The ROYAL COLLEGE of OPHTHALMOLOGISTS

The ROYAL COLLEGE of OPHTHALMOLOGISTS

Physician Associate Preceptorship Pilot Project

April 2025

Contents

Project details

Project programme name
Physician Associate (PA) Preceptorship Pilot

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Overview

Key dates
Project initiation date	March 2023
Completion date	April 2025
Pilot start date	November 2023
Pilot completion date	October 2024

The Royal College of Ophthalmologists was offered the opportunity to lead a pilot to evaluate the potential for physician associates (PAs) to practice in ophthalmology. This report focusses on the work carried out prior to the pilot, the pilot itself, and its outcomes.

1: Executive summary

The publication of NHS England's Long-Term Workforce Plan (LTWP)[1] in June 2023 highlighted the need to review the NHS workforce and commit to its reforming to enable it to evolve with the NHS.

"The publication of our NHS Long Term Workforce Plan (LTWP) is therefore one of the most seminal moments in our 75-year history. This is the first time the government has asked the NHS to come up with a comprehensive workforce plan; a once-in-a-generation opportunity to put staffing on a sustainable footing and improve patient care."[1]

The LTWP based its strategic direction on three cornerstones: ***Train***, ***Retain*** and ***Reform***.

One of the most contentious strategies to emerge from the publication of this document was a commitment within the Reform section:

"Increasing Physician Associate (PA) training places to over 1,500 by 2031/32. In support of this, around 1,300 physician associates (PAs) will be trained per year from 2023/24, increasing to over 1,400 a year in 2027/28 and 2028/29, establishing a workforce of 10,000 PAs by 2036/37."[1]

At the time of publication of the LTWP there were, in England, approximately 160 qualified anesthesia associates (AA)[2] and 1,508 full-time equivalent (FTE) qualified physician associates (PA) working in NHS trusts. There were a further 1,707 FTE physician associates working in GP practices and primary care networks (PCNs). There were no physician associates working within ophthalmology.

This document summarises the preceptorship undertaken between the Royal College of Ophthalmologists (RCOphth) and NHS England between November 2023 and April 2025.

This scheme was established to enable information to be gathered around this possible new proposed workforce for ophthalmology. As there were no PAs within the specialty before this scheme it was a unique opportunity allowing the RCOphth to look in detail at this proposed new staff role within the delivery of eye services and base this review on a combination of the preceptorship but also the other cornerstones of the LTWP: Train and Retain.

At the commencement of the project there was significant attention on the role of PAs and AAs within the NHS. There was some concern within the wider ophthalmology workforce that PAs would be employed within trusts before the completion of the preceptorship and the publication of the RCOphth report. The RCOphth, therefore, issued a statement [3] that no appointments to the role of PA with an interest in ophthalmology should be made until the completion of the preceptorship and the publication of the findings. This would mean that any trust employing a PA in ophthalmology would do so without recommendations, guidelines or a scope of practice.

It was noted that at the time of this pilot several specialties were changing the scope of practice for PA/AA[4] due to public and inter specialty concerns regarding patient safety. The RCOphth was aware of this and wanted to ensure patient safety was the priority of the preceptorship.

This report reviews all elements of the scheme from its conception to conclusion. It will also discuss some of the challenges that arose within the extended medical community from the publication of the LTWP relating to the commitment to expand the role of the physician associates and how this affected the RCOphth preceptorship.

2: Background to the PA role

Physician associates are a relatively new group of healthcare professionals in the UK[2–4]. The profession was first introduced in the UK in 2003 as a pilot based on the role of physician assistants in the USA. The number of practising PAs in the UK began to increase significantly from 2015 when the Faculty of Physician Associates (FPA) and the UK Association of Physician Associates (UKAPA) launched[5]. The number of PAs increased from 223 in 2015 to 2,486 in 2021 according to census data published by the FPA[6]. This represents the biggest increase in numbers of any healthcare professional group during this period.

There are currently 36 universities offering Physician Associate Studies degree programmes in the UK. These consist of a four-year undergraduate programme or a two-year postgraduate programme (for this an applicant must hold a degree in biomedical sciences or relevant healthcare field). Upon successful completion of the course at the higher education institute (HEI) all PAs must pass the Physician Associate National Exam (PANE). The PANE consists of an objective structured clinical examination (OSCE) and a written component. Passing the PANE is a requirement to practise in the UK as a PA.

As of 2025, completion of the degree and PANE allows the PA to be registered with the General Medical Council (GMC) which, in December 2024, became the governing body for PAs in the UK.

As noted above, at the commencement of the preceptorship there were no PAs in ophthalmology. Given that the UK PA role was originally based on the same named role in the US we looked at how many PAs there were in the USA with an interest in ophthalmology. The data suggested that in 2024 that there were 94 such PAs in the USA[7]

There are currently more than 185,000 PAs in the USA across multiple specialties. The first PA graduated in the USA in 1967. In the almost 60-year history of the role less than 1% of PAs have specialised in ophthalmology.

Ophthalmology, however, has changed significantly in the last 60 years. It is responsible for the most common operation done in the NHS (cataract removal plus lens insertion) and the highest number of outpatient appointments a year with almost nine million required in England in 2024.

