Modernising the perioperative workforce
Report of a review of the perioperative workforce in NHSScotland

March 2010
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Foreword

This review of the perioperative workforce in Scotland has been a challenging piece of work to undertake, but it has proved to be a worthwhile challenge.

I, and all the members of the Steering Group, have been struck by the level of commitment from all the staff we have interacted with and their desire to provide high quality services. They have expressed a universal desire to have the work that they do more widely and crucially, more formally recognised, in order that they can expand and develop their teams to meet the challenges that they face in today’s NHS in Scotland.

I would like to take the opportunity to thank the members of the national steering group who provided us with their expertise and helped considerably in accessing data for the review. I hope that you are able to use this report as a vehicle for reflection and discussion: to consider with your teams what your workforce might look like in the future, what education and training is required and agree on your priorities for the future. I commend this report to you.

Dr Jane Burns is Chair of the Modernising the Perioperative Workforce National Steering Group and Associate Medical Director, NHS Lanarkshire
Executive Summary

There is an increasing spotlight on operating theatres across the UK\(^1\) as an environment where improvements in efficiency can be made. In addition, as outlined in the Quality Strategy, patient safety, clinical effectiveness and person centred care within the perioperative environment is paramount\(^2\).

The cornerstone to all of the programmes is an appropriate and sustainable workforce, suitably trained and educated, within a system which provides strategic and clinical leadership.

In order to achieve the optimal use of resources including staff resources, it is vital that staff are effectively recruited and retained, educated and trained and continually developed throughout their career. Significantly, in the current economic climate, there is evidence that one of the highest bank and overtime / agency and locum staff spending comes from theatres.

In December 2008, the Scottish Government Health Directorate invited NHS Education for Scotland to lead a programme of work in 2009 to explore the current perioperative workforce, review the education and training provision and consider recommendations for the future. This report provides the findings of a perioperative workforce audit and related consultation events.

The work programme found that the perioperative workforce is very complex and not at all straightforward to quantify or define. The rapid pace of perioperative service change exacerbates the difficulties in describing the nature of the perioperative workforce. Changes in the medical workforce, notably in relation to Modernising Medical Careers and the implementation of the European Working Time Directive have impacted on the non-medical workforce. The nature of the non-medical workforce, together with the clear need for succession planning, evidence the urgency for workforce development. In particular, the review found that there was a need to

- Develop a defined national dataset on the perioperative workforce to ensure a consistent approach to workforce development to address evolving service needs;
- Develop a national perioperative career framework which defines the key competencies for safe, effective and person-centred service;
- Develop a national approach to education which is accessible, flexible and transferable; and which supports the NHSS career framework; and
- Commission Operating Department Practitioner training in a way which is consistent with other non-medical healthcare professionals.

\(^1\) The Productive Operating Theatre. NHS Institute for Innovation. www.institute.nhs.uk/quality_and_value/productivity_series
\(^2\) Scottish Patient Safety Programme. www.patientsafetyalliance.cst.nhs.uk/programme
Section 1
Modernising the Perioperative Workforce Programme
1. Modernising the Perioperative Workforce Programme

The perioperative workforce serves a variety of extremely diverse service models of care with varying demands placed on their skills. As such, there is no ‘one size fits all’ workforce model and supporting training programme.

The National Theatres Project Final Report was published in November 2006, and refocused the attention of NHS Boards on improving productivity and efficiency within operating theatres in Scotland. Although much work had already been done to develop the necessary roles and supporting education, the last few years have seen an increased focus on developing the workforce required to support the necessary increased clinical activity. A variety of specialist and generalist roles have been developed, some at national level and others more locally, and although many of these have common core skills, they are spread across the work of a wide range of different health care workers and there is little in the way of common understanding of agreed competencies required within these roles.

In December 2008 the SGHD invited NHS Education for Scotland (NES) to lead a programme to address perioperative workforce issues through the establishment of a national steering group on modernising the perioperative workforce. The remit of this group is outlined in appendix A.

In order to support the work of the national steering group, a review of the NHSScotland perioperative workforce and related stakeholder engagement was commissioned in March 2009. This work was designed to determine

- Local, regional and national staffing profiles for the medical and non-medical Perioperative Workforce
- The appropriateness and availability of the educational preparation at local, regional and national level
- Current and possible future career pathways ensuring fitness for practice and consideration of regulatory issues

This report provides the findings of the perioperative workforce audit and related stakeholder engagement. It provides a baseline audit of the workforce, identifies key issues for NHS Boards and makes recommendations for the way forward.
Section 2
The Strategic Context
2. The Strategic Context

The policy context relating to the perioperative workforce, is complex, driven by the Better Health Better Care Action Plan (December 2007), and focusing on improving services through efficiency and process management taking a whole systems approach. The central drive from Better Health Better Care, through the National Improvement Framework and monitored through HEAT targets (also now included in the Scotland Performs Scottish Government Framework), leads to a focus on efficiency and productivity, the patient journey and specific projects and initiatives. These incorporate work from the National Theatre Project, Remote and Rural issues and Safer Patients initiatives.

The publication of the Better Health Better Care Action Plan in December 2007 set out the Government’s programme to deliver a healthier Scotland by helping people to sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to health care. The action plan includes a commitment to investing in “staff skills, training and competencies to help improve services for patients, support team working and enhance Scotland’s reputation as a base for leading health care science and research.”

In relation to remote and rural areas the action plan made a specific reference to the Medical Training Pathways group’s recommendations for a competency framework for doctors within a multi-disciplinary team, specifically considering Anaesthetists, Physicians, Surgeons and General Practitioners adapting the general training curricula for each specialty when required.

The final report of the Remote and Rural Steering Group (May 2008) proposes a staffing model, but doesn’t focus on how this impacts on the perioperative workforce. It noted that skills decay is an acknowledged problem in remote areas where exposure rates to practice are low.

Many national initiatives and policies impact on the perioperative environment, notably the 18 weeks service redesign and transformation programme and the Scottish Patient Safety Programme.

In November 2006 the National Theatres Project identified theatres as places where improvements in efficiencies and effectiveness could take place, but stressed that this environment was within the context of the whole system. Other drivers placing the spotlight on the perioperative environment include Productive Operating Theatres and the LEAN improvement methodology.
Operating theatres are emphasised as a key environment which requires processes that underpin patient safety: the perioperative workstream of the Scottish Patient Safety Programme places a strong emphasis on creating a safety culture through team working and recognition of others roles within the team.

The National Theatres Project argued that the development of comparability, efficiency and quality must be underpinned by

- strong leadership in theatre services;
- the development and maintenance of a learning culture; and
- appropriate use of “fit for purpose” information technology.

Better Health, Better Care (2007) led to the establishment of the NHS Efficiency and Productivity Steering Group in April 2008, and aims to assist NHS Boards to identify and share opportunities for improvement and deliver efficiency savings to ensure optimal deployment of resources to the delivery of front line patient care. The work of the National Theatres Implementation Group, which was established following the

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National Theatres Report, has been incorporated into this programme.

The Improvement and Support Team (IST) has been running National Improvement Programmes since early 2005. These programmes are integrated with the Scottish Patient Safety Programme and NHSScotland’s patient experience programme – ‘Better Together’.

Current improvement programmes include:

- Cancer Target Delivery
- Cancer Performance Support
- 18 Weeks Referral To Treatment (RTT), Service Redesign and Transformation Programme
- The Service, Innovation & Transformation Programme
- Education, Training & Knowledge Management
- Efficiency & Productivity Programme
- Emergency Access
- My Job Programme

The 18 Weeks RTT Programme is heavily dependent on the efficiency of the perioperative environment\(^7\). Whether the imperative is securing operating theatre capacity for cancer surgery or ensuring a maximum 18 week referral to treatment, the key is that improved capacity planning as well as improved efficiency and productivity are absolute requirements to deliver these targets and both require a team approach to the provision of perioperative care, often with flexibility of roles required from a single team of staff.

One of the key improvement areas of the 18 week referral to treatment programme is to make day surgery normal practice where clinically appropriate. This requires an effective team approach to the delivery of care.

The cornerstone to all of these programmes is the need for an appropriate and sustainable workforce; and the recognition is that this workforce is – and has been for some time – under considerable pressure. This can be evidenced by the expenditure on bank and overtime/agency and locum staff. There are concerns at both local and national levels around this and in an attempt to improve recruitment and retention, a number of new roles have been introduced into the perioperative environment to try to improve the career structure that is perceived as lacking within the environment.

There is a sense within all NHS Boards that financial pressures will continue to increase and that there is a need to develop a national career framework for the perioperative workforce through a baseline audit of the current staffing profiles within theatres. It is also vitally important that training and supported development that is available has been taken advantage of within that perioperative environment to support workforce development.

\(^6\) http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/Delivery-Improvement/1835
\(^7\) CEL 12 (2008)
2.1 The NHSScotland Workforce

The shape of the NHSScotland workforce is constantly changing. It is shaped both by demographic factors and policy factors including the implementation of the European Working Time Directive, and Modernising Medical Careers. These factors mean that there is a need for the medical workforce to no longer rely on doctors in training for service delivery; and that some of this activity may be displaced to existing or new non-medical roles.

2.1.1 The Medical Workforce

It is Scottish Government policy to move towards a service delivered by trained doctors and to reduce the reliance on doctors-in training for front-line service delivery. This will require a clear understanding of likely expansions in career-grade doctors and consequent reductions in junior doctors numbers and availability. A number of priority specialties have been identified, primarily those where there are acute resident on-call requirements currently being staffed by junior doctors. These are Emergency Medicine, Acute Medicine, General Surgery, Trauma & Orthopaedic Surgery and Anaesthesia.

