- Assistance with patient positioning, including tissue viability assessment.
- Skin preparation prior to surgery and draping.
- Use and maintenance of specialised surgical equipment relevant to the area of their work.
- Handling of tissues and manipulation of organs for exposure or access under direct observation of the operating surgeon.
- Superficial and deep tissue retraction (NB. retractors should not be placed by the SFA but by the operating surgeon).
- Assistance with haemostasis to secure and maintain a clear operating field, including indirect application of surgical diathermy as directed by the operating surgeon (NB. activities such as application of direct electro surgical diathermy to body tissue, applying haemostats or ligaclips to vessels and cast bandaging are the remit of the surgeon, supervised surgical trainee or surgical care practitioners and not the SFA).
- Use of suctions guided by the operating surgeon.
- Camera and instrument manipulation under the direction of the surgeon during minimal access surgery (NB. camera insertion and application of instruments should be performed by the operating surgeon).
- Cutting of deep sutures and ligatures.
- Simple wound closure and skin suturing (see below*).
- Application of dressings.
- Assistance with the transfer of patients to the postoperative anaesthetic care unit.

SUPERVISION AND MANAGEMENT

- Clinical responsibility to the consultant surgeon once trained.
- Day-to-day work under the direction of the operating surgeon and the theatre management team.
- Line management as part of the theatre team.

AUTONOMY

- The surgical first assistant works under the direct supervision of a surgeon who must remain in theatre until surgery is completed.
- (*) SFAs are not allowed to undertake tasks considered to be surgical interventions. However, they are allowed to undertake skin suturing to close simple wounds provided they have received appropriate training and assessment (eg through the *Intercollegiate Basic Surgical Skills* course or through demonstrating competence at the same level).

TRAINING	• Successful completion of a nationally recognised programme of study. There are two training routes:
	  • A university accredited programme, such as the College of Operating Department Practitioners' BSc in operating department practice. NB. Universities that offer accredited modules for SFAs must ensure that the programme offered follows the recommendations of the Perioperative Care Collaborative.
	  • An in-house training package supported by the AfPP SFA Competency Toolkit.

ELIGIBILITY FOR ENTRY INTO THE TRAINING	• Registration as a healthcare professional (eg nurse, operating department practitioner or physiotherapist). • 12 months of post-registration experience. • Aptitude for clinical and operative practice.
PROFESSIONAL ACCOUNTABILITY	• Nursing and Midwifery Council, or Health and Care Professions Council, for their original, non-extended roles. • It is recommended that SFAs follow the AfPP voluntary code of conduct for registered practitioners working in advanced surgical roles, as well as the codes of conduct and performance of their regulatory bodies.
BANDING	Band 5–7
FURTHER INFORMATION	Association for Perioperative Practice Surgical First Assistant Competency Toolkit

OTHER PRACTITIONER ROLES WORKING IN THE SURGICAL CARE TEAM

Other practitioner roles such as advanced critical care practitioners and physician associates are frequently recruited to support the surgical care team within the scope of their competence and expertise.

PHYSICIAN ASSOCIATES (PAs)

Physician associates (PAs) are healthcare professionals who have undertaken an accredited two-year postgraduate qualification following a degree in a medical science. They are trained to the medical model. They are not required to be registered healthcare professionals although they are regulated through a voluntary register run by the Faculty of Physician Associates at the Royal College of Physicians. Their scope of practice includes a number of surgical interventions and are set out in detail the guidance *An Employer's Guide to Physician Associates* (Faculty of Physician Associates, 2017).

ADVANCED CLINICAL PRACTITIONERS (ACPs) AND ADVANCED NURSE PRACTITIONERS (ANPs)

Advanced clinical practitioners (ACPs) and advanced nurse practitioners (ANPs) are experienced registered healthcare practitioners who have undertaken a Master's qualification or equivalent that encompasses the four pillars of clinical practice, management and leadership, education, and research, with demonstration of core and area-specific clinical competence. Training is delivered locally. According to Health Education England, advanced clinical practice is *'a level of practice characterised by a high level of autonomy and complex decision-making […] Advanced Clinical Practice embodies the ability to manage complete clinical care in partnership with patients/carers. It includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions to enhance patient experience and improve outcomes'* (HEE, 2016).

At the time of writing this document, there is no nationally agreed curriculum or portfolio for ACP training programmes. An apprenticeship standard has been approved, with the end-point assessment standard currently under review. This will eventually support the standardisation of training programmes for advanced clinical practice. However, for those practitioners who wish to work within the surgical care team such a curriculum is currently under development by the RCS, due to be completed in the coming year. This offers the potential for the formal recognition of such practitioners' skills and knowledge if they wish to work in surgery. A similar programme has been completed in emergency medicine.

ADVANCED CRITICAL CARE PRACTITIONERS (ACCPs)

Advanced critical care practitioners (ACCPs) are registered healthcare professionals who have undertaken a dedicated two-year full-time academic programme in compliance with the *Curriculum for Training for Advanced Critical Care Practitioners* set out by the Faculty of Intensive Care Medicine. Their scope of practice focuses on the delivery of critical care and emergency medicine and is set out in detail by the Faculty of Intensive Care Medicine in alignment with the *National Education and Competence Framework for Advanced Critical Care Practitioners* (Department of Health, 2008) and *The Advanced Practice Toolkit for Scotland* (Scottish Government, 2008).

All ACCPs, ACPs, ANPs and PAs have attitudes, skills and knowledge to deliver care and treatment within the team under defined levels of supervision. As with all other members of the surgical care team, their scope of practice, their autonomy and level of supervision needs to be agreed in advance and on a case-by-case basis with the responsible surgeon and ratified by the hospital management. It should reflect their training and experience.

DEVELOPMENT OF OTHER ROLES AS SURGICAL CARE PRACTITIONERS

Practitioners such as advanced critical care practitioners (ACCPs), physician associates (PAs), advanced clinical practitioners (ACPs) and advanced nurse practitioners (ANPs) and physicians' assistants (anaesthesia) (PA(A)s) frequently form part of the surgical care team with responsibilities circumscribed by their competence and training. Although these practitioners do not need to train as surgical care practitioners to be a member of the surgical care team, for those who wish to transition into an SCP role as well as for surgical first assistants, there can be a more streamlined route into the SCP role.

The training of these roles includes a number of overlapping generalist skills. In addition, ACCPs, ACPs, ANPs and SFAs are required to be registered healthcare professionals. Such registration is not a prerequisite for PAs and PA(A)s to enter training and to qualify, although they are normally expected to join voluntary registers currently run by the Faculty of Physician Associates at the Royal College of Physicians and by the Royal College of Anaesthetists respectively.

NB. At the time of writing of this document, the government was in the process of consulting on proposals to introduce statutory regulation for physician associates and consider revised regulation for physicians' assistants (anaesthesia), surgical care practitioners and advanced critical care practitioners. For these roles, as well as for ACCPs and SFAs, we would therefore recommend that SCPs are registered as healthcare professionals, as a route of entry into an SCP training.