The Chief Medical Officer's annual report in 2019 looking at health in 2040 showed ophthalmology as the subspecialty with the biggest predicted increase in number of attendances, with need for care significantly outstripping healthcare resources.

When combining an ageing population with a significant increase in demand for ophthalmological services it is entirely appropriate to review the current workforce and consider how best to design it for the future eyecare needs of the nation.

It was with this background knowledge that the College engaged with NHS England to look at whether the role of PA specialising in ophthalmology could be a beneficial and economically viable addition to the eyecare delivery workforce. The College was entirely neutral about the answer to this question. It would wait to draw its conclusions once the pilot has ended.

3: Initiation of collaborative preceptorship

The Royal College of Ophthalmologists was offered the opportunity to lead a pilot to evaluate the potential for PAs to practise within ophthalmology.

There were several considerations for the project:

- Appointment of trusts
- Appointment of PAs
- Supervision of PAs
- Timetable of PAs
- Training and resources
- Communications
- Governance
- Evaluation

Appointment of trusts

Participating trusts were paid a salary contribution for each physician associate they employed as part of the pilot and received an additional payment to support educational and clinical supervision (ES, CS) throughout the year. Trusts were wholly responsible for any other costs including pension contributions.

Appointment of PAs

Participating trusts were required to undertake the recruitment process for the appointment of the PA(s) in their trust.

Supervision of PAs

During the pilot programme a trust-appointed appropriate educational supervisor was the day-to-day point of contact for participating PAs. This provided a 'touch-point' for the RCOphth to ensure the appropriate delivery of the pilot programme and to provide advice and guidance on issues

encountered. In addition, a single education lead was appointed at the College for all the PAs to ensure they had equal support.

Timetable

By running this pilot programme, the College made recommendations related to timetables to all host trusts. The preceptorship was known to be contentious for College members and so was necessary to establish a scope of practice and a framework to ensure that there was no engagement in care pathways that the College considered either inappropriate for the PAs' skills and experience or unsafe for patients. It was agreed with all trusts that if they wished to change the activities of the PA from the recommended timetable or scope of practice published on the RCOphth website they would need to have direct discussion with the project lead. The College was aware of other scopes of practice which have been published for the specialty (eg BMA) but ours is the only one that was supported by a pilot.

Training and resources

The College established a welcome webinar and four set training courses of two days' duration during the year for all PAs enrolled onto the pilot programme. As PAs have minimal ophthalmology-specific training during their degree programme, this covered the fundamentals of ophthalmology as well as practical skills required for patient assessment.

The pilot scheme places came with additional educational funding to allow the PAs to engage in self-chosen education during the year. The PAs were required to apply to the RCOphth to approve the educational activities and request funding. The ES at the College met with the PAs on at least a monthly basis. The PAs all collected evidence of skill accrual across multiple domains during their year. Although the RCOphth portfolio for ophthalmology trainees was not available to the PAs they were shown all the assessment tools and links, which allowed them to complete work-based assessments with supervisors if desired.

Communications

Communication channels were established between PAs recruited to the pilot programme and the College. In addition, communication between the College and participating trusts was established. This involved HR departments, clinical leads, educational and clinical supervisors and ophthalmology trainees within the participating departments.

Governance

The College's Training Committee was the reporting committee with the Chair of the Training Committee as the project lead. A small working group was established to ensure the report was reviewed and written by a group rather than an individual.

Evaluation

The scheme was continually evaluated throughout the year with feedback from relevant members of staff and clinicians from the College, trusts, PAs and their supervisors. Engagement with lay members of the college and the RNIB was sought to try and ensure the patient voice was heard. NHS England required this report at the end of the preceptorship.

Budgets

The programme provided funding, which was split between salary contributions to NHS trusts to support the employment of PAs, individual educational budgets and funds to develop and deliver training of PAs at the College, specifically including the procurement of the necessary simulation and clinical equipment as well as the appointment of a project manager. The pilot was funded entirely by NHSE, with no funding coming from College budgets.

4: Details of preceptorship

Timelines of Activity

Pre 2023
Discussions between College and Health Education England (HEE) to undertake a PA pilot in ophthalmology.

End of Mar
Contract signed between HEE and College.

Jun
Money arrived from HEE. Eight PAs would be involved in the pilot.

Aug
News story published on College website announcing pilot.
EyeMail (enewsletter) item linked to website news story

Oct
Mention of pilot in President's intro to College members' magazine, *College News*

Nov
First PA appointed.
Members' webinar, providing information and answering questions, took place.
Follow up message in *EyeMail*.
Updates to webpages.

Feb
Follow-up webinar for College members.
First PA course, London
(while PAs had not started in post, all were in the process of being appointed and were able to attend the first course)

Apr
Third and fourth PA appointed.
Second PA course, Hull

Jun
Third PA course, London
Presentation by PAs of their experience at Congress
Updates to webpages.
One-to-one feedback from PAs with project lead and Director of Education, Training and Events
Education webinar for PAs by the Fellow

Oct
Fourth and final PA course, London.