In June 2009, the Government asked NHS Boards to project future medical workforce requirements (CEL 28 (2009)). Estimates were required by the end of November 2009\(^8\) and were to consider the development of models of care to reflect the 25\% reduction (in most specialities) of junior doctors in training and the 40\% reduction of middle grade doctors in training. The CEL stressed that

“not all the activities of doctors in training will need to be replaced. Boards will need to consider which activities are directly service, as opposed to training related, and consider the best way to replace or redesign those activities. Boards should take account of potential for work to move between clinical disciplines and try to estimate the answer to the following question: ‘Within the total clinical work that will be done by this department what workload needs to be done by doctors and how many of which grades are required?’.”

2.1.2 The Non-medical Workforce

The Nursing and Midwifery Workload and Workforce Planning Programme is a key strand in the Scottish Government’s drive for improvement in workforce productivity. As part of the programme, a series of workload tools for nursing and midwifery, covering 80\% of services have been trialled and now are being implemented in territorial Boards to help NHS Boards to set appropriate nursing and midwifery establishments and – in due course – will provide a database of staffing profiles across NHSScotland.
Alongside this, the NHS Education for Scotland, Building Workforce Capacity Programme includes several role development initiatives. The following initiatives relate to the perioperative workforce:

- Anaesthetic Assistants
- Operating Department Practitioners
- Physician Assistant - General
- Physician Assistant - Anaesthesia
- Advanced Scrub Practitioner Training
- Endoscopy
- Rural General Surgeons Training
- Health Care Support Worker perioperative competencies
Section 3
The Approach and Methods
3. The Approach and Methods

The review of the perioperative workforce involved four aspects

- An audit of the perioperative workforce in each territorial NHS Board
- Consultation meetings with each territorial NHS Board
- National consultation workshops
- Ongoing engagement and consultation with key stakeholders, including the NHS Workforce Planning Regions and the relevant professional bodies.

All aspects of the review were discussed and agreed with the National Steering Group.

Modernising the Perioperative Workforce Programme was launched on 23 April 2009 with a national stakeholder workshop (see appendix B for programme and attendees).

The audit template was piloted in 4 NHS Boards (Lanarkshire, Greater Glasgow & Clyde, Forth Valley and Orkney). The pilot was undertaken during May 2009. The National Steering Group reviewed the pilot and agreed the final audit template.

It was important to have a clearly defined (by the Board Chief Executive) lead individual for the audit as data were required from across different departments/directorates, and not always readily available. The audit process (including meetings with Boards) included a varied mix of clinical staff, managers, workforce planners and finance officers. In five Boards, no medical staff were involved either in data collation or the Board meeting.

The audit provides a snapshot description of the perioperative workforce during week beginning 25 May 2009.

The Programme Manager (and a National Steering Group member where relevant and possible) met with each Board to discuss the completed audit template. The lead individual was asked to invite to the meeting all people involved in completing the audit template, the 18 week programme manager and other relevant individuals to the meeting. See appendix C for the topic guide for the Board consultation meetings.

9 Where National Steering Group member was from a Board, they attended the Board consultation meeting.
Following each Board meeting, the MPW Programme Manager drafted a full report on the Perioperative Workforce in that Board. This contained the data provided through the audit and included a summary of key issues for the perioperative workforce. Each Board was asked to review the draft report and final reports were agreed with each Board. See appendix D for the outline structure of each Board report. The reports detailing the perioperative workforce in each Board remain confidential to the Board: they informed this national report, but are not part of it.

Two national stakeholder consultation events were held in late November/early December 2009. Everyone who had been involved in the perioperative workforce review, and other stakeholders, were invited to an event. See appendix E for programme, participants and evaluation. Each event provided draft findings of the workforce review, and included facilitated workshops to consider the draft findings. The events informed this final report.
3.1 Data Limitations

This is the first time that an audit of the perioperative workforce has been undertaken, and although it provides a baseline, it cannot – and was not designed to – provide a benchmark.

The data cannot be regarded as complete, and are indicative rather than definitive. This was due to several challenges.

A key issue was the lack of consensual definitions, including

- the length of an operating session: this varied in from 3.5 hours to 6 hours
- how operating sessions relate to medical staff job plans and allocated contractual hours
- whether the perioperative environment included areas such as pre-assessment, endoscopy day surgery or critical care.

Further difficulties were incurred when using HR and role data provided to ISD/SWISS. This provided difficulties in

- disaggregating ODPs – and other distinct roles from the ‘job families’ which ISD/SWISS map these roles to, such as ‘general acute’
- disaggregating perioperative staff hours from all contracted hours
- disaggregating non-recurrent costs (agency/bank/overtime/waiting list initiative payments) specific to the perioperative environment.

Not all Boards provided data relating to all audit fields, for example funded WTE, age.

Finally, as the individual Board reports remain confidential to the Board, detailed comparison, for example of skills mix, was impossible.
Section 4
The Service Model
4. The Service Model

The service model varies widely across the NHS Boards – and varies from hospital to hospital within Boards.

- Day surgery is a standalone service, with a separate, distinct workforce in six Boards. Two of these Boards have not included this workforce in the perioperative workforce audit.
- Endoscopy is a standalone service, with a separate, distinct workforce in seven Boards. Four of these Boards have not included this workforce in the perioperative workforce audit.
- Paediatrics is a standalone service in three Boards – notably those with separate children’s hospitals.
- Recovery is integrated within the perioperative environment in twelve out of the fifteen Boards. Three Boards have separate recovery non-medical teams.
- The perioperative workforce – in particular anaesthetists and a range of non-medical staff – support other service areas, notably pre-assessment, ICU/HDU, pain services, obstetrics, ECT, and inter-hospital patient transfers. These areas have been variously included in the workforce audit: it is particularly difficult to disaggregate out the perioperative work of medical staff (contractually allocated time or programmed activities).

It was not possible to identify consistent Board ‘types’ and to analyse workforce issues in relation to typology. The service model varied across several variables, including those described above.

4.1 Out of Hours

The data on Out of Hours staffing showed considerable variation across Boards. The non-medical model was generally three – four registered staff plus one unregistered staff on duty, depending on the speciality. On-call staffing was much more variable.

Although Boards were asked to provide Out of Hours data by WTE, the unit of measurement varied from WTE to headcount to hour count.
4.2 Remote and Rural issues

Specific issues emerged for the perioperative workforce in remote and rural areas. These related in particular to the high variation, low volume case mix typical of remote and rural areas which

- provides limited career development opportunities for medical staff
- causes recruitment difficulties, particularly of general surgeons
  - Which causes a significant dependence on locums
  - Which are exacerbated as individual-dependent systems develop – that are not sustainable when that person leaves.
- Provides difficulties for staff at all levels to maintain their competencies
- Means that staffing/workforce models are relatively expensive as relevantly competent staff need to be available to handle complex cases.
  - Band 6 staff may need to be appointed rather than Band 5 staff in order to have the necessary experience and expertise
  - Out of Hours cover is expensive

This reflects the relationships between Boards, in particular to provide visiting consultants to deliver speciality sessions to remote, rural and smaller Boards.
4.3 Planned Changes

Perioperative services are undergoing significant change.

A key overarching issue throughout the review was the widening scope of the ‘perioperative’ environment, which had led to

- an increasing emphasis on pre-assessment (including surgical, anaesthesia and nursing staff) to enhance day case rates and same day of admission surgery as well as minimising patient cancellation rates and supporting informed consent.
- increasing use of day surgery facilities
- the development of diagnostic services, in particular endoscopy
- the repatriation of cases from national/regional centres, notably in relation to orthopaedics
- Surgical procedures taking place out with theatres e.g. out patient facilities, minor ops units, and some ward areas
Section 5

The Perioperative Workforce
5. The Perioperative Workforce

5.1 The Medical Perioperative Workforce

It was not the remit of this report to outline in detail the medical workforce and anticipated changes to it in the foreseeable future. However, the steering group acknowledged that consultant 'owned' sessions represented the majority of the clinical activity that is supported by the perioperative workforce. The group were of the view that it was essential to try to establish the size and nature of the contribution that the various grades of the medical workforce currently made to the perioperative environment and also to give some indication of how that may change in relation to the planned service changes outlined above and the inevitable changes to the contribution from doctors in training as previously discussed.

5.1.1 Definitional Issues

Key definitional issues emerged in relation to

- Consultants job plans, notably the number and nature of programmed activities:
  - One WTE consultant is formally measured by ISD as 10 programmed activities (PAs) (40 hours per week) but the widespread use of EPAs (extra programmed activities) for most consultants leads many boards to define 12 PAs as 1 WTE. This has implications for the counting of WTE consultants, both actual and funded establishment.
  - Operating sessions can vary in length and therefore cannot always be directly reconciled with contracted hours as these are split into 4 hour time periods that each equate to 1 PA. Disaggregating perioperative PAs is therefore complex.

- SWISS: Many honorary consultations are not recorded on SWISS.

- Locums
  - Disaggregating perioperative locum time/costs from whole locum time/costs. The majority of locums were employed for continuity/maintaining compliance of Out of Hours rotas and the perioperative contribution is highly variable.

- Paediatric Surgery
  - In all except two cases this was included in the specialty and not identified separately.