4. Introducing a new surgical care team

CARE AND STAFFING MODELS

Healthcare providers should adopt different models for the deployment of extended surgical care team roles based on the needs of their service and its patients. They should try to make best use of these roles' professional and clinical skillset across the patient pathway while delegating the right level of autonomy and decision-making based on their training and experience.

Surgical care team roles should be developed with the aim of improving patient experience, training and service delivery rather than being introduced to undertake tasks that other clinical staff do not wish to do. The job plans of surgical team members should be developed flexibly to support the delivery of high-quality patient care. This promotes the development of the service by ensuring that all team members have opportunities for high-quality training and learning experiences.

Key factors that should be considered when designing a care model that includes extended surgical care team roles are the following:

- Attention should be given to the whole patient pathway, from outpatient, admission to discharge and follow-up in both the operating and non-operating environment.
- The job plans of extended roles should include a combination of clinical and administrative responsibilities.
- Emphasis should be placed on integrating the practice and training of these roles within the wider surgical team, and avoiding lone roles with strictly task-based job plans.
- Experienced practitioners can provide valuable learning opportunities for early-year trainees. SCPs in particular can facilitate controlled withdrawal of supervision with medical trainees in the operating theatre, as it has been recognised that the experienced SCP can act as a skilled surgical assistant. The transition for the junior trainee is from operating with a consultant present to operating with the consultant contactable but not directly in theatre. This should be considered when introducing these roles into the surgical team.

- The introduction of extended roles should be flexible and sensitive to the varying needs of other staff such as trainees, and the training opportunities available to them. In some cases, for example, it might be important that some operating lists are reserved for trainees to ensure sufficient exposure to specific procedures to meet the requirements of the particular stage of their training.
- Extended roles can be embedded within a surgical team, or attached to a specific ward.
  - The **team-based** system involves surgical care team roles being attached to one or more consultant teams and looking after all the patients in their care, regardless of where they are located in the hospital. Such an approach provides benefits to patients, such as continuity of care. It also offers more opportunities for learning and feedback and fosters closer relationships between the surgical care team member and the wider surgical team.
  - The **ward-based** system involves surgical care team roles being stationed on particular wards and looking after all the patients on those wards regardless of which consultant is in charge of their care. Such an approach has been shown to have positive implications for patient morbidity and mortality as well as length of stay, and can improve the collaboration between practitioners and nurses. They also provide a steadier workload than the team-based system.

  Both approaches have advantages and disadvantages and can be used depending on what those introducing the new model consider will provide the best outcomes for patient care, meet the needs of the service, and support the development of a high-quality training and learning environment. Hybrid models may also be considered.

ROTAS

Surgical care team members can provide cover at night and weekends, working with more senior trainees under the supervision of the on-call consultant. Currently, many rotas include gaps and often there are not enough surgeons able to provide generic ‘first on-call’ cover. This means that those in training may work rotas with an excessive number of night duties. Practitioner roles in the surgical care team could contribute to such rotas, allowing early-year surgical trainees to spend more time in daytime care that supports their training.

However, we strongly recommend that no practitioners should work exclusively at night-time or over weekends to avoid isolation and to ensure that surgical trainees also gain sufficient experience of delivering surgical care at these times.

Rotas for the surgical care team can include both elective and emergency work within the scope of their practice, and should be used flexibly to ensure an appropriate balance is achieved between the individual training and development needs of team members (including surgical trainees) while maintaining the best-quality patient care. For example, where a surgical trainee is working with a consultant surgeon on an elective care list, a surgical care team member might be used to support emergency activity. A varied and flexible approach should be adopted that is sensitive to the needs of patients, service delivery and training.

Surgical care team members can have their own rotas, providing continuity of care for the patient, supporting rotating trainees, and helping services to meet waiting targets.

Experienced surgical care team members could also be part of a mixed rota with doctors in training, addressing service delivery needs and increasing trainees’ opportunities to attend elective theatre sessions and clinics that are crucial to that stage of their training and development.

INTRODUCING A NEW MODEL OF SERVICE

The introduction of surgical care team roles requires a strategic and managed approach to ensure successful and sustainable implementation. An organisation needs to have a clear understanding of how the role contributes to the quality of patient care, and the organisation's priorities for the development and delivery of services.

The questions below can be used to support the planning, development and introduction of surgical care team roles.

PLANNING AND RECRUITING

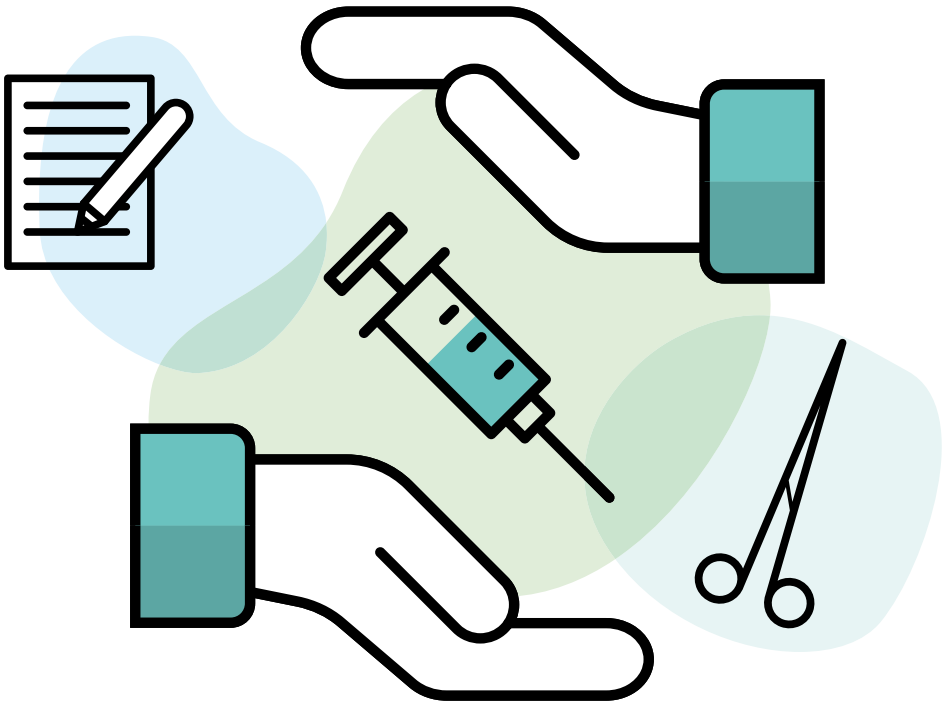
1	Is there a service and workforce requirement for the extended role in the surgical team?
2	What are the benefits of introducing this role to the service, to patient experience and surgical training?
3	Is there sufficient case volume and case mix to ensure that extended roles and trainees have adequate exposure to training opportunities, supervision and assessment?
4	Can the service need identified be addressed through the skills and competencies of existing roles and staff?
5	Will the practitioners be recruited from existing staff and, if so, how will the service gap be addressed?
6	Is there support from senior consultant surgeons for the role? Is there managerial agreement?
7	Is there approval from the clinical governance committee?
8	What are the clinical activities that the practitioner will carry out on a day-to-day basis? Is the caseload appropriate for the extended role?
9	Are there arrangements for cover in case of absence, eg sickness absence?
10	Are local policies in alignment with the role and responsibilities of the extended team member?
11	Is there a completed risk assessment to determine the range of procedures that the extended role can perform, and to set an action plan to mitigate risks? *(see Appendix I for a risk assessment template)*
12	Are clear responsibilities detailed in the job description and supported by local policy?
13	How will the salary and costs of training and professional development of this role be funded? Are the costs sustainable?
14	What type of employment contract will the practitioner have?
15	How will other members of staff be informed about the new practitioner?
16	How will patients be informed about the new practitioner?