Nov
First PA completes pilot.
Pilot ends
Physician Associate Working Group's third meeting.

2023

Jan-Mar
Discussion with HEE and within the College Executive and Council to agree that the College will take on the work of the PA pilot.

Apr-May
Communication out to clinical leads to see who would be interested in taking on a PA in their unit.
Packs prepared for trusts with information on PA pilot.

Jul
Panel convened to review applications received.
Letter to trusts confirming acceptance of pilot.
Four PAs now to take part.

Sept
EyeMail message from President to allay concerns.
Delays in PAs being appointed by the four trusts so PAs will start later than planned.
New PA webpages created on College website.
Preparation of packs for PAs

Dec
Scope of practice published.
Notification of this posted in *EyeMail* and the college website

2024

Jan
Coverage in *College News* with mention in President's intro, news story 'PA pilot is underway', and mention in OTG update.
Promotion of February webinar

Mar
Second PA appointed

May
PAs attended Congress

Jul
Physician Associate Working Group convened and had its first meeting.
One-to-one feedback from PAs with project lead and Director of Education, Training and Events.
Education webinar for PAs by the Fellow.

Sept
EyeMail – update to keep membership informed.
Physician Associate Working Group's second meeting.
Education webinar for PAs by the Fellow.

2025

Dec '24 to Apr '25
Support to remaining three PAs in post.
PAs complete their year.
One-to-one feedback from PAs with project lead and Director of Education, Training and Events.
Physician Associate Working Group's fourth meeting.
Education webinar for PAs by the Fellow

Application by trusts

This was open to eligible NHS trusts within England. The College received five applications from interested trusts, following a call-out to all clinical leads who wished to take part in the PA preceptorship pilot. A small panel was convened to look at the applications to ensure consistency.

All five trusts were offered PAs. The maximum number of PAs agreed for the pilot was eight and it was agreed that these would be spread between the five units.

The trusts taking part in the pilot were:

- Buckinghamshire NHS Trust
- Leeds Teaching Hospitals NHS Trust
- Mid Cheshire Hospitals NHS Foundation Trust
- University Hospitals Bristol and Weston NHS Foundation Trust

Moorfields NHS Trust withdrew from the process and the College enquired whether any of the other trusts were able to offer more than one PA post.

Proposed plan

One PA would be placed in each of the following trusts:

- Buckinghamshire NHS Trust
- Leeds Teaching Hospitals NHS Trust
- Mid Cheshire Hospitals NHS Foundation Trust
- University Hospitals Bristol and Weston NHS Foundation Trust

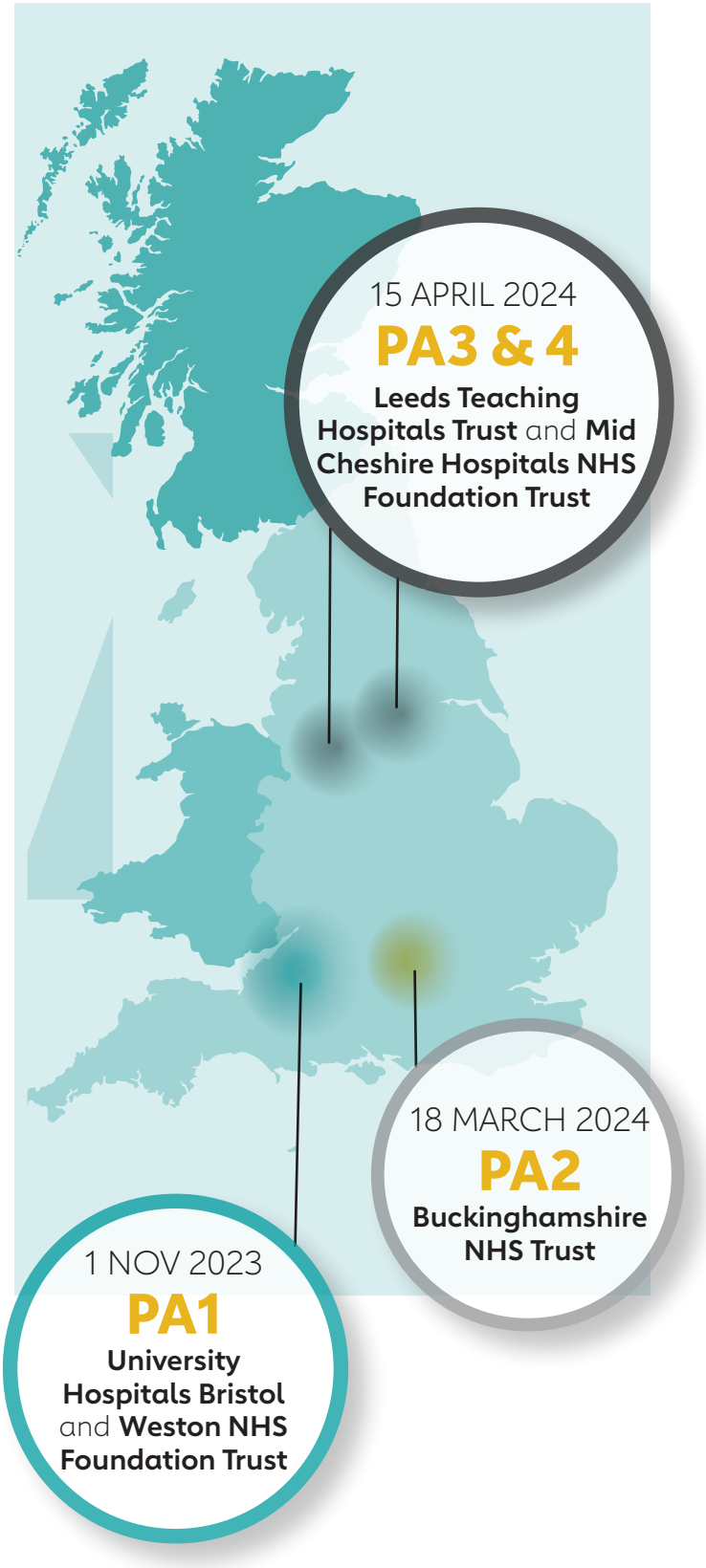
The pilot was conducted with four PAs only. The start of the pilot was pushed back due to the delay in PAs being appointed in the trusts.