Specialities which had very little (or no) perioperative activity were not included in the analysis that follows.
Many Boards collated ISD specialities as follows:

<table>
<thead>
<tr>
<th>Speciality</th>
<th>Collated Speciality</th>
</tr>
</thead>
<tbody>
<tr>
<td>General surgery</td>
<td>General &amp; Vascular Surgery</td>
</tr>
<tr>
<td>Vascular surgery</td>
<td>General &amp; Vascular Surgery</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>Oral &amp; Maxillofacial Surgery</td>
</tr>
<tr>
<td>Maxillofacial</td>
<td>Oral &amp; Maxillofacial Surgery</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>Gynaecology &amp; Obstetrics</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>Gynaecology &amp; Obstetrics</td>
</tr>
<tr>
<td>Clinical radiology</td>
<td>Clinical &amp; Interventional Radiology</td>
</tr>
<tr>
<td>Interventional radiology</td>
<td>Clinical &amp; Interventional Radiology</td>
</tr>
</tbody>
</table>

These collated specialties are used in the analysis overleaf.
Table 1: Medical staff headcount by speciality

<table>
<thead>
<tr>
<th>Speciality</th>
<th>Consultants</th>
<th>Specialty Doctors including Staff &amp; Associate Specialists</th>
<th>Total Doctors</th>
<th>Ratio of consultants to non-consultants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>32</td>
<td>5</td>
<td>37</td>
<td>6.4</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>23</td>
<td>5</td>
<td>28</td>
<td>4.6</td>
</tr>
<tr>
<td>Respiratory medicine</td>
<td>32</td>
<td>2</td>
<td>34</td>
<td>16</td>
</tr>
<tr>
<td>General &amp; Vascular Surgery</td>
<td>223</td>
<td>33</td>
<td>256</td>
<td>6.75</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>574</td>
<td>79</td>
<td>653</td>
<td>7.26</td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>27</td>
<td>4</td>
<td>31</td>
<td>6.75</td>
</tr>
<tr>
<td>ENT</td>
<td>78</td>
<td>11</td>
<td>89</td>
<td>7.09</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>22</td>
<td>0</td>
<td>22</td>
<td>N/A</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>102</td>
<td>33</td>
<td>135</td>
<td>3.09</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>202</td>
<td>26</td>
<td>228</td>
<td>7.76</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>36</td>
<td>2</td>
<td>38</td>
<td>18</td>
</tr>
<tr>
<td>Paediatric Surgery</td>
<td>23</td>
<td>1</td>
<td>24</td>
<td>23</td>
</tr>
<tr>
<td>Urology</td>
<td>69</td>
<td>11</td>
<td>80</td>
<td>6.27</td>
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<tr>
<td>Oral &amp; Maxillofacial Surgery</td>
<td>32</td>
<td>8</td>
<td>40</td>
<td>4</td>
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<tr>
<td>Gynaecology &amp; Obstetrics</td>
<td>124</td>
<td>40</td>
<td>164</td>
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<tr>
<td>Clinical &amp; Interventional Radiology</td>
<td>99</td>
<td>0</td>
<td>99</td>
<td>N/A</td>
</tr>
<tr>
<td>Dental Surgery</td>
<td>34</td>
<td>9</td>
<td>43</td>
<td>3.77</td>
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<td>TOTALS</td>
<td>1732</td>
<td>269</td>
<td>2001</td>
<td>6.43</td>
</tr>
</tbody>
</table>

Analysis of the funded establishment of the medical perioperative workforce has been done only for those Boards which were able to provide data on funded establishment (3 Boards were unable to provide these data)\(^{10}\).

\(^{10}\) Consequently, the WTE figures are lower than the headcount.
Some Boards had opted to increase the complement of Specialty Doctors in certain specialties that had started to develop shortages at junior doctor level, although they acknowledged that this was likely to be only a temporary workforce solution as these middle grade posts would become harder to recruit into. Many Boards reported that they were already experiencing difficulty in recruiting suitable applicants into middle grade Specialty Doctor (including Staff & Associate Specialist grades) which have traditionally received many applications per post. Vacancies at Consultant level are not uncommon due to the lengthy recruitment process and subsequent notice periods of appointees.

The relatively high percentage of unfilled non-consultant posts (14.9%) confirms the concerns expressed by Boards that there is already pressure on the non-medical perioperative workforce to support consultants in this environment, for example to fill the role of first assistant. The progression away from doctors in training to provide assistance to consultants in service delivery may increase the need for recruitment of more Specialty Doctors (or other Healthcare Professionals). If the current recruitment difficulties continue (and most Boards believed that they would), an increased shortfall would present further challenges for existing non-medical perioperative staff in terms of both roles and staffing levels. The data indicate that this pressure is likely to be most acute in ENT, Oral and Maxillofacial and General & Vascular surgery.
<table>
<thead>
<tr>
<th>Speciality</th>
<th>Consultants actual</th>
<th>Consultants funded</th>
<th>Consultants unfilled %</th>
<th>Total Sp, SAS actual</th>
<th>Total Sp, SAS funded</th>
<th>Total Sp, SAS unfilled %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>19.6</td>
<td>19.6</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>14.2</td>
<td>14.2</td>
<td>0</td>
<td>2.86</td>
<td>2.6</td>
<td>-10</td>
</tr>
<tr>
<td>Respiratory medicine</td>
<td>21.5</td>
<td>21.5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>General and vascular Surgery</td>
<td>188.15</td>
<td>203.52</td>
<td>7.5</td>
<td>25</td>
<td>29.81</td>
<td>16.1</td>
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<tr>
<td>Anaesthetics</td>
<td>436.98</td>
<td>447.76</td>
<td>2.4</td>
<td>54.9</td>
<td>61.8</td>
<td>11.1</td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>20</td>
<td>20.5</td>
<td>2.4</td>
<td>4</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>ENT</td>
<td>62.42</td>
<td>62.42</td>
<td>0</td>
<td>5.4</td>
<td>10.88</td>
<td>50.3</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>18</td>
<td>17</td>
<td>5.8</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>75.26</td>
<td>82.58</td>
<td>8.8</td>
<td>22.83</td>
<td>25.86</td>
<td>11.7</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>147.53</td>
<td>162.74</td>
<td>9.3</td>
<td>10.55</td>
<td>9.89</td>
<td></td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>30.6</td>
<td>30.21</td>
<td>-1.2</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Paediatric Surgery</td>
<td>15.2</td>
<td>15.7</td>
<td>3.1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Urology</td>
<td>50.65</td>
<td>50.54</td>
<td>-0.2</td>
<td>7.27</td>
<td>6.27</td>
<td>-15.9</td>
</tr>
<tr>
<td>Oral and Maxillofacial Surgery</td>
<td>21.7</td>
<td>25.7</td>
<td>15.5</td>
<td>4.5</td>
<td>8.33</td>
<td>40.5</td>
</tr>
<tr>
<td>Gynaecology and obstetrics</td>
<td>83.25</td>
<td>93.52</td>
<td>10.9</td>
<td>19.86</td>
<td>26.23</td>
<td>24.2</td>
</tr>
<tr>
<td>Dental Surgery</td>
<td>24.55</td>
<td>28.05</td>
<td>12.4</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TOTALS</td>
<td>1288.11</td>
<td>1312.04</td>
<td>1.8</td>
<td>162.17</td>
<td>190.67</td>
<td>14.9</td>
</tr>
</tbody>
</table>
5.2 The Non-medical Perioperative Workforce

The national non-medical perioperative workforce comprised 3717 people; of which 2887 were registered staff, and 830 are unregistered. The ratio of registered to unregistered staff within the adult nursing workforce across Scotland is 2.7 registered to every one unregistered staff member. The national ratio within the perioperative workforce is 3.5 registered staff to every unregistered staff member.

Table 3: non medical staff national headcount

<table>
<thead>
<tr>
<th>Pay band</th>
<th>Number of staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 2</td>
<td>588</td>
</tr>
<tr>
<td>Band 3</td>
<td>223</td>
</tr>
<tr>
<td>Band 4</td>
<td>19</td>
</tr>
<tr>
<td>Band 5</td>
<td>1917.4</td>
</tr>
<tr>
<td>Band 6</td>
<td>708</td>
</tr>
<tr>
<td>Band 7</td>
<td>239</td>
</tr>
<tr>
<td>Band 8a</td>
<td>22</td>
</tr>
</tbody>
</table>

Both the registered and unregistered workforces were bottom heavy, with staff clustered at Band 2 and Band 5. Across the Boards, however, the ratio varied quite widely – from a ratio of 2.5 registered staff to every unregistered staff member in one Board, to 27 registered staff to every unregistered staff member in another. Smaller Boards tended to have higher ratios of registered to unregistered staff.

Analysis of the funded establishment of the non medical perioperative workforce has been done only for those Boards which were able to provide data on funded establishment (4 Boards were unable to provide these data). This analysis showed that there were fewer staff employed than the funded establishment provides. See Table 4.