TRAINING, MANAGEMENT AND SUPERVISION

1	Have you considered the professional, clinical and managerial responsibility and accountability for this role?
2	Do consultant surgeons have capacity, ability and willingness to provide clinical supervision, management and support to the new role?
3	Whom will this role be clinically responsible to and who will be supervising them?
4	Are there induction plans, as well as mentoring and peer support networks, in place?
5	How will the practitioner access theoretical and clinical training and development? Is there access to an appropriate training programme?
6	How will the practitioner's theoretical knowledge and clinical skills be assessed?
7	Is there a role-specific appraisal framework in the organisation? Who will have the responsibility for undertaking the practitioner's appraisal, development review and personal development plan?
8	Are there plans in place to support the practitioner's continuing professional development?
9	Have the minimum qualifications for this role been taken into account?
10	Is there sufficient employer liability insurance for each individual practitioner? What are the limits of this role in line with the organisation's liability arrangements?
11	How will the effectiveness of this role be audited/evaluated? What are the measures of success?

RISK ASSESSMENT

1	Is this activity commensurate to the approved scope of practice of the extended team member?
2	Is this activity supported by a job description and departmental policy?
3	What training and education has the extended team member received?
4	Has the extended team member's competence been assessed appropriately?
5	Are there arrangements for supervision by a senior consultant during the activity when being trained?
6	Is there an adverse impact on the educational opportunities available to surgical trainees?
7	Does the extended team member agree to carry out the activity?



5. Clinical governance of the surgical care team

All extended roles in the surgical team should work within a local clinical governance framework. This ensures that:

- Quality of patient care can be assured.
- There is consistency and standardisation of practice.
- The boundaries of the extended roles are documented in written protocols.
- Appropriate responsibilities and supervisory arrangements are clarified and agreed with the extended team member, senior members of the surgical team and service managers.
- Every member of the multidisciplinary team is aware of the accountability, responsibility and scope of practice of those roles and how they fit into the surgical team.
- There are clear arrangements and support for the professional development, monitoring and review of the roles.

A register of all practitioners acting as extended members of the surgical team should be kept in each department where these roles have been introduced.

SCOPE OF PRACTICE

All surgical care team members must work within the limits of their competence. The scope of practice of the practitioner, their autonomy and level of supervision needs to be agreed in advance and on a case-by-case basis with the responsible surgeon and ratified by the hospital management. It should reflect their training and experience while allowing for professional development and learning.

Typically, newly qualified practitioners will need closer support and supervision (with direct supervision during training). Over time and as the supervising consultant surgeon is satisfied that the surgical care team member works safely and competently within their role there will be less need for direct supervision, and the surgical care team member can carry out his or her responsibilities under proximal supervision. Experienced practitioners should work with a level of autonomy, but with the supervising surgeon available for consultation even if he or she is not physically present.

Surgical care team members may develop specialist expertise through practical learning and continuing professional development, but where possible they should maintain relatively broad clinical knowledge and not allow their role to become too narrow, so that there is flexibility in the service, as well as space for their own longer-term professional development and career progression.

SCOPE OF PRACTICE IN THE OPERATING THEATRE

Supervision and support will be necessary in all hospital environments, but this will be particularly important for practitioners who work in the operating theatre environment. Under these circumstances the following levels of supervision are possible.

- Direct – with the supervising surgeon scrubbed and standing alongside the practitioner, usually during training.
- Indirect – with the supervising surgeon unscrubbed but in the theatre.
- Proximal – with the supervising surgeon not in theatre but within the hospital and easily contactable.

Senior surgical care practitioners can potentially perform surgical procedures independently at a level equivalent to a core surgical trainee year two level (and sometimes up to a specialty trainee year three level). However, surgical first

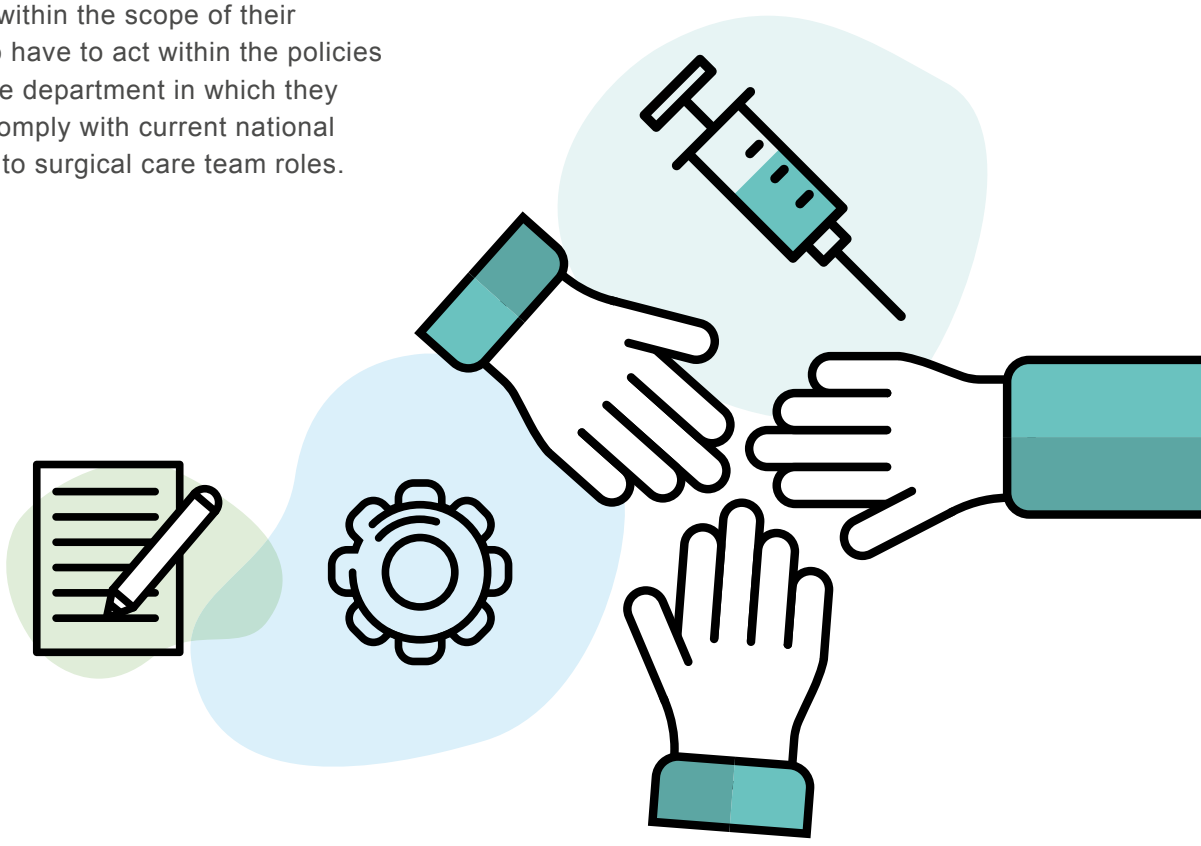
assistants should not perform procedures that might be considered surgical intervention, with the exception of skin suturing to close simple wounds, provided they have received appropriate training and assessment (eg through the *Intercollegiate Basic Surgical Skills* course or through demonstrating competence at the same level). It is important that local policies are in place to reflect the role and responsibilities of surgical care team members.