Communications

Our communications activity was planned to meet the following aims:

1. Make stakeholders aware of the College's plan to lead a 12-month pilot to evaluate the potential for Physician Associates (PAs) to practise within ophthalmology
2. Ensure stakeholders – and specifically resident doctors – understood that our work to promote an increase in training places continued and would not be impacted by our work on the pilot
3. Ensure stakeholders understood the content and scope of the pilot

PAs appointed



4. Ensure stakeholders understood that the pilot was not funded from College fees
5. Ensure stakeholders understood this was an investigative pilot
6. Ensure stakeholders felt informed
7. Ensure stakeholders felt they were being listened to and their concerns were being addressed
8. Persuade stakeholders to regard the pilot positively or neutrally.

5: Concerns and how these were addressed within the membership

Introduction

In September 2023 a number of ophthalmologists began to voice their concerns about the introduction of the PA pilot programme in ophthalmology. Several communication channels were established by the pilot to address these. The issues voiced included poor early communication with the membership about the pilot, and a belief that the pilot was being rushed through behind closed doors with a foregone conclusion. This was against a backdrop of increasing concern about the role of PAs in medicine, with increasingly toxic discussions taking place on social media.

A few months earlier, there had been a significant social media campaign highlighting the use of anaesthesia associates in multiple units. An independent pressure group, Anaesthetists United (AU), was formed to push the Royal College of Anaesthetists into holding an Extraordinary General Meeting (EGM) so that the wider College membership could raise concerns about the perceived uncontrolled roll-out of AAs.

At the beginning of communications with the RCOphth, the group of ophthalmologists seeking clarification about the pilot wanted to pursue a similar avenue. Several of them were in training roles, and they did not feel they could request an EGM at their career stage. A senior ophthalmologist who had no existing relationship with the College beyond being a member was recruited as the lead voice for this group.

The concerns raised echoed those in other specialties including: the potential impact on patient safety; the potential impact on ophthalmology training opportunities; the potential for patients to be confused about the role/ability of the person they were seeing; the potential impact on the existing allied healthcare professional groups (optometrists, orthoptists and clinical nurse specialists) that already worked in ophthalmology; and the potential for scope of practice creep if PAs were employed without agreed frameworks and scopes of practice.

A group (akin to AU) Ophthalmologists Convergent (OC) was convened. This was a steering group designed to represent multiple grades of ophthalmologists from different regions of England and Scotland. A WhatsApp group was created for discussion, and posts were made on Twitter, LinkedIn, and Reddit to encourage as many College members as possible to engage in the discussion. Posts on all three social media sites were met with good engagement from ophthalmologists of all grades.

Initial concerns and engagement with the College

This was at a time when EGMs were being requested on similar grounds at the Royal Colleges of Physicians, Anaesthetists and Surgeons. OC explored the possibility of an EGM at the RCOphth but following several engagement meetings this was deemed unnecessary.

The College Chief Executive replied promptly to OC's meeting request and was able to deliver all the information requested by the OC. A meeting was arranged between the President, the Chief Executive, the Chair of Training, and representatives from OC. This proved to be productive and pivotal to the success of the project, as the background, aims, and rationale of the pilot programme were transparently set out at the meeting. These were all matters which had been discussed at the appropriate College committees but widespread detailed understanding of them among College members had not been achieved. The OC felt that the College representatives were receptive to the concerns raised by the membership and acknowledged that the wider picture around PAs in medicine and anaesthesia had changed since the inception of the pilot. A members-only webinar was arranged for 13 November 2023 to explain the pilot to a wider audience, with invited questions and open dialogue encouraged.

The PA webinar and College response

To facilitate broader discussion, another WhatsApp group was created for ophthalmologists to discuss the issue before and after the webinar. This group, along with other networks, was used to disseminate webinar details more widely. At the time of the webinar, there were nearly 100 ophthalmologists in the WhatsApp group, none of whom had been aware of the planned webinar before the details were posted there. This significantly improved attendance and engagement at the webinar.