<table>
<thead>
<tr>
<th>Total</th>
<th>Registered</th>
<th>Unregistered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual WTE staff</td>
<td>2879.93</td>
<td>2233.53</td>
</tr>
<tr>
<td>Funded WTE staff</td>
<td>3029.95</td>
<td>2310.62</td>
</tr>
</tbody>
</table>

Analysis by pay band indicated that the funded establishment for unregistered staff was concentrated on band 2, with 31.4% posts unfilled. Similarly within the registered workforce, the funded establishment was concentrated at band 5, where 24.1% posts were unfilled. At higher pay bands, the establishment provided for fewer staff than were actually employed. This indicates that there is little scope for the funded establishment in providing for career progression through the pay bands.

\[ ISD baseline data 2008 \]
Table 5: Actual and funded non medical staff, by pay band

<table>
<thead>
<tr>
<th>Pay Band</th>
<th>Actual WTEs</th>
<th>Funded Estab</th>
<th>Unfilled Posts</th>
<th>% Unfilled Posts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 2</td>
<td>424.27</td>
<td>618.48</td>
<td>194.21</td>
<td>31.4%</td>
</tr>
<tr>
<td>Band 3</td>
<td>209.46</td>
<td>86.85</td>
<td>-122.61</td>
<td>-141.1%</td>
</tr>
<tr>
<td>Band 4</td>
<td>12.67</td>
<td>14</td>
<td>1.33</td>
<td>9.5%</td>
</tr>
<tr>
<td>Band 5</td>
<td>1440.43</td>
<td>1898.47</td>
<td>458.04</td>
<td>24.1%</td>
</tr>
<tr>
<td>Band 6</td>
<td>589.09</td>
<td>326.64</td>
<td>-262.45</td>
<td>-80.3%</td>
</tr>
<tr>
<td>Band 7</td>
<td>185.73</td>
<td>73.08</td>
<td>-112.65</td>
<td>-154.1%</td>
</tr>
<tr>
<td>Band 8a</td>
<td>18.28</td>
<td>12.43</td>
<td>-5.85</td>
<td>-47%</td>
</tr>
</tbody>
</table>

The model for staffing one additional operating session varied by Board and by specialty. In general, 5-6 staff in total (including recovery care) were allocated to each additional session, with 3-5 staff being registered. This may have implications for those Boards with ratios of registered to unregistered staff higher than 5 to 1.

The national age profile of non-medical perioperative staff\(^\text{12}\) indicates a need for succession planning for the Band 7 and 8 workforce: all Band 8 staff were over the age of 55; 12% of Band 7 staff were over the age of 55; and 11.6% of Band 6 staff were over the age of 55.

\(^{12}\) This analysis is based on data from 14 out of the 15 NHS Boards providing perioperative services: one Board was unable to provide this information.
13 out of 15 Boards provided a disaggregated headcount of ODP staff: there were 125 ODPs in total. This was 4.3% of the registered workforce.

Six of the 15 Boards supported the development of the Physician’s Assistant (Anaesthesia) (PAA) role, with qualified and/or trainee PAA’s in post.

Other advanced roles within the perioperative environment included

- physicians assistant (Orthopaedics)
- advanced scrub practitioner
- surgical nurse practitioner
- specialist nurse (pain, endoscopy, urology)
- play specialist (paediatric surgery)

### 5.3 Operating Sessions

The volume of operating sessions corresponded with the medical staff profile – notably that most sessions are provided in General & Vascular Surgery and Trauma & Orthopaedics. Two Boards were able to provide the staff mix of operating sessions – if provided for all Boards, these data would provide a very comprehensive picture of the staff mix of sessions across the speciality. The data provided to this audit indicate only that some sessions in some Boards are led by non-consultants, including nursing staff – in particular endoscopy sessions.
5.4 Staffing/Skills Mix Issues

In consultations with NHS Boards, three key issues relating to staffing/skills mix emerged:

- Workforce flexibility;
- The need to define the skills and staffing mix; and
- Non-medical capacity/resource issues

Boards were all working to enhance the flexibility of the perioperative workforce. This included the development of

- working beyond 9am – 5pm, e.g. by moving to a 2.5 or 3 session days
- flexible sessions in some consultants job plans. This model had been developed specifically by some Boards and specialties to ensure that there were minimal cancelled sessions
- rotating non-medical staff around the specialties and perioperative areas

All Boards were concerned about the capacity of the non-medical workforce – in particular to cover the reduced availability of junior doctors due to reduced hours through the implementation of the European Working Time Directive and reduced numbers and skill mix following the implementation of Modernising Medical Careers. Capacity to cover Out of Hours recovery was identified as particularly challenging.

Boards were concerned over inconsistencies in Agenda for Change pay banding and in the developing role of Health Care Support Workers within the perioperative environment. This related to concerns about the need for national guidance\(^{13}\) on perioperative skills mix to ensure patient safety.

In particular, Boards called for a national definition of the perioperative skills mix to go beyond specifying a ratio of 3 or 4 registered staff to 1 unregistered staff to provide for the development of a multi-skilled team of individuals by addressing the competencies required rather than the pay bands required.

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\(^{13}\) AFPP guidance was not seen as strong enough to ensure patient safety
5.6 Recruitment and Retention

Recruitment and retention of staff within the perioperative workforce varied widely across the Boards. In relation to medical staff, there were some concerns over difficulties in recruiting and retaining middle grade doctors, in particular in anaesthesia. This gave particular concern in relation to the ability to cover out of hours anaesthetic on call rotas which are viewed as essential to the safe delivery of 24/7 emergency services.

Other concerns related to

- the very specific skills mix of some posts (e.g. General Surgery with a Breast sub-speciality), which provided some recruitment difficulties; and
- recruitment of general surgeons to Rural General Hospitals (especially in the Island Boards) due to
  - The high variation, low volume case load
  - The significant (and unattractive) on call commitment for the small team of surgeons and anaesthetists
  - Limited career development opportunities

NHS Borders development of a regional approach to medical recruitment

NHSB is working to develop a regional approach to medical recruitment, including tertiary exposure for local DGH consultants included in agreed job plans. Consultant Posts in a DGH with this innovative approach to their clinical workload will be more attractive in the recruitment market. To date this has resulted in successful appointment to difficult to fill posts e.g. a consultant surgeon who provides 2 DCCPAs each week to NHS Lothian to ensure that he maintains his specialty skills in breast surgery, ENT Surgeons with theatre sessions at RIE/St Johns, and a regional network in Urology.

In relation to non-medical staff, Boards noted difficulties in recruiting ‘theatre ready’ Band 5 staff, and in recruiting ODPs.

In relation to Band 5 staff, some Boards were working with HEIs to provide perioperative practice placement for pre-registration students to improve the recruitment of new nursing graduates. Boards were also making use of the national new nursing graduates’ initiative to intensively train newly qualified practitioners for the perioperative environment during their 4 month supernumerary period.

Boards noted particular difficulties in the supply of ODPs: they linked this to the lack of opportunities to train as Operating Department Practitioners.

Boards were also concerned over the high turnover of theatre managers.
5.7 Non-recurring Perioperative Workforce Costs

The audit asked Boards to provide data on non-medical agency/bank usage, non-medical overtime, and Waiting Time Initiative Payments. It was generally very difficult for Boards to provide disaggregated data for the perioperative workforce; and the unit of measurement varied from financial cost to annual hours, to hours for the audit week. This made it impossible to provide any national analysis of the non-recurring costs within the perioperative environment.

Whilst most Boards had local policies to reduce the use of overtime and agency staff, most Boards also reported that Waiting Time Initiative Payments was a ‘significant’ non-recurring cost.

ISD collects no data on staff overtime; it publishes only nursing bank and agency data.
Section 6
Career Pathways
6. Career Pathways

Perioperative services in each Board ranged from highly specialised complex activity undertaken in teaching Boards to less specialised work taking place across all theatre services. There was no single perioperative service model, and within Boards the perioperative service model often varied across sites. It was not possible to provide a typology of NHS Boards in Scotland or a typology of service models. Each service has developed within a specific context to meet local needs in accordance with professional standards. Different service models and contexts allow the development of different perioperative roles, and consequently different career patterns and pathways.

Medical career pathways are very well defined to doctors pursuing specialist training in order to achieve a Certificate of Completion of Training (CCT) and gain entry to the GMC Specialist Register. These are not explored in any further detail within this report.

6.1 Career Frameworks

Career frameworks specific to the non medical perioperative workforce have been developed by some Boards. These aim to promote the continuous professional development of the workforce, and to support both the flexibility of the workforce, and the retention of staff to the workforce.

NHS Lanarkshire provides perioperative services over three acute sites, with hub and spoke arrangements for some specialties. In 2006 it undertook a review of the perioperative workforce in order to identify and define

- The roles required for an integrated perioperative team
- The competencies required for the varying roles
- Training and development requirements and available opportunities
- A career pathway to support the continual development of perioperative support staff and registered practitioners.

This resulted in an aspirational framework that the Board found difficult to implement systematically in the absence of a national approach taken by all Boards. Some of the framework has been incorporated into the perioperative staff induction programme. The perioperative job descriptions have been fully implemented.

NHS Grampian has explicitly adopted the Perioperative Career Framework. This provides a clear progression from Perioperative Support Worker (band 2) to Theatre Manager (band 8). The Framework – including job titles – is used within one hospital within the Board, and there are plans to implement it throughout the Board with appropriate education/training at each level. The Board is currently developing relevant business cases.
Grampian Perioperative Career Framework

Theatre Manager – Band 8
Staff working at a very high level of clinical expertise and/or have responsibility for planning of services.

Perioperative Senior Nurse – Band 7
Registered Nurse or ODP with current registration. Professional knowledge acquired through Degree/Diploma supplemented by specialist clinical, managerial training.

Perioperative Practice Educator – Registered Practitioner,
MSC in Nursing and PgCert in Education, Extensive Perioperative Experience.

Perioperative Team Leader – Band 6
Registered Nurse or Operating Department Practitioner. Evidence of post registration/graduate education and extensive experience within perioperative practice.

Advanced Scrub Practitioners – Band 6
Registered Nurse or Operating Department Practitioner. Post registration Advanced Scrub Practitioner course. Extensive experience within perioperative practice.

Emergency Perioperative Practitioner – Band 6
Registered Nurse or Operating Department Practitioner, extensive experience within Perioperative Emergency care.