LIABILITY

In secondary care delivered by the NHS, extended practitioners are normally covered by their employer through vicarious liability, provided they have an employment contract and an agreed job description. However, this only applies if the conditions outlined in the practitioners' job descriptions are met and the practitioners work within the scope of their practice. They also have to act within the policies and protocols of the department in which they are working, and comply with current national guidelines relating to surgical care team roles.

Vicarious liability does not apply to the private sector, so separate professional indemnity insurance has to be agreed with their employer in that case, or it can be sought independently through other organisations such as the Medical Protection Society, the Medical Defence Union or the Association for Perioperative Practice.

It is the responsibility of the practitioners working in an extended role to ensure that they have liability cover that is up to date and sufficient for their level of practice.



REGULATION

Currently, surgical care team members have no statutory regulatory body for their specific surgical care team role. Most practitioners (SCPs, SFAs, ACPs and ANPs) will normally hold a registration with the Nursing and Midwifery Council or the Health and Care Professions Council, but this applies only to their original qualification (eg as a nurse or as an operating department practitioner). It does not cover their extended practice in surgery. This means that extended practitioners work outside their primary (and registered) scope of practice. It is therefore crucial that local clinical governance mechanisms are able to establish the validity of their qualifications and competence before they are recruited, as well as ensure the surgical care team member is able to maintain his or her skills once he or she is part of the team.

For those surgical care team members who have qualified through the physician associate route, or the physician assistant (anaesthesia) route, there are voluntary registers operated by the Royal College of Physicians and the Royal College of Anaesthetists, with the Professional Standards Authority regulating organisations holding such voluntary registers.

The Royal College of Surgeons of England is currently exploring the development of a voluntary register for surgical roles, but we are also of the view that eventually all extended roles should be subject to statutory regulation. At the time of writing, the government had announced a consultation on the potential options for future regulation of PAs, SCPs, PAAs and ACCPs.

Lack of statutory regulation also results in some limitations on practice. Practitioners in extended roles cannot request ionising radiation unless they are registered healthcare professionals and have undergone additional certification in Ionising Radiation (Medical Exposure) Regulations (IRMER). Practitioners in extended roles also have no prescribing authority until they have received appropriate training for non-medically qualified prescribers defined by their employing trust. The RCS would encourage facilitating surgical care practitioners' ability to prescribe basic medicines and to request ionising radiation within the limits of their competence.

ACCOUNTABILITY AND MANAGEMENT

It is important that there is clarity over the specific lines of clinical, managerial and professional accountability for extended surgical roles, as well as how their ongoing performance will be assessed. Surgical care team members should work to the medical model that includes professional accountability to consultant surgeons, and compliance with the same set of procedures that doctors are trained to follow including presenting complaint, history, physical examination, diagnosis and treatment.

The surgical care team member is clinically responsible to the supervising consultant surgeon who will delegate aspects of surgical care and will work with him or her as an integral part of the surgical care team. The supervising consultant surgeon must be satisfied that the practitioner has the appropriate qualifications, skills and experience to provide competent and safe care to the patient. During their training, surgical care team members will normally be assigned a named clinical supervisor and a mentor for the duration of the training programme, whereas other senior surgeons may provide day-to-day supervision. The responsibility for the overall management of the patient's care remains with the supervising consultant surgeon.

Managerial and professional accountability is currently varied, and reflects the ad hoc development of these roles. Given that these practitioners work closely with the medical team, providing care for surgical patients, there is a rationale for managerial and professional responsibility to lie within the medical team (including performance management, leave, expenses, mandatory training and rotas).

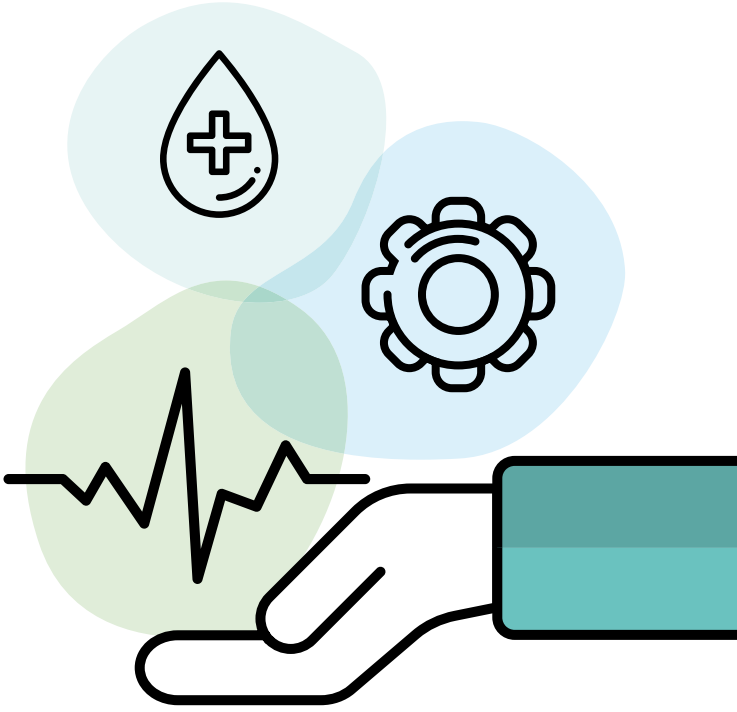
This would have implications for such issues as appraisal and governance, and would likely also have budgetary implications. It should be noted that line management involves skills that are not intuitive, so those taking on this responsibility may need some training and support. Each trust may also consider the possibility of having a faculty board comprising clinical supervisors of all staff in extended roles.

WORKING WITH CONSULTANTS AND TRAINEES

The leadership and support from consultant surgeons is crucial for the successful and sustainable implementation of care models that include members of the surgical care team. Consultant surgeons need to be committed to supporting these roles and integrating them into their teams. They have the responsibility, with the support of the hospital's management team, to create an environment that encourages questioning and learning and is suitable for training and supervising surgical care team members, trainees, and other clinical and non-clinical staff. Sufficient time needs to be built into their job plan to support these activities.