The webinar covered:

- The rationale behind the pilot
- The terms of reference
- The defined scope of PA roles
- Plans for post-pilot evaluation

Attendees were given the opportunity to ask questions. During the webinar, the OC chair was publicly invited by the Chair of Training to contribute to the pilot report, as well as any eventual guidelines.

Following the webinar, the College acknowledged historic communication issues between the College and its members. In response, concrete steps were outlined to improve transparency, including increasing email communication and better dissemination of information regarding the activities of the President and Chief Executive.

Continued engagement and regular stakeholder meetings

Recognising the need for continued engagement, the College took proactive steps to establish regular stakeholder meetings. This ensured that key stakeholders – including OC, Patient Voice and the Ophthalmologists in Training Group (OTG) – were involved in the ongoing discussions about the PA pilot. This shift marked a clear effort by the College to improve transparency and facilitate greater member engagement.

As a result of this structured engagement, the OC steering group decided to defer the EGM request and instead take up the College's offer of structured and continued dialogue. A timeline of this is included in Appendix C.

Further engagement was sought to address the patient voice via patient voice engagement meetings. It was important for the pilot team to hear the concerns of the visually impaired. Visually impaired patients cannot see name tags and rely on vocal descriptors to know who they are being cared for by. There were specific concerns that PAs may not introduce themselves in such a way that the patient were clear of their role or remit, leading to confusion that they were doctors. The patient voice group clearly differentiated and wanted clear differentiation between these two groups.

There has been significant coverage of PAs in the UK misdiagnosing or mismanaging patients (although not in ophthalmology). The patient engagement meetings highlighted real concerns regarding this. We know from Burton et al Lancet Global Health[8] that vision is the most precious sense worldwide, therefore, it is unsurprising that our patients are anxious about who is looking after their eyes. The patient voice group, rather like the OC group, felt that this pilot may in fact help allay their fears. It was recognised that, in the absence of any previous experience of PAs in ophthalmology, the pilot provided a unique opportunity to establish whether PAs can safely work within ophthalmology.

Conclusion

This section of the report has gone to some lengths to try and explain the time and effort that went into addressing the fears of our membership and extended stakeholders regarding the pilot.

In conclusion, the report recognises the scepticism within our healthcare community at the proposal of a new role. The fact that this role was felt to be conceived and supported by the LTWP and not a clinician-developed role exacerbated reservations. In addition, the timing of the expansion of PA and AA came at a very challenging time in particular for doctors and doctors in training. The COVID 19 pandemic resulted in significant loss of training opportunities for ophthalmologists in training. In conjunction with this the large backlog of patients has created further strain on healthcare pathways within ophthalmology that were already stretched before the pandemic. Senior clinicians have both care delivery and training fatigue. To add another role that requires training from scratch, as well as supervision was not a welcome proposal.

While the factors that contributed to the unprecedented concerns about the pilot were understood and acknowledged, the preceptorship was able to proceed unchanged and without predetermining its outcome. In other words, the concerns of stakeholders were listened to. However, those concerns did not override the process of the preceptorship nor determine its outcome.

6: Delivery of the project

The pilot published a scope of practice and framework document before the first PA started. These were placed on the College website.

A summary is included here to help the reader understand both what activities were proposed for the PAs in the pilot but also what was determined to be inappropriate.

The scope of practice document was to help support the PAs understand what activities they should feel comfortable undertaking in their role.

We considered the scope of practice under four areas:

1. Do I have the skills and knowledge to carry out the activity safely and effectively?
2. Can I complete training or receive other support (such as supervision) that will give me the skills and knowledge needed to carry out the activity safely and effectively?
3. Is the activity restricted by law (eg prescribing) and, if so, can I legally, do it?
4. Does my professional indemnity insurance cover the activity?

Example timetable

Any changes to this had to be discussed with the PA pilot lead

	Monday	Tuesday	Wednesday	Thursday	Friday
am	Eye Casualty	Intravitreal injections	Scribe clinic	Scribe Clinic	Eye Casualty
pm	Pre-assessment	Ward/ Admission/ Discharge	Study/Research	Telephone clinic	Teaching

Activities that will not be carried out by PAs during the preceptorship

1. No intraocular surgery
2. No minor operative surgery
3. No independent treatment plan
4. No independent management plan
5. No initiation of investigations or treatments/medications
6. No unsupervised responsibility for patient care or management plans.

Proposed activities

Areas of work (not exclusive)

- Outpatient activity
- Telephone based activity
- Preoperative and post operative activity
- Admission and discharge activity
- Site specific role (telemedicine, imaging, emergency care etc.)

Other examples of appropriate activity including (but not limited to):

- Scribe within clinic with senior clinician
- Providing protocol delivered care
- History taking and initial examination in emergency eye setting
- Supporting doctors to make referrals between hospital departments
- Providing support to patients in hospital ward-based settings
- Admission and discharge from theatre

- Checking consent and marking patients
- Intravitreal injections

Training outline

The PAs in the pilot were given a clear outline of the training at the College to be delivered during the year. In addition, they were funded to attend the RCOphth Congress in Belfast and additional independently-chosen educational events.