Perioperative Practice Education Facilitator – Band 6
Registered Practitioner, Degree qualification and PgCert in Education

Perioperative Nurse/Operating Department Practitioner – Band 5
Registered Nurse undertaking the Perioperative Staff Nurse Development Programme
Operating Department Practitioner - OU

Theatre Assistant Practitioner – Band 4
SVQ Perioperative Care-Surgical Support Level 3 and Perioperative Care-Surgical Support Level 3 additional units
Certificate in Higher Education
Diploma in Higher Education

Student ODP – Band 4
Undertaking ODL modules in Operating Department Practice

Senior Perioperative Healthcare Support Worker – Band 3
SVQ Perioperative Care-Surgical Support Level 3

Perioperative Healthcare Support Worker – Band 2
NHS Grampian has introduced the Advanced Scrub Practitioner role and is developing proposals for a structured roll out of the role. It hopes that this Band 6 post will attract experienced practitioners. To ensure backfill for these posts NHS Grampian hopes to re-introduce the training of Operating Department Practitioners through open and distance learning. These student posts would commence at a Band 4 progressing to a Band 5 on qualifying. The Board hopes that this role will attract a variety of candidates including Science graduates. NHS Grampian is in the process of developing a Band 3 Senior Healthcare Support Worker role and Band 4 Assistant Theatre Practitioner. It plans to continue to recruit from newly qualified nurses into Band 5 roles. Developing these roles will provide a strong perioperative career framework offering variety and progression from Band 2 to 7.

**6.2 Developing Roles**

The review indicated the range and variety of non-medical workforce roles (and job titles) being developed by NHS Boards. These have developed in relation to specific local contexts and needs and suggest that there are complex local career pathways.

**First Assistant to the Main Operator**

This duty was formerly undertaken for the most part by junior doctors: all NHS Boards were addressing how best to fulfil this duty. Although many Boards consider that this may be a development of the Advanced Scrub Practitioner or Physicians Assistant role, all consider there was an urgent need to clarify who would undertake this task and the competencies required to support it. There was a general concern that there was an emerging pressure that scrub staff would undertake the assisting role as part of their overall role – without additional training or capacity. Further, there has not been any agreement of the Royal Colleges of Surgeons on competencies for this role.

**Physicians Assistant – Anaesthesia**

Six Boards supported the development of the Physician’s Assistant – Anaesthesia (PAA) role, with qualified and/or trainee PAAs in post; and one further Board had plans to support this role. This role was too new (during the audit period there were only twelve qualified PAAs) to assess its development and impact.

**Physicians Assistant**

This role was used by one Board (NHS Lanarkshire), where there were seven Physicians Assistants in post during the audit period. The Board was piloting this role for applicability to General & Vascular Surgery as well as Trauma & Orthopaedics.

**Advanced Nurse Practitioner**

Three Boards stated that they were developing this role, including use for day surgery, cardiac surgery, neurosurgery, plastic surgery and the Hospital at Night.
The development of the Advanced Nurse Practitioner Role by NHS Greater Glasgow and Clyde included plastic surgery Nurse Practitioners in minor surgery. This role had been developed in conjunction with the relevant medical staff. In 2006 NHS GG& C developed a one year course with GCU to train these staff. Consultants are the supervisors and mentors of these Nurse Practitioners, who are now regarded as ‘the operator’ for minor surgery and supported by scrub nurses. They provided ten sessions each week. The Nurse Practitioners also provided operating sessions within the RAH. This role was not seen as that of a ‘first assistant’.

**Advanced Scrub Practitioner**

Nine Boards stated that they were developing this role. One Board was not supporting this role, seeing a greater need for basic scrub practitioners; and also having concerns about the impact of maintaining the advanced competencies on the work balance of the non-medical perioperative team.

**Anaesthetic Assistant**

The development of national core competencies for anaesthetic assistants has supported the development of this role. Although generally very welcome, Boards identified that Staff may be repeating competency training gained through other routes following the implementation of the competencies. NHSQIS Anaesthesia Standards follow up exercise is currently assessing progress with implementation of these competencies as part of its review process.

**Other extended roles**

One Board (NHS Lanarkshire) was currently piloting the role of Trauma and Emergency Liaison Nurse – this extended role was being undertaken by an experienced theatre nurse to support the preoperative and postoperative care of patients.

**Operating Department Practitioners**

Two Boards reported that they were actively developing this role: these Boards noted the limited training provision for ODPs in Scotland and this was reflected by other Boards who were unable to commit to training these staff but could see the importance of this role within the perioperative environment. (see section on available education).

NHS Grampian is supporting one Band 1 to train as an ODP: fees and travelling expenses etc are provided through an endowment fund.

Three Boards stated that they were not developing this role as they see it as less flexible than the role of registered nursing staff.
**Unregistered staff**

Ten Boards reported that they were explicitly developing the role of unregistered staff within the perioperative environment, in particular through supporting them to gain the SQV 2/3 in Perioperative Support.

In NHS Fife 4 Nursing Assistants/Perioperative Assistants (Band 4s) have been supported to the role of Advanced Perioperative Assistants at the level of SVQ level 3 with additional scrub units to allow them to undertake the scrub role. NHS Fife has funded this training, which is provided by NHS Lothian.

NHS Greater Glasgow and Clyde has worked with NES to develop core competencies for perioperative healthcare support workers.

NHS Borders was working with Napier University to develop core competencies for perioperative healthcare support workers.

**6.3 Approaches to Career Development**

Several Boards were working to develop the flexibility of the non-medical workforce through rotation around the perioperative areas (scrub, anaesthesia, recovery); and through the specialties.

**NHS Highland – opportunities through secondment**

The Board has

- seconded a theatre manager to NHS Orkney for six months and is considering the development of reciprocal secondments/placements to enable Boards to share skills
- supported six-eight staff with a week placement at Yorkhill Hospital to enable them to develop paediatric skills

**The National Waiting Times Board development of Surgical Care Practitioners**

This highly specialised service has made very recent appointments of three registered nursing staff, employed by the cardiothoracic directorate, to the surgical care practitioner on line training programme. This is in response to reduction in the number of cardiothoracic surgical trainees. The candidates will train in a joint venture with Papworth hospital.
Tayside Healthcare Academy
The Tayside Healthcare Academy (run by NHS Tayside and the local authority job centre) provides a 36 week training programme providing opportunities for unemployed people to gain employment as HCSWs. The Board provides some perioperative placements for these trainees: some have thrived and have succeeded in gaining perioperative jobs with the Board.

NHS Tayside Healthcare Academy is a multi agency partnership working within national, regional and local frameworks addressing social inclusion, recruitment and the long-term health of the local population through the provision of employment opportunities within in NHS Tayside and partner agencies.

The NHS Tayside Healthcare Academy works in partnership with Dundee College, Dundee Social Work Dept and Private Providers to deliver the Dundee Health and Social Care Academy.

NHS Tayside Theatres continue to support the 36 week SVQ 2 Foundation Course providing clinical placements for Healthcare Academy students.

Students successfully completing the programme are guaranteed an interview should they apply for a substantive Theatre Support Worker post.

6.4 Key Issues Relating to Career Pathways
Consultation at Board and national levels indicated the need to develop roles within clear career pathways to support the development of an appropriately skilled workforce. Two key issues emerged

- the need to develop roles and career pathways at national, rather than Board, levels. Board specific career pathways/roles designed to fulfil Board specific needs/gaps etc could be developed within a national framework
- the need for the development of any new roles to be
  - fundamentally robust regarding clinical governance and vicarious liability
  - underpinned by education explicitly related to national frameworks.

The development of advanced/extended roles and unregistered staff roles were the main areas for development. In relation to advanced/extended roles, the key challenge was the need for Royal College agreement on the skills/competencies: in particular the role of ‘first assistant to the main operator was seen as particularly important.
Boards also identified the need for the national development of competencies for

- pre-assessment
- specialist in addition to core competencies for anaesthetic assistants
- (non-advanced) scrub practitioners
- recovery staff
- Unregistered staff (band 2 – 4)

The workforce audit indicated that many Boards were developing local competency frameworks for their perioperative workforces. There was an identified concern to develop these at a national level to ensure consistency and transferability of roles.

Consultation also indicated that planned career pathways may be easier in bigger Boards as they may have a more developed infrastructure, with training/education departments etc.
Section 7
Education for the Perioperative Environment
### 7.1 Available Higher and Further Education

A full review of the websites\(^\text{14}\) of all Higher and Further Education Institutions in Scotland undertaken in November 2009 found the provision relevant to the perioperative workforce detailed in Table 7.