Consultant surgeons also have the responsibility for the supervision and ongoing performance appraisal of the extended roles. They are responsible for the delegation of tasks to surgical care team members and for ensuring that training opportunities are spread appropriately across the team. This should ensure the best quality of care for patients while enabling the training of future surgeons and the development of surgical care team roles. Good leadership will allow teams to make the best use of extended practitioners' skills to support the learning environment for surgical trainees, and may help to free up time for training rather than restrict valuable training opportunities. Surgical care team roles can be particularly useful in helping trainees to settle into their new posts, and providing them with 'on the ground' learning opportunities and assistance in surgery that supports them when they start to operate independently.

To support team-working between trainees and extended surgical practitioners, it is recommended that trainees receive a specific induction into the development and use of these roles to help them understand the nature and scope of their practice, as well as its value. It will also help them to understand how responsibilities will be shared and delegated within the team



WORKING WITH PATIENTS

Members of the extended surgical care team often provide continuity of care for patients and can be in much more frequent contact with the patient than other medical professionals throughout their care pathway. They therefore have a significant impact on patient experience and satisfaction.

Research carried out by The Royal College of Surgeons of England in collaboration with Health Education England found that patients were happy to be treated by a member of the extended surgical care team, provided first that the surgical care team member was competent to perform the tasks they were undertaking, and second that he or she was working as part of a team under the supervision of the consultant surgeon. Patients also said that it was important to them to be told in advance who would be involved in their care. They preferred to receive information at the moment it was practically relevant. Although they indicated that they did not need to be overloaded with too much information about the background of the individual role, they did value clear explanation and the familiarity and reassurance that such roles could offer from the perspective of continuity of care.

Patients should always be informed that a surgical care team member forms part of the surgical team that will be caring for them. This should be through discussion with patients in advance of their treatment, reinforced by the provision of patient information leaflets, available in a range of formats and community languages. Where applicable, it might also be useful to create ‘branding’, by choosing a specific type or colour of hospital uniform to create clear identities for the different staff groups.

REFUSAL TO BE TREATED

Patients are entitled to refuse care by a surgical care team member in just the same way as they can refuse care from any healthcare professional. The patient’s decision should be respected by all team members.

PROFESSIONAL DEVELOPMENT AND CAREER PROGRESSION

Once qualified, practitioners within the surgical care team are responsible for keeping themselves up to date and maintaining competence in all areas of their practice. This should form the basis of a role-specific annual appraisal and continuing skills assessment, using the competencies outlines in the relevant curriculum or the AfPP competency toolkit (for surgical first assistants). Like all members of the surgical team, they can undertake 50 hours per year of continuing professional development and educational activities across all aspects of their work to support their skills, knowledge and career development. Once training is complete, it is good practice to have a mentor who is different from the clinical supervisor and who has no line management responsibility for the practitioner.

A surgical care team member should have a formal educational and professional development plan agreed with their consultant supervisor, which should be reviewed on a regular basis and at least once a year. Placing value on education and offering further training to extended practitioners also helps retain them over time. Employers should support these roles’ development by allocating the necessary budget as well as adequate time into their job plan (including study leave) to allow them to carry out such activities and meet the objectives of their agreed personal developmental plan. The funding for such a budget will depend on available resources and should be offered when existing contractual requirements around internal mandatory training and performance targets are met. NHS Employers recently launched the Apprenticeship Levy scheme, which could also be used to support the training and development of practitioner roles.

Surgical care team members should keep a diary of their CPD activity as well as an accurate portfolio of evidence of all their procedures and clinical activity (eg a logbook). They should engage in quality assurance processes and quality improvement activities including participation in local audits and annual appraisals/performance reviews, and they should participate in their surgical team's collection of patient and colleague feedback at least once every five years.

They should participate in multidisciplinary team meetings as well as morbidity and mortality meetings to avoid isolated practice.

Career progression for surgical care team members often takes place through gaining more autonomy, more responsibilities, and dealing with more complex patients, in line with the advancement of their knowledge and practical skills. They may also take on management and teaching roles such as leading audit or service development, or delivering training to other extended roles or junior trainees. Career progression can also take place by moving from junior to more senior roles, eg from surgical first assistant to surgical care practitioner by following the career pathway for SCPs offered by the RCS, or by moving to more specialised roles. Career progression should be structured with remuneration and banding appropriate to the responsibilities of the roles.

It is important that employers develop a clear career path and opportunities for advancement for surgical care team members in order to retain their skills. This will be particularly important for stability of the care team when there are workforce shortages.

ASSESSMENT

The appropriate assessment of competence in any role is critical for patient safety. It enables those in clinical practice to demonstrate that they are able to undertake the identified requirements of that role to an appropriate standard. Such assessment can be identified in a number of different contexts, enabling individuals to demonstrate:

- the ability to undertake a specific role after completion of a specific training programme;
- the ability to move from one role to another role or another training pathway based on clinical experience; and
- the ongoing ability to continue in a role through continuing professional development and review of practice.

Each of these contexts could require different approaches to assessment. For example, contexts that require the demonstration of appropriate progression towards an identified standard of practice will necessarily be formative in nature (assessment for learning).

Meanwhile, contexts that require the demonstration of the achievement of this standard will necessarily be summative in nature (assessment of learning), or at least look to formulate a picture of competence based on a synthesis of information gained from a range of formative assessment encounters.

Irrespective of the specific context, however, all assessment needs to be sufficiently focused on the tasks required for the role in question to ensure that the information provided is sufficiently relevant to contribute to the overall ability of an individual to fulfil that role safely and effectively.

In terms of assessment to demonstrate ability to undertake a specific role, the surgical care practitioner role has an established *Curriculum Framework* (RCS, 2014), in which a number of specific workplace-based assessments adapted from the Intercollegiate Surgical Curriculum Programme (ISCP) are recommended.

KEY RELEVANT TOOLS ARE THE FOLLOWING:

- Case-Based Discussion
- Mini-Clinical Evaluation Exercise
- Mini-Peer Assessment Tool
- Direct Observation of Procedural Skills
- Procedure-Based Assessment
- Multi-Source Feedback
- Acute Care Assessment Tool

All these tools are available through the ISCP website: **https://www.iscp.ac.uk/curriculum/surgical/assessment_wbas.aspx.**

Each tool will contribute to an overall picture of an individual's ability to apply clearly defined skills – be they clinical, procedural or in communication, with a patient or a colleague – to demonstrate progression and achievement of the required standard of a practising SCP.

Similarly, the surgical first assistant has an established list of competencies identified in the Association for Perioperative Practice Surgical First Assistant competency toolkit, which also contains a list of assessment tools.

For those wishing to move into an extended surgical role from other roles, it may be possible to use existing experience in lieu of some of the identified training time of an established curriculum. Assessment in this context will aim to allow the individual to demonstrate that he or she has applied the skills identified in the part of the training from which they are exempt in another clinical context that is sufficiently similar to illustrate equivalence.