In between the formal courses there were monthly webinars providing opportunities to monitor progress and to participate in case-based discussions.

Progress throughout the year was assessed at each of the in-person training days formatively. The PAs on the pilot completed other assessments at their host organisation during their placement.

Documentation

Each PA at conclusion of the year had:

- Documentation of courses attended
- Documentation of assessments (formative and summative) completed
- Documentation of all CS and ES meetings
- Personal development plan reviewed three times during the year
- Workplace-based assessments – PAs could use any of the WBA forms available to AHP on the college website. These could be used as evidence of direct observation of skill, case discussions, reflective practice etc
- Completed three pieces of reflective practice in the year

Table of in person training at RCOphth/ Hull

Training type	Dates and outline
Introductory webinar	Introduction of faculty and outline of plan for preceptorship
In-person training 1 (2 days)	• Overview of ophthalmology as a specialty (main 5 diagnoses plus naming all SIA) • Scribing in ophthalmology – nomenclature, acronyms and details • Clinical examination techniques – visual acuity, pupil assessment, colour vision, direct ophthalmoscopy and slit-lamp examination • Formative assessment
In-person training 2 (2 days)	• Investigations and imaging in ophthalmology – to cover fundus photography, OCT of macula and optic discs, visual field testing • Assessment of red eye – clinical differentials, history taking, case presentations • Formative assessment
In-person training 3 (2 days)	• Summary of guidance of sight-impairment and how visual aids can support patients • History taking with cases • Formative assessment
In-person training 4 (2 days)	• Improving theatre efficiency before and after the operation • Working alongside a high-volume cataract surgeon and how a PA can improve the flow of theatre • Overview of cataract pathway • Pre-op and post-op assessment of cataract

7: Economic modelling of the PA role within the current ophthalmology workforce

Eyecare within the UK is delivered by a multidisciplinary team including – but not limited to – ophthalmic nurses, optometrists, nurse practitioners, orthoptists, eyecare technicians, image graders and doctors.

At the outset of the pilot, it was determined that the work of the PA would be compared to team members already carrying out these roles. All of the activities by the PAs in this pilot were already being carried out by nurses and allied health professionals (AHPs) and not doctors.

One of the more commonly voiced concerns about the role of PAs in ophthalmology was that we already had trained allied eye care professionals, with additional qualifications to enable them to be able to deliver well established parts of eye care pathways. These clinicians were noted at the start of the pilot to be paid less than the starting salary of a PA. In the current NHS environment of financial constraint, it is challenging to ask a skilled practitioner to train someone who is being paid more than them. This is particularly challenging if the learner has no experience in the area they are being taught and is likely to be supernumerary for the duration of the attachment.

Below we review the economic comparison of PAs to those who are typically employed to deliver the tasks. PA are placed into the pay scale 'Band 7' upon graduation. During the 1-year PA pilot in Ophthalmology, PAs were paid at a Band 6 salary due to the fact that they had no prior experience in this role and would be almost entirely supernumerary. This would not be possible for employment outwith a pilot as pay scales are nationally guided.

Comparisons:

Paid less than a new PA:
Newly qualified optometrist working within the hospital eye service will be paid at a Band 6 salary. In this role they will work independently but under supervision. In this role, they will see patients and undertake tasks without direct supervision but are still accountable to a supervisor. Progression from Band 6 role to Band 7 role would require several years, further qualifications and a job description at Band 7 level including management duties.

Nurse practitioner with an extended role in hospital eye service is employed at a Band 6 level.
Nurse practitioners may spend many years developing their practical skills and knowledge specific to ophthalmology before being able to progress to a Band 6 role. All the activities in the PA pilot timetable can be carried out by such a nurse practitioner and some of the activities could be done by a Band 5 nurse.

Paid the same as a new PA:
Band 7 role optometrists and nurse practitioners. This is a senior clinician role with more than five years of ophthalmic specialist training. This role would be expected to independently deliver clinics with consultant supervision. None of the PAs during the year-long pilot were able to deliver the tasks carried out by this level of practitioner.

Comparing PA to nurses and optometrists

***Table 1* – The role of physician associates in ophthalmology across pay scales**

AFC Band	Pay scale (2024-25)	Role and responsibilities	Prescribing ability	Additional qualifications required
Band 7	£43,742 - £50,056	This was to be determined by this pilot.	No independent prescribing.	Physician Associate studies degree

***Table 2* – The role of nurses in ophthalmology across pay scales**

AFC Band	Pay scale (2024-25)	Role and responsibilities	Prescribing ability	Additional qualifications required
Band 5	£28,407 - £34,581	Entry-level ophthalmic nurse. Assists in triage, pre-assessment, and post-op cataract care. Administers eye drops, measures visual acuity. Works under supervision in outpatient clinics.	No independent prescribing.	Registered nurse (RN) with ophthalmic training. No prescribing qualification required.
Band 6	£35,392 - £42,618	Specialist ophthalmic nurse. Works in glaucoma, AMD, and post-op cataract clinics. May assist in laser procedures and intravitreal injections. Works with some autonomy but under consultant guidance.	No independent prescribing (unless V300 qualification is obtained).	Completion of specialist ophthalmic nursing training. V300 qualification (if independent prescribing is required).
Band 7	£43,742 - £50,056	Advanced nurse practitioner (ANP) in ophthalmology. Runs independent clinics in glaucoma, medical retina, emergency eye care (MECS). May have independent prescribing (V300 qualification). Leads nurse-led clinics for stable conditions under consultant supervision.	Requires V300 Independent Prescribing qualification.	V300 Independent prescribing for NPs. Additional postgraduate diplomas in ophthalmic care.