**Table 7: Courses offered by Higher & Further Education Institutions in Scotland.**

<table>
<thead>
<tr>
<th>Course</th>
<th>Qualification</th>
<th>H/FEI</th>
<th>Level</th>
<th>Length</th>
<th>Mode</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesthetics and Recovery</td>
<td>PG Cert NES Portfolio of Core Competencies for Anaesthetic Assistants</td>
<td>Napier</td>
<td>11</td>
<td>1 year</td>
<td>PT (distance)</td>
</tr>
<tr>
<td>Anaesthetics and Recovery</td>
<td>Graduate Certificate (NES Portfolio of Core Competencies for Anaesthetic Assistants)</td>
<td>Napier</td>
<td>9</td>
<td>1 year</td>
<td>PT (distance)</td>
</tr>
<tr>
<td>Operating Department Practitioner</td>
<td>Dip HE</td>
<td>GCU</td>
<td>8</td>
<td>2 years</td>
<td>FT</td>
</tr>
<tr>
<td>Anaesthetic Practice Course</td>
<td>60 level 3 SHED points</td>
<td>GCU</td>
<td>9</td>
<td>9 months</td>
<td>mixed</td>
</tr>
<tr>
<td>Anaesthesia, Critical Care</td>
<td>Masters, MPhil and PhD</td>
<td>UoE</td>
<td>11</td>
<td>1-6 years</td>
<td>FT/PT</td>
</tr>
<tr>
<td>Anaesthesia Practice</td>
<td>MSc</td>
<td>UoE</td>
<td>11</td>
<td>2 years</td>
<td>PT</td>
</tr>
</tbody>
</table>

\(^\text{14}\) The review was of websites only
<table>
<thead>
<tr>
<th>Students per annum</th>
<th>Frequency</th>
<th>Other details provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>n/a</td>
<td>annual</td>
<td>For registered nurse or operating department practitioner (OPD) currently working in a department of anaesthesia to upgrading position to anaesthetic assistant.</td>
</tr>
<tr>
<td>n/a</td>
<td>annual</td>
<td>These courses are part of the NES role development initiative</td>
</tr>
<tr>
<td>25</td>
<td>annual</td>
<td>Eligible to register with the Health Professions Council as an Operating Department Practitioner (ODP).</td>
</tr>
<tr>
<td>n/a</td>
<td>annual</td>
<td>Covers NES Portfolio for Anaesthetic Assistants. Can be used towards degree. 12 study days per module</td>
</tr>
<tr>
<td>n/a</td>
<td></td>
<td>working towards Physician’s Assistant role</td>
</tr>
</tbody>
</table>
7.2 Workforce Experience of Education for the Perioperative Environment

The perioperative workforce audit provided indicative trends on the qualifications specific to the perioperative environment achieved by non-medical staff:

- More staff had or were undertaking the portfolio of core competencies for anaesthetic assistants than any other defined qualification
- More unregistered staff had achieved SVQ2 in Perioperative Practice than any other defined qualification
- There were many courses relevant to the perioperative environment that had been undertaken by non-medical staff.

80 different courses were listed by Boards (see appendix F), with 37.9% of the non-medical perioperative workforce having undertaken some form of education relevant to the perioperative environment.

Table 8: Perioperative courses undertaken by the non-medical perioperative workforce

<table>
<thead>
<tr>
<th></th>
<th>Registered Nurses</th>
<th>ODPs</th>
<th>Unregistered staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perioperative education</td>
<td>925</td>
<td>243</td>
<td>239</td>
</tr>
<tr>
<td>Total staff</td>
<td>3592</td>
<td>125</td>
<td>830</td>
</tr>
</tbody>
</table>

The very high percentage (94.4%) of ODP staff with ODP qualifications indicates that there were approximately 100 dual qualified nursing/ODP staff across Scotland.

It is difficult to identify the level and currency of the courses listed, but it is possible to identify (through course names) that the majority of courses are anaesthesia (16.5%). See Table 9.

Table 9: Nature of courses identified through course names

<table>
<thead>
<tr>
<th>Total staff</th>
<th>% non-medical workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesthesia courses</td>
<td>613</td>
</tr>
<tr>
<td>Operating department courses</td>
<td>276</td>
</tr>
<tr>
<td>Perioperative courses</td>
<td>251</td>
</tr>
<tr>
<td>Scrub/recovery courses</td>
<td>67</td>
</tr>
</tbody>
</table>

The most frequently listed courses for registered staff were those which related to the anaesthetic core competencies. More ODPs had completed the SVQ 3 in Operating Department Practice (136) than the Diploma of Higher Education in Operating Department Practice (62). The most frequent qualification for unregistered staff was the SVQ 3 in Perioperative Support, although NICHE qualifications were also well used by unregistered staff.

15 Defined by the National Steering Group on Modernising the Perioperative Workforce
### 7.3 Education/Training Provided by NHS Boards

Table 10 describes the education/training opportunities provided by NHS Boards to perioperative staff.

<table>
<thead>
<tr>
<th>National core competencies for anaesthetic assistants</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>SLAs (including perioperative-related education) with HEIs</td>
<td>1</td>
</tr>
<tr>
<td>Staff part of education team at HEI</td>
<td>1</td>
</tr>
<tr>
<td>Working with HEIs to develop provision</td>
<td>2</td>
</tr>
<tr>
<td>Staff fees for HEI courses</td>
<td>5</td>
</tr>
<tr>
<td>Monthly education ‘session’</td>
<td>1</td>
</tr>
<tr>
<td>Various courses including</td>
<td></td>
</tr>
<tr>
<td>• Advanced Life Support Training</td>
<td></td>
</tr>
<tr>
<td>• paediatric ALS</td>
<td></td>
</tr>
<tr>
<td>• emergency resuscitation</td>
<td></td>
</tr>
<tr>
<td>• emergency obstetrics training</td>
<td></td>
</tr>
<tr>
<td>• Scrub</td>
<td></td>
</tr>
<tr>
<td>• Recovery</td>
<td></td>
</tr>
<tr>
<td>• Generic induction &amp; mandatory training</td>
<td></td>
</tr>
<tr>
<td>• Specialist perioperative skills</td>
<td></td>
</tr>
<tr>
<td>Local in house competencies developed in</td>
<td></td>
</tr>
<tr>
<td>• Ophthalmology (being developed) D&amp;G</td>
<td></td>
</tr>
<tr>
<td>• Scrub (FV, NWT)</td>
<td></td>
</tr>
<tr>
<td>• Recovery (FV, Lanarkshire, NWT)</td>
<td></td>
</tr>
<tr>
<td>• Neurosurgery (GG&amp;C)</td>
<td></td>
</tr>
<tr>
<td>• Unregistered staff (GG&amp;C)</td>
<td></td>
</tr>
<tr>
<td>• Anaesthetics (Lanarkshire)</td>
<td></td>
</tr>
<tr>
<td>• Obstetrics &amp; Gynaecology (support staff working in a perioperative environment where there is not a distinct scrub practitioner) (Lothian)</td>
<td></td>
</tr>
<tr>
<td>• Emergency call out (NWT)</td>
<td></td>
</tr>
<tr>
<td>• Pre-assessment (Lanarkshire)</td>
<td></td>
</tr>
</tbody>
</table>
7.4 Perceptions of Available Education

Boards raised the following concerns about currently available education:

- Generally in-house training was preferred for cost/capacity reasons.
- There was a need to balance training resources available for generic mandatory training and perioperative-specific training.
- The lack of local/accessible (i.e. on-line, blended learning) ODP training was a real issue.
  - Currently there was only one full time two year ODP course available in Scotland.
  - Boards found it difficult to afford to support staff to access this training (course fees, backfill).
  - There were no opportunities for Band 2/3 staff to qualify as ODPs unless they had relevant academic qualifications – unlike opportunities to undertake pre-registration nursing programmes.
  - There was a need for a central/government approach to the provision and funding of ODP training.
- There was no provision or perioperative specific non medical education/training out with the Central Belt.
- There was a need to develop better partnerships with HEIs to ensure that education/training was relevant to service needs.
- Different Boards made use of different qualifications for providing the same competencies: this made transferability & benchmarking almost impossible.

Two key issues in relation to education for the perioperative workforce emerged from Board discussions and national consultation:

- The need for more opportunities for people to train as Operating Department Practitioners.
- The need for a national approach to the education of the non-medical perioperative workforce explicitly related to the development of competencies designed to meet service needs.
Section 8
Summary of findings
8. Summary of Findings

Data on the perioperative workforce
1. This first review of the nature of the perioperative workforce in Scotland has revealed that it is very complex and differs across NHS Boards and individual acute sites in Scotland. Despite an increasing focus on workforce planning in NHSScotland over the last five years, data relating to the nature of the perioperative workforce were not readily available. These needed to be collated through medical and non-medical workforce planners, finance staff and clinical staff. Although there were significant challenges for Boards in collating data, all Boards contributed to the review which provides the first baseline audit of the perioperative workforce in Scotland.

2. This medical and non-medical staff group has not been examined in this level of detail up until now: this review has shown that there are significant staff groups – such as radiologists and perfusionists which interface with the perioperative workforce, but whose contribution to the perioperative environment is difficult to quantify, and may have an impact on efficiency.

3. This review has emphasised the need to develop whole systems data, covering both the medical and the non-medical workforce.

4. The difficulties in collating data were exacerbated through a lack of consensual national definitions of the perioperative environment and workforce.

The perioperative service model
5. Perioperative services are undergoing significant change, including the development of day surgery, diagnostic services, in particular endoscopy, the repatriation of cases from national/regional centres, notably in relation to orthopaedics, and the involvement of the perioperative workforce in pre-assessment.

6. The perioperative service model varies widely across the NHS Boards, and from hospital to hospital within Boards. It was not possible to develop any consistent ‘typology’ of Boards.

7. Out of Hours staffing varied across Boards and specialities.

8. Boards in remote and rural areas have developed service models with a particular emphasis on maintaining skills and competencies with the high variation, low volume case mix typical of these areas.

The perioperative workforce
9. The non-medical perioperative workforce is bottom heavy, with staff clustered at Band 2 and Band 5. Across the Boards, however, registered to non-registered workforce varied quite widely according to local need: however there was broad consistency across skills mix, if not band mix.

10. The model for staffing one additional operating session varies by Board and by speciality. In general, five - six staff in total (including recovery care) are allocated to each additional session, with three - five staff being registered.
11. The national age profile of non-medical perioperative staff\(^\text{16}\) indicates a need for succession planning, in particular for the Band 7 and 8 workforces.

12. There is a small percentage of ODPs nationally; however this is a key staff group for some Boards, in particular where training for ODPs is available.

13. Changes in the medical workforce – notably related to Modernising Medical Careers and the implementation of the European Working Time Directive – are impacting on the non-medical workforce. This review did not include medical trainees, who have historically provided much support to the trained medical workforce. The review has shown that non-medical staff roles are being developed to provide this support.