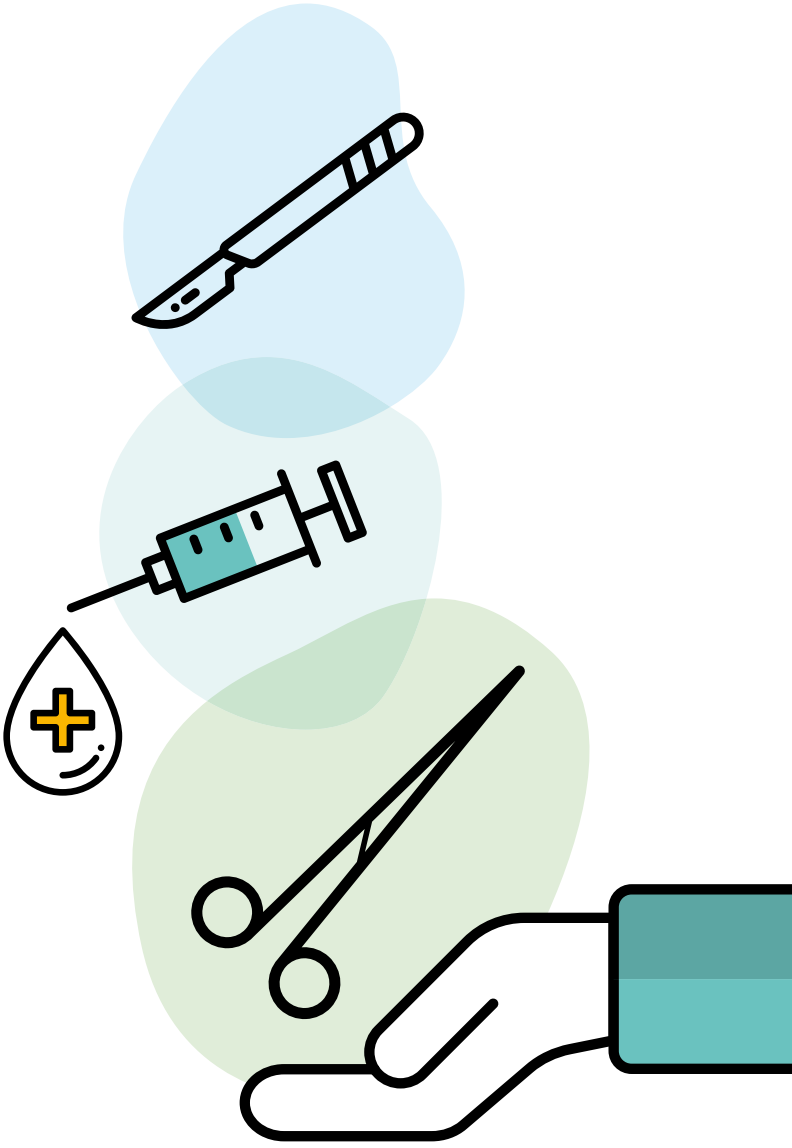
For example, a current SFA wishing to move into a SCP role could demonstrate this relevant experience through the assessment of a submitted portfolio of evidence documenting the appropriate foundation of knowledge and skills in key areas of the SCP curriculum. This assessment, in addition to the completion of the relevant conversion module, could enable the individual to enter a two-year programme at the start of the second year.

Finally, where an individual is already undertaking a specific role within the surgical care team, regular appraisal is required to enable the demonstration of ongoing competence in a specific clinical context, much as a registered medical or surgical practitioner is required to undergo cyclical revalidation. For some surgical care team roles where the scope of practice remains unchanged, such appraisal should follow the evidence submitted for the revalidation process, as set out in the GMC *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013), and the *RCS Guidance on Supporting Information for Revalidation* (RCS, 2013):

- evidence of carrying out approximately 50 hours of CPD activity per year;
- quality improvement activity and audit/review of practice based on a portfolio documenting the volume of procedures and the associated clinical outcomes;
- documentation and discussion of significant events; and
- feedback from colleagues and patients.

Where the scope of practice has changed within a role, observation of practice by the responsible consultant surgeon can be undertaken and documented using the relevant workplace-based assessment tool for the clinical practice observed. Such reviews of practice should be undertaken on an annual basis, or at six-monthly intervals during an individual's first year within a given role.

If assessment within the surgical care team is approached judiciously, it should serve the interests of patient safety while providing practitioners with the confidence that their skills are sufficient to undertake the requirements of their role, and remain so over time. The burden of assessment – placed on both the assessors and those being assessed – should be proportionate in providing sufficient opportunities, but not excessive requirements, for practitioners in training and in practice to demonstrate the appropriate skills and competence. The framework for such assessment is already in existence and, where necessary, can be tailored to ensure that, in each of the contexts identified, members of the extended surgical care team have demonstrated their ability to carry out a specific role to the appropriate standard.



6. Professional code of conduct

Extended roles have a duty of care and professional responsibility to their patients through professional codes of conduct such as *Good Surgical Practice*, the *Professional Values for the Surgical Care Practitioner* or the voluntary *Code of Conduct of the Association for Perioperative Practice* for registered practitioners working in advancing surgical roles.

Practitioners who are registered with the Nursing and Midwifery Council and the Health and Care Professions Council are periodically required to undergo a monitoring and appraisal process to maintain their registration, so they will need to work collaboratively with colleagues in the relevant clinical areas to assist them with this.

The key professional values for all members of the surgical care team are set out in this section. Members of the surgical care team must:

KNOWLEDGE, SKILLS, PERFORMANCE

- recognise and work within the limits of their competence;
- act within their agreed scope of practice;
- take responsibility for maintaining their skills, knowledge and competencies, in consultation with their supervising consultant;
- take responsibility for the continuous improvement of their practice and their professional development, alongside the development of other members of the surgical team;
- be up to date with and adhere to all current and relevant clinical guidelines in their area of practice; and
- make informed decisions.

SAFETY AND QUALITY

- comply with local processes of quality assurance and quality improvement including audit, measuring of outcomes, peer reviews and participation in multidisciplinary meetings and morbidity and mortality meetings;
- take part in local appraisal or other individual assessment processes; and
- take action or ‘speak up’ through the relevant channels when safety concerns arise.