***Table 3* – The role of optometrists in ophthalmology across pay scales**

AFC Band	Pay scale (2024-25)	Role and responsibilities	Prescribing ability	Additional qualifications required
Band 6	£35,392 - £42,618	Newly qualified hospital optometrist. Works in general ophthalmology, cataract pre/post-op assessments. May assist in triage and emergency eye care. Works under supervision with some independent practice.	No independent prescribing.	Optometrists must be GOC registered with a BSc in Optometry.
Band 7	£43,742 - £50,056	Specialist optometrist in HES. Runs independent glaucoma, AMD, and emergency eye care (MECS) clinics. Independent prescribing (IP) optometrist. May supervise Band 6 optometrists and trainees. Often holds higher qualifications (e.g., College of Optometrists Diplomas).	Requires Independent Prescribing (IP) qualification.	Independent Prescribing (IP) qualification. Additional postgraduate diplomas in glaucoma, medical retina, or advanced optometry.

Summary of economic comparison

This pilot recognised some variability in skill accrual between the PAs involved in this pilot but after a one-year focused preceptorship none of the participants practised at a level comparable to a newly qualified optometrist within the hospital eye service.

Both a PA and an optometrist are post-degree entry careers. The optometrist has completed a degree focused in eye health and the PA has completed a degree in generic medical and healthcare studies. The optometrist starting salary is Band 6 and the PA Band 7.

The economic findings of this pilot were that AHP currently working within ophthalmology are economically more viable to deliver eye care than PAs. In addition, the skill and experience that the current AHPs start their extended roles with make them even more financially viable than a PA who would require focused training in ophthalmology for an undetermined time.

It was shown in the pilot that none of the PAs reached the level of a newly qualified optometrist after 12 months of focused training.

Recommendations

The economic modelling from this pilot would recommend investment in established AHP within ophthalmology and additional training numbers for ophthalmologists rather than a new role of PA with an interest in ophthalmology.

8: Findings of the project

PA experience

All four of the PAs participating in the pilot reported that they enjoyed ophthalmology, but it was not without its challenges. They all expressed that they had learned nothing within their degree to prepare them for work in ophthalmology.

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	Eye Casualty	Intravitreal injections	Scribe clinic	Scribe Clinic	Eye Casualty
PM	Pre-assessment	Ward/ Admission/ Discharge	Study/Research	Telephone clinic	Teaching

This was the sample timetable and in the main these were the roles that the PAs in the pilot took part in. Not all were able to do intravitreal injections, and none managed to complete a full intravitreal list independently (currently delivered in most units by Band 6 ophthalmic trained nurses).

There was concern expressed before the pilot started about PAs working outside their scope of practice. There was no report of this happening and none of the PAs took any part in the list of not to do activities listed in Part 6.

The list of proposed activities within the scope of practice were:

- Scribe within clinic with senior clinician
- Providing protocol delivered care
- History taking and initial examination in emergency eye setting
- Supporting doctors to make referrals between hospital departments
- Providing support to patients in hospital ward-based settings
- Admission and discharge from theatre
- Checking consent and marking patients
- Intravitreal injections.

The PAs fulfilled these tasks other than admission and discharge from theatre and checking consent and marking patients.

The quarterly feedback between the PAs and the project lead revealed the challenges that they all faced at the start of the placement. In addition to the above it was highlighted by the PAs on the pilot that their ability to undertake certain clinical roles was limited due to the negative reception of PAs that had surfaced in the period overlapping the pilot.

They found the learning curve very steep with little or no prior knowledge that helped them. Skill accrual for examination was challenging. As eye care practitioners we take for granted the ophthalmic-specific tools we use but they take a long time to learn and the PAs found this difficult to achieve in one year such that they could carry out independent practice. The area in which they considered themselves most useful was eye casualty and triage as they were able to take histories and help triage patients. This is currently done by band 5 or 6 nurses.

At the completion of the year none of the departments extended the role of PA in ophthalmology and only one of the participants had a job to go to: she moved to a role as PA in respiratory medicine in the same trust.

Supervisor/trainer experience

Summary of surveys for clinical supervisors

The supervisors were encouraging about the attitude and work ethic of the PAs. There was general acknowledgment that they came with no ophthalmic experience, and it was time-consuming to train them to the level that would be needed to deliver care within the department. Given the need within an ophthalmology department to already train many AHP and doctors it was felt that the time and energy would be better expended on those with prior ophthalmic experience.

No supervisor expressed a desire to extend the duration of the role of PA in ophthalmology.

No supervisor described a role that they had found for the PA in their department that was not able to be delivered by less expensive non medical staff.