14. Specialist and advanced roles are developing variously across Boards. These include
   a. physician assistant (Anaesthesia)
   b. physician assistant (Orthopaedics & General / Vascular Surgery)
   c. advanced scrub practitioner
   d. surgical nurse practitioner
   e. specialist nurse (pain, endoscopy, urology)
   f. play specialist (paediatric surgery)

15. All Boards are working to develop the flexibility of the perioperative workforce, for example through
   a. rotation around the perioperative areas (scrub, anaesthesia, recovery)
   b. rotation around the specialties
   c. secondment to other Boards

Staff recruitment and retention

16. There are difficulties in recruiting
   a. ‘theatre ready’ band 5 staff, largely due to the nature of pre-registration nursing education; and
   b. Operating Department Practitioners, largely due to the shortage of training opportunities.

17. Locally specific career pathways have been developed in response to specific local recruitment difficulties.

Career pathways and education

18. Some Boards were working to develop a perioperative career framework: participants in the review considered that the lack of a nationally agreed framework was hindering this development.

19. The need to fulfill the duty to provide assistance to the main operator was identified by most Boards as key area for development due to changes in the medical workforce.

20. Participants in this review considered that the development of new roles needs to be fundamentally robust regarding clinical governance and vicarious liability.

\(^\text{16}\) This analysis is based on data from 14 out of the 15 NHS Boards providing perioperative services; one Board was unable to provide this information.
Nationally agreed core competencies for anaesthetic assistants are being implemented: participants in this review considered that there was a need to develop national competency frameworks for:

- a. The duty of assistance to the main operator
- b. Pre-assessment practice
- c. Specialist competencies for anaesthetic assistants
- d. Non-advanced scrub practitioners
- e. Recovery staff
- f. Unregistered perioperative staff

The development of non-medical competencies should be a consideration of the perioperative team.

Boards support the educational development of their perioperative workforces in many ways, including:

- a. Developing local in-house competency frameworks for aspects of the perioperative environment
- b. Providing in-house training on specific aspects of the perioperative environment
- c. Supporting participation in Higher Education is less consistent, with more limited opportunities for staff due to existing entry qualifications, and less explicit linkages with careers frameworks.

There is a wide diversity of training/education opportunities for perioperative staff, with more focus on training related to anaesthesia.

Boards raised the following concerns about currently available education:

- a. The lack of local/accessible (i.e. on-line, blended learning) ODP training is a real issue.
  - i. Currently there is only one full time two year ODP course available in Scotland
  - ii. Boards find it difficult to afford to support staff to access this training (course fees, backfill)
  - iii. There are no opportunities for Band 3 staff to qualify as ODPs unless they have relevant academic qualifications – unlike opportunities to undertake pre-registration nursing programmes.
  - iv. There is a need for a central/government approach to the provision and funding of ODP training.
- b. All nursing staff working within the perioperative environment require perioperative specific education and development as they are not ‘theatre ready’ at the point of registration.
- c. There is no provision of perioperative specific non-medical education/training outwith the Central Belt.

Other emergent key issues

A key overarching issue was the widening scope of the ‘perioperative’ environment, with many areas traditionally out with the perioperative environment now being supported by the perioperative workforce.
Section 9
Recommendations
9. Recommendations

1. Build on this first baseline review of the perioperative workforce in Scotland to develop a defined national dataset on the perioperative workforce so as to ensure a consistent approach to workforce development to address evolving service needs.

2. Develop a national perioperative career framework which defines the key competencies required for safe, effective and person-centred service.

3. Develop a national approach to education to support the perioperative career framework which is accessible, flexible and above all transferable within NHS Boards. This should include work-based and accredited learning.

4. Commission Operating Department Practitioner training in a way that is consistent with other non-medical healthcare professionals.
Section 10
Appendices
Appendix A: National Steering Group

Remit:
To provide Scottish Government Health Directorates (SGHD) and NHS Education Scotland (NES) with information and advice on matters relating to the future Perioperative Workforce and their associated career pathways and educational requirements.

Functions
- To gather and interpret workforce intelligence on the perioperative workforce
- To generate evidence to support NHS Boards with decision-making and planning of the future perioperative workforce
- To provide links to workforce planning processes both locally and nationally
- To advise SGHD and NES on the development of initiatives to support the modernisation of the perioperative workforce
- To engage with the relevant stakeholders to implement recommendation of Steering Group
- To develop a career pathway for perioperative workforce
- To horizon-scan and future-proof evolving clinical practice and models of care

Membership
Tracey Gillies, Consultant Surgeon, 18 WRTT Lead & NHS Lothian
Alastair Cook, Senior Medical Officer, SGHD
Andrew Kinninmonth, Consultant Orthopaedic Surgeon, Golden Jubilee National Hospital
David Baird, Principal Information Analyst, ISD
Diane Keir, Theatre Manager, NHS Forth Valley
Frances Dodd, Associate Nurse Director, NHS Lanarkshire
Dorothy Armstrong, Programme Director, NES
George Inglis, Theatre Manager & CODP, NHS Lothian
Henry Robb, Consultant Anaesthetist, NHS Forth Valley
Irene Barkby, Nurse Director, NSS/Co-Chair of the Nursing and Midwifery Workload and Workforce Planning Programme
Jane Burns (CHAIR), Associate Medical Director, NHS Lanarkshire
Kenneth Ferguson, Associate Medical Director, NHS Ayrshire & Arran
Paul Mathews, Partnership Rep, Royal College of Nursing
Rhoda Walker, Nurse Director, NHS Orkney
Rodney Mountain, Consultant Surgeon, RCSE
Susan Kinsey, Lay member
Neil O’Donnell, Consultant Anaesthetist, NHS Glasgow & Clyde
Jacquie Campbell, General Manager, NHS Glasgow & Clyde
Jane Grant, Director of Surgery, NHS Glasgow & Clyde
Audrey Warden, General Manager, NHS Tayside
Appendix B: Initial Stakeholder Information Meeting

Modernisation of the Perioperative Workforce
Stakeholder meeting
Thursday 23 April, 2009: 1pm – 2.30pm
Novotel Hotel, Edinburgh Park

Purpose of the meeting:
- To launch the workplan to review the perioperative workforce in order to develop recommendations to the Scottish Government Health Directorate and NHS Education for Scotland
- To provide stakeholders with details of the workplan, which will include a survey of NHS Board data, and stakeholder perspectives

Agenda
Lunch with the National Steering Group will be provided from 12.00

1.00pm Welcome and introductions
Dr Jane Burns (Chair of the National Steering Group on Modernising the Perioperative Workforce)

1.15pm Introduction to the Perioperative Workforce Modernisation project
Dorothy Armstrong (Programme Director, NHS Education for Scotland) and Irene Barkby (Nurse Director, NHS National Services Scotland)

1.30pm The Perioperative Workforce Modernisation workplan
Dr Sheila Inglis, Project Manager

1.45pm Plenary questions and discussion

2.30pm Close
Present:
Jane Burns, NHS Lanarkshire
Dorothy Armstrong, NHS Education for Scotland
Sheila Inglis, MPW Project Manager
Neil O’Donnell, NHS Greater Glasgow & Clyde
Rhoda Walker, NHS Orkney
Diane Keir, NHS Forth Valley
Karen Andrews, NHS Ayrshire & Arran
Elizabeth Kelso, NHS Ayrshire & Arran
Hazel Parsons, NHS Ayrshire & Arran
Christine Hughes, NHS Borders
Derek Pate, NHS Borders
Alison Todd, NHS Borders
Nigel Leary, NHS Borders
Grace Carr, NHS Greater Glasgow & Clyde
Jill Ferbrache, NHS Grampian
Joseph Collier, NHS Grampian
Alec Milne, Golden Jubilee National Hospital
Eleanor Bathgate, NHS Fife
Audrey Warden, NHS Tayside
Anne Couser, NHS Tayside
Rosemary Wood, NHS Orkney
Derek Philips, SEAT
Betty Flynn, North of Scotland Planning Group

Apologies:
Patricia Leiser, West Workforce Planning Region
Pamela Cremin, NHS Highland
Gavin Hookway, NHS Highland
Mary Glasgow, NHS Tayside
Steve McIntosh, NHS Tayside
Stuart Jack, NHS Tayside
Rosanne MacQueen, NHS Tayside
Lorraine Hall, NHS Shetland
Lorraine Allinson, NHS Shetland
Willis Peel, NHS Dumfries & Galloway
Gordon Smith, NHS Fife
Robert Campbell, NHS Greater Glasgow & Clyde
Appendix C: Topic guide for consultation meetings with Boards

Key issues

- What are the three main issues/challenges for the perioperative workforce?
- Defining the perioperative workforce
  - Review the definition provided with the audit template
  - Organisational chart/people involved in completing the template
  - Service model
  - Standalone areas
  - Recovery model (standalone/integrated)
  - Out of hours
  - Any planned changes
  - Response to demand for increased capacity
- The workforce
  - Review the completed audit template
- Workforce issues
  - Medical/non-medical workforce staff mix
  - Medical trainees
  - Career pathways
- Available education/training
  - Provided by Board
  - Provided by other providers
  - Perceived appropriateness and effectiveness of available education/training
  - Recruitment hot spots/staff turnover issues
- Other issues relating to the perioperative environment
Appendix D: Outline structure of Board reports

- Participants
  - XXX NHS Board
  - National MPW Steering Group representative/s

- Key issues
  - Defining the Perioperative Workforce
    - In relation to the audit template
    - Organisational chart & people involved in completing the template
    - Service Model
    - Standalone areas
    - Recovery Model
    - Out of Hours
    - Planned changes
    - Response to demand for increased capacity