WORKING WITH PATIENTS

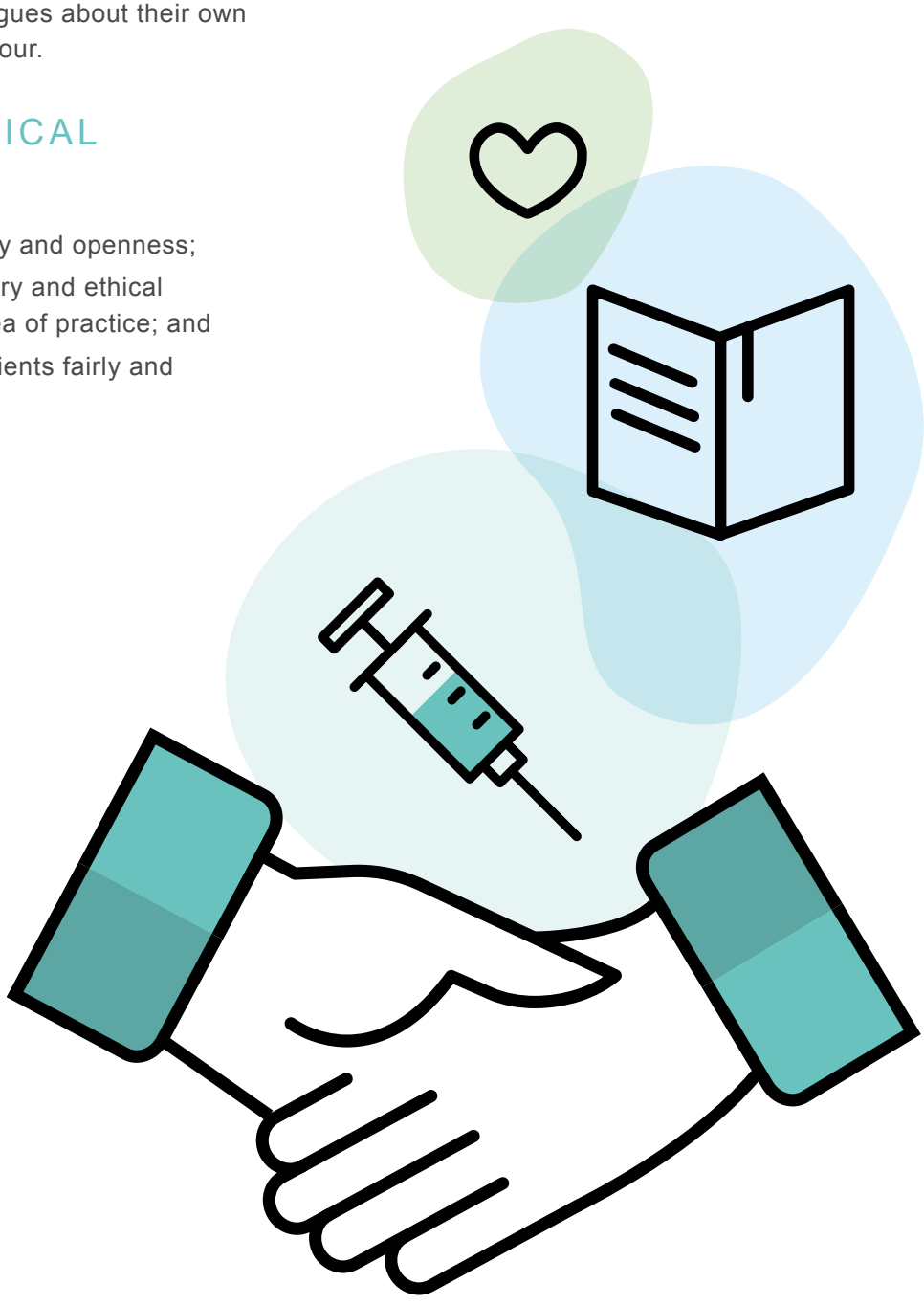
- put the needs of patients at the centre of their practice and decision-making;
- hold the health, safety and dignity of patients as their primary responsibility;
- communicate clearly, openly and compassionately with patients;
- commit to developing a partnership with patients, honouring the relationship of trust and respecting and supporting patients’ autonomy in making decisions about their care; and
- inform patients of the nature of their clinical role.

TEAM-WORKING

- work effectively with other members of the surgical care team;
- communicate respectfully with colleagues; and
- be open to feedback and be willing to reflect on feedback from colleagues about their own performance and behaviour.

TRUST AND ETHICAL BEHAVIOUR

- act with integrity, honesty and openness;
- adhere to legal, regulatory and ethical requirements in their area of practice; and
- treat colleagues and patients fairly and without discrimination.



7. Templates and supporting resources

BUSINESS CASE TEMPLATE

When developing a business case for extending the surgical team, consider the following points:

BUSINESS CASE
REASON FOR EXTENDING THE SURGICAL TEAM
IMPACT OF INTRODUCING EXTENDED ROLES ON IMPROVING SERVICES AND PATIENT EXPERIENCE IN LINE WITH LOCAL PRIORITIES
IMPACT ON TRAINING
RISKS OF INTRODUCING THESE ROLES AND HOW THOSE CAN BE MITIGATED
STRENGTH OF LOCAL CLINICAL SUPPORT

CAPACITY TO SUPERVISE AND TRAIN THE ROLE

COSTS OF ROLE, INCLUDING:

Salary	
On costs (eg national insurance, pension costs)	
Work equipment (eg uniform, computer access)	
Training	
Continuing professional development	
Supervisors' time	

COSTS MITIGATED BY THE ROLE, INCLUDING:

Reduced locum costs	

PRACTICE STANDARDS AND EXPECTATIONS

(ie the framework within which the extended roles will operate)

RECRUITMENT CRITERIA (qualifications and criteria)

NEED TO REVIEW LOCAL POLICIES TO ACCOMMODATE THE NEW MODEL OF CARE

FUNDING FOR TRAINING AND DEVELOPING THE ROLE

SURGICAL CARE TEAM PRACTITIONER: JOB DESCRIPTION TEMPLATE

Hospitals can choose to adapt as appropriate the job description below.

NAME OF HOSPITAL SURGICAL CARE TEAM PRACTITIONER JOB DESCRIPTION

Role title:	
Responsible to:	
Accountable to:	
Unit:	
Department:	
Band:	

BACKGROUND:

Background to the hospital and the service, where relevant

ROLE SUMMARY:

Under the direction and supervision of the consultant surgeon, the post-holder will be able to undertake preoperative and postoperative care, to perform surgical interventions, to participate in the smooth running of clinics, and to work in clinical practice as a member of the surgical care team.

KEY WORKING RELATIONSHIPS:

- Consultant surgeons
- Junior medical staff
- Nursing staff
- Ward staff
- ODP workforce
- Anaesthesia consultants
- Anaesthetic trainees
- General manager
- Clinical director
- Rota coordinators

CLINICAL DUTIES AND RESPONSIBILITIES:

THEATRE DUTIES AND RESPONSIBILITIES:

ADMINISTRATIVE AND MANAGEMENT DUTIES:

EDUCATION AND RESEARCH:

COMMUNICATION:

SURGICAL CARE TEAM PRACTITIONER: PRACTICE PLAN TEMPLATE

Hospitals may choose to use and adapt as appropriate the practice plan below.

SURGICAL CARE TEAM PRACTITIONER PRACTICE PLAN

The purpose of the practitioner practice plan is to provide a framework for clinical practice and supervision of the extended practitioner.

An interim practice plan may be developed during the initial period of employment with the trust. A final practice plan is then agreed with the supervising consultant surgeon and is submitted for approval to the medical director.

Interim practice plan		**Practice plan**	
Practice plan start date	D D / M M / Y Y	**Practice plan review date**	D D / M M / Y Y

SURGICAL CARE TEAM PRACTITIONER

Practice location(s)	
Name	
Contact number	

CLINICAL SUPERVISOR

Name	
Position title	
Contact number	
Scope of clinical practice	

RESPONSIBLE CONSULTANT SURGEON (IF DIFFERENT TO THE ABOVE)

Name	
Position title	
Contact number	
Scope of clinical practice	

DELEGATED PRACTICE

Surgical care team practitioners practise under delegation. Collaboratively, the surgical care team member and the supervising consultant surgeon will determine the appropriate delegated practice. Practitioners should only accept assigned activities that are:

- within the scope of their practice;
- consistent with their education, training, experience and competence; and
- consistent with their job description.

This is not meant to be a complete list of activities or responsibilities, but should be indicative of the types of activities that the practitioner may likely perform in the role with direct, indirect or remote supervision.

SUPERVISION REQUIREMENTS

The practitioner is responsible for making a professional judgement about when an activity is beyond his or her capability or scope of professional practice, and for initiating a consultation with his or her supervising surgeon or other members of the surgical team as appropriate.

ACTIVITIES THAT WILL BE UNDERTAKEN ONLY UNDER DIRECT SUPERVISION:

ACTIVITIES THAT WILL BE UNDERTAKEN ONLY AFTER CONSULTATION:

ACTIVITIES THAT WILL BE UNDERTAKEN AFTER CONSULTATION IF THE PRACTITIONER REQUIRES THIS:

PRACTICE EXCLUSIONS

There are some activities which a practitioner is prohibited to undertake:

- Signing a death certificate. A surgical care practitioner may, however, declare life extinct in lieu of the supervising surgeon.
- Complete or sign a prescription (see *Medicines and Healthcare Products Regulatory Agency's guidelines*)
- Request clinical imaging with ionising radiation
- Perform any medical service, procedure, function or activity that is outside of the assigned role.
- Other:

SERVICE SUPPORT ACTIVITY

Surgical care team roles should normally include a combination of clinical and administrative responsibilities. This section includes non-clinical or administrative responsibilities assigned to this role. This is not meant to be a complete list of activities or responsibilities, but should be indicative of the types of activities that the practitioner may likely perform in the role.

OTHER ACTIVITIES

This section includes any activities around service development, quality improvement, teaching and supervising other roles, et al.

TRAINING AND PERSONAL DEVELOPMENT PLAN

This section includes the practitioner's training and developments needs and how they will be addressed:

TRAINING AND DEVELOPMENT GOALS

HOW WILL THOSE BE ADDRESSED AND BY WHAT DATE

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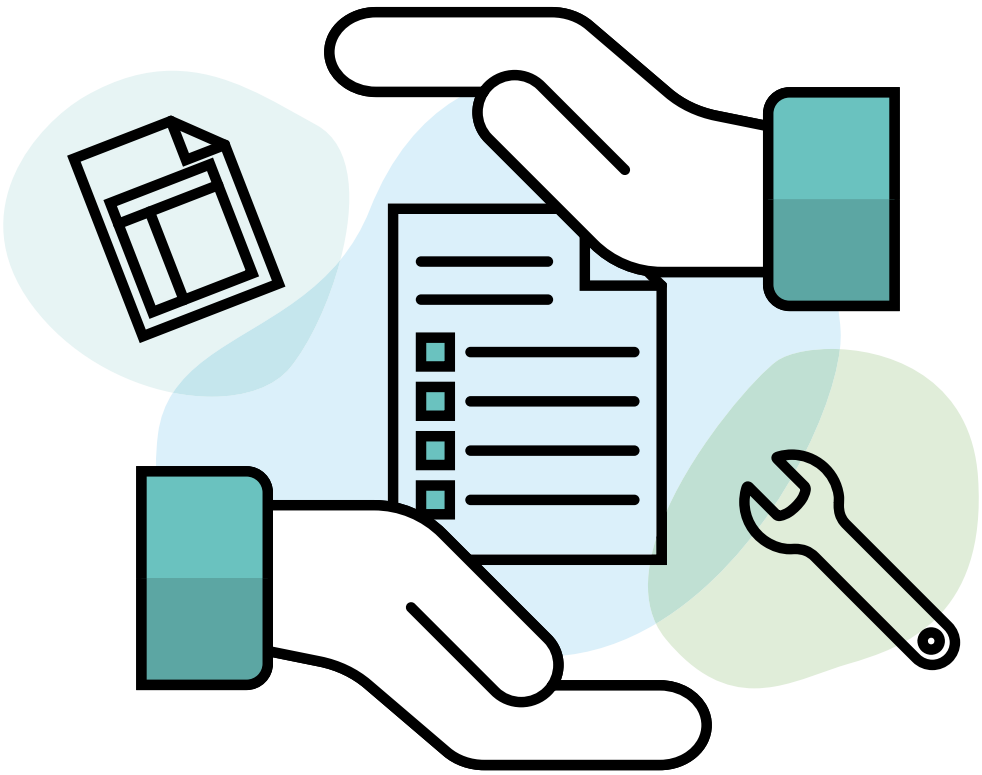

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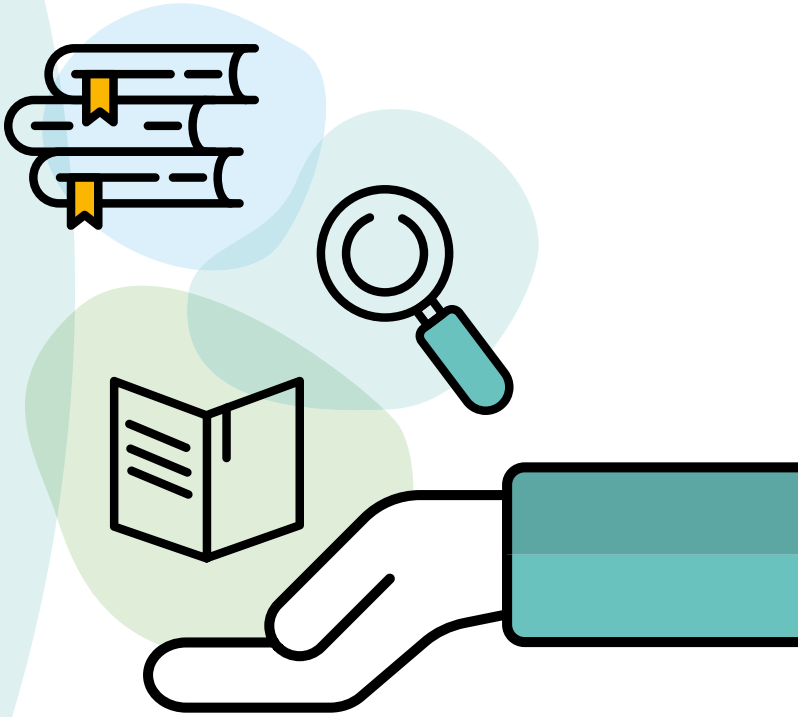

ACCESS OUR **GUIDANCE AND STANDARDS** ONLINE AT **www.rcseng.ac.uk/standardsandguidance**

THE RCS HAS LAUNCHED MEMBERSHIP FOR ROLES WITHIN THE SURGICAL CARE TEAM. **FIND OUT MORE AT** **www.rcseng.ac.uk/associates**

The Royal College of Surgeons

Access our guidance and standards
online at **www.rcseng.ac.uk/standardsandguidance**

The RCS has launched membership
for roles within the surgical care team.
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