- The perioperative workforce
  - The audit period
  - The medical workforce
    - The role of doctors in training within the perioperative workforce
    - Headcount/WTE; actual/current funded establishment
      - Age profile
      - Locums
    - WTEs and DCCs
    - Planned & unscheduled perioperative DCCs
    - Visiting consultants
    - Speciality issues
    - Board specific issues
    - The non-medical workforce
    - Headcount/WTE/actual/current funded establishment
      - Age profile
      - Staff mix
      - Qualifications
• Board specific issues
• Operating sessions
• Scheduled planned
• Scheduled emergency sessions
• Unscheduled sessions
• Out of Hours nursing/ODP
• Out of Hours anaesthetists duties
• Agency/bank staff
• Non-medical staff overtime
• Waiting time initiative payments

• Workforce issues
  • Medical trainees
  • Career pathways
  • Available education/training
    » Provided by Board
    » Provided by other providers
    » Perceived appropriateness and effectiveness of available education/training
    » Managing annual/study leave
    » Built in prospective cover
  • Recruitment/staff turnover issues
  • Other workforce issues

• Other issues relating to the perioperative environment
Appendix E: National Stakeholder Consultation Workshops

Modernising the Perioperative Workforce
National consultation workshops:
27 November at Stirling Management Centre
3 December at King James Thistle Hotel, Edinburgh

Purpose of the workshops
- To share the findings of the workforce audit & Board meetings with stakeholders
- To consider the implications of the findings of the workforce audit and meetings with Boards
- To inform the development of recommendations for modernising the perioperative workforce in Scotland

Programme
10.00am Registration with coffee/tea
10.30am Welcome and introduction to the workshop
Dr Jane Burns, Chair of the National Steering Group on Modernising the Perioperative Workforce
10.45am The strategic context
Dorothy Armstrong, Programme Director NHS Education for Scotland
11.00am The research findings
Dr Sheila Inglis, Modernising the Perioperative Workforce Programme Manager
11.30am Introduction to the workshops
Dr Sheila Inglis, Modernising the Perioperative Workforce Programme Manager
11.35am Workshops (with coffee/tea) to consider the implications of the findings.
12.45pm Plenary with Panel Discussion
Chaired by Dr Jane Burns
1.15pm Lunch and close
Participants
John Aleksandrowicz, NHS Highland
Patricia Allwood, NHS Greater Glasgow & Clyde
Dorothy Armstrong, NHS Education for Scotland
Irene Barby, NHS National Services Scotland
Noelle Boddie, NHS Grampian
Jacquie Campbell, NHS Greater Glasgow & Clyde
Michelle Carr, NHS Greater Glasgow & Clyde
Alastair Cook, Scottish Government
Frances Dodd, NHS Lanarkshire
Lorna Ferguson, NHS Forth Valley
Betty Flynn, North of Scotland Planning Group
Mary Glasgow, NHS Highland
Davina Grant, NHS Grampian
Louise Hamill, NHS Forth Valley
Gavin Hookway, NHS Highland
Heather Hosie, NHS Greater Glasgow and Clyde Royal College of Anaesthetists Board in Scotland
Sheila Inglis, SMCI Associates
Diane Keir, NHS Forth Valley
Agnes Lafferty, Glasgow Caledonian University
Craig Lean, NHS Ayrshire & Arran
Patricia Leiser, West of Scotland Region
Claire Lewsey, Glasgow Caledonian University
Rosanne Macqueen, NHS Tayside
Elaine Martin, NHS Greater Glasgow and Clyde
Lesley McCallan, NHS Grampian
Steven McIntosh, NHS Tayside
Alec Milne, Golden Jubilee National Hospital / National Waiting Times Board
Carole Morley, NHS Greater Glasgow and Clyde
Neil O’Donnell, NHS Greater Glasgow and Clyde
Andrew Palfreyman, NHS Education for Scotland
Michele Redmond, Lorn & Island Hospital NHS Highlands
Gordon Smith, NHS Fife
Fraser W.H. Sutherland, National Waiting Times Board
Eva Konstanze Weslter, NHS Greater Glasgow and Clyde
Pauline Yeung, NHS Highland
Stuart Jack, NHS Tayside
Elaine Melrose, NHS Ayrshire & Arran
Jane Burns, NHS Lanarkshire
Cathy Dunn, NHS Lanarkshire
Susan Friel, NHS Lanarkshire
Sarah Aither, NHS Lothian
Peter Alston, NHS Lothian
Eleanor Binnie-Mcleod, NHS Grampian
Catherine (Karen) Boylan, The Golden Jubilee National Hospital
Wilma Brown, NHS Fife
Nancy Campbell, NHS Dumfries and Galloway
Kerry Chalmers, Scottish Government
Carol Colligan, NHS Shetland
Ailsa Connelly, Glasgow Caledonian University
Anne Couser, NHS Tayside
Kathryn Coutts, NHS Grampian
Tracy Davidson, NHS Dumfries & Galloway
Joan Donnelly, LUHD, NHS Lothian
Jill Ferbrache, NHS Grampian
Jillian Galloway, NHS Tayside
Shona Innes, NHS Forth Valley
Elizabeth Kelso, NHS Ayrshire & Arran
John Knox, NHS Dumfries & Galloway
Nigel Leary, NHS Borders
Karen Lockhart, Scottish Government Health Directorates
Linda McMullin, NHS Greater Glasgow and Clyde
Hazel Parsons, NHS Ayrshire & Arran
Willis Peel, NHS Dumfries & Galloway
Jill Perchard, NHS Grampian
Pamela Philp, NHS Greater Glasgow and Clyde
Susan Pirie, Association for Perioperative Practice
Jamie Redfern, NHS Greater Glasgow and Clyde
Fiona Ritchie, Glasgow Caledonian University
Ian Ritchie, NHS Forth Valley
Henry Robb, NHS Forth Valley
Lynn Ross, NHS Greater Glasgow and Clyde
Kay Sandilands, NHS Lanarkshire
Gail Thomson, NHS Grampian
Val Thurston, NHS Dumfries and Galloway
Ann Traquair Smith, NHS Greater Glasgow and Clyde
Neil Wilson, NHS Lothian
Gill Wood, NHS Lothian
Andrew Palfreyman, NHS Education for Scotland
Dorothy Armstrong, NHS Education for Scotland
Appendix F: Courses Listed by Boards

Anaesthesia
Anaesthetic assistance PG Cert L11 (Napier)
Anaesthetic course UWS
Anaesthetic practice principles (Professional Studies 2)
Cardiac Diploma Level 1 RCN, 5 years Post Grad Experience
Perioperative Practice P.G. Dip,
Anaesthetic & theatre perioperative care modules UWS
Anaesthetic Nurse Practice Course Caledonian University
Anaesthetic Assistants Core Competencies - Qualifications
Anaesthetic Assistants Portfolio of Core Competencies
Anaesthesia Practice MSc
Anaesthesia Practice PG Dip
Anaesthesia: care of patient requiring anaesthesia (Professional Studies 2 )
Anaesthetic (Post Anaesthetic Care) ENB A94
Anaesthetic assistant Graduate Certificate L9 (Napier)
Anaesthetic Care ENB 182
Anaesthetic Course
Anaesthetic course PS2
Anaesthetic module practice
Anaesthetic module USW
Anaesthetic Nursing SVQ3
Anaesthetic practice module fitness for practice L 9 (Dundee)
Anaesthetic support course in house at Raigmore NICHE
Anaesthetic/Recovery Practice Principles Caledonian University
Anaesthetics & Recovery (PS 2)(Dundee School of Nursing)
Anaesthetics and Recovery (Foundation Level 9) Postgraduate Certificate
Anaesthetics and Recovery (Napier/Dundee)
BAHA (ENT)
C&G Decontamination
Cardiac Physiology Honors Degree NASPE
City & Guilds assessor course
City &Guilds
City &Guilds
Core module GCU
ENB 998 Teaching & Assessing
Endoscopy Nursing SVQ3
Health & Social Care SVQ
Health Care Assistant SVQ3
In house theatre programme GRI
In-house competencies in anaesthetics and recovery
Intraoperative Environment Patient Care Fitness to Practice
Laparoscopic Skills for Theatre Nurses (Cardiff Skills Centre)
LASER Safety Training
Level 1 RCN
NiCHE
NVQ
Operating Department Assistant (ODA) City & Guilds 752
Operating Department Nursing ENB 176
Operating Department Nursing JBCNS course 188
Operating department practice Certificate
Operating Dept Practice Dip HE
Operating Dept Practice SVQ 3
Operating Theatres JBCNS course 176
Ophthalmic Certificate
Ophthalmic Diploma
Pain Management PGDip
Peri op module UWS
Peri operative course WSU
Perioperative module Fitness for practice L9 (Dundee)
Perioperative Practice Principles of UWS
Perioperative Practice BSc Specialist Practitioner
Perioperative Assistant (advanced)
Perioperative Care ENB 183
Perioperative Practice PG Dip Queen Margaret University
Perioperative scrub course
Perioperative Support SVQ 3
Perioperative Support SVQ 3
Peri-Operative Theatre Nursing degree (KH Lier, Belgium) 1 yr full-time course
Perioperative nursing SVQ
Preassessment module (Southampton University)
Preparation for practice
Preparation for practice assessors course
Recovery module GCU
Scrub + circulating module Napier Accredited
Scrub and anaesthetics - off island refresher course
Scrub Practitioner (Advanced) training
Society Clinical Perfusion UK, Clinical Perfusionist’s PgDip/ MSc
Theatre Competencies NICHE
Theatre course - 6 months (Scottish course - 1982) - 1