In all four trusts the supervisors would rather have AHPs with ophthalmic experience than PA to support eye care delivery.

Resident doctors' in pilot trusts

Resident doctors working in the trusts participating in the pilot were asked to share their experiences and views through a survey carried out by the Ophthalmologists in Training Group (OTG) between September and December 2024. Thirteen residents from the four sites involved in the pilot scheme took part. The survey results are presented in Appendix E. Overall resident doctors

did not feel that PAs had a positive impact on their training, and more than half of them do not see a role for physician associates in ophthalmology.

Training course feedback

The four physician associates in the pilot attended a series of two-day courses. They were provided with small group teaching on common clinical presentations in ophthalmology, history taking, basic examination skills and data interpretation. They had the opportunity to practise their clinical skills on each other as well as with the use of simulation and were provided with feedback based on this during the courses.

The purpose of the courses was to provide the PAs with the best possible opportunity to develop their clinical skills in ophthalmology taking into account their lack of prior experience in ophthalmology and the limited duration of the pilot. Although there was a notable difference in ability between the PAs on the course, all four were able to develop their clinical skills and knowledge over the course of the year.

College staff feedback

All four PAs were enthusiastic about their role and taking part in the first-ever pilot for PAs in ophthalmology in the UK. They attended all courses run by the College and in Hull with enthusiasm and eagerness to learn new skills. They also attended Congress and did a presentation on what they had learnt following this event. They attended several external events which added to their experience and knowledge.

Catch-ups were held with the individual PAs on a regular basis with the Chair of Training and Director of Education, Training and Events, where they updated us on their timetables and experiences in their trusts.

9: Summary of findings

This was a time-consuming and costly pilot to run for four PAs with an interest in ophthalmology.

The starting salary of a year 1 ophthalmology trainee is £43,924 - £55,329. The starting salary of optometrists and ophthalmic nurses are included in this report and the starting salary of a PA is £43,742 - £50,056.

This report was not designed to compare what a year one ophthalmic doctor does in comparison to a year one PA with an interest in ophthalmology but the discussions within our College membership quickly included these questions:

Given the LTWP commitment to expanding PAs in the UK is it possible for us as a profession to support this role at this price bracket within eye care?

Are there any findings within the pilot to allow the College to produce recommendations for such a role and indeed a scope of practice?

The answer to both of these based solely on this pilot is a resounding no.

Ophthalmology already has a diverse, complex, multidimensional health care team. Given the experience, diverse scope of practice and pay scales associated within these extended roles (including ophthalmic nurses, orthoptists and optometrists, imagers) the College could not find evidence that would support the creation of a new role of PA in ophthalmology.

This pilot suggested that the time required to upskill a PA to the level within ophthalmology that would allow efficient, economically viable practice was found to be too long to justify endorsing this role in comparison to other options available.

The PAs in the pilot reported that there was no useful ophthalmology training within the PA university degree courses that they completed.

Ophthalmology is an unusual specialty with little or no ward work and – in the great majority – day case surgery only. The emergency care is eye-specific and, with no previous experience of ophthalmology, all participants found the learning curve of assessment of patients in eye casualty very steep.

During the pilot all the PAs carried out tasks that are currently undertaken by Band 5 or 6 nurses. Given the starting pay scale of PAs it is not possible to economically justify the role.

In addition to the above finding this report must emphasise the disquiet among the membership and ophthalmic community about this role.

News about the PA pilot on our information sharing platforms had more views than all other news stories and the membership of social media groups and attendances at our PA webinars exemplifies a groundswell of negativity about the creation of this role.

The RCOphth fully appreciated the need to deliver unprecedented numbers of ophthalmic appointments and operations both in 2025 and in the next 30 years. It is essential that this is done with the patient's best interest as a priority. Our patient voice and membership voice strongly recommended that the expansion in roles should be in doctors, ophthalmic nurses, optometrists, orthoptists and ophthalmic trained AHP. There was no finding in this preceptorship to dispel this.

10: **Recommendations**

The RCOphth endorses the commitment of the LTWP to "expand extended, advanced and associate roles, to increase the breadth of skills within multidisciplinary teams, to increase capacity and flexibility of the multidisciplinary team and to reduce the overall workload pressure on other clinicians" but believes that this should focus on the following recommendations:

Recommendations

1 Increase in training numbers in ophthalmology[9]

2 Further funding for extended roles in ophthalmology (nurses, orthoptists and optometrists)

3 Investment in AI and improved IT interopability to manage image-based decision-making in chronic ophthalmic conditions

4 Developing community pathways to continue to manage ophthalmic conditions out of the traditional hospital setting

11: The Leng Report and how it affects this pilot

This pilot notes the Leng report, first published in 2025, and summarises its main findings here in conjunction with our findings.

Summary of the Leng Review on Physician Associates (PAs) and Anaesthesia Associates (AAs) with RCOphth pilot response

KEY: *L* = Leng Report
***R* = RCOphth pilot response**

The Leng Report key objectives:

L: Establish a nationally agreed scope of practice and ceiling of practice for PAs and AAs
***R:* This pilot does not believe this is currently appropriate in ophthalmology**
L: Define roles within multidisciplinary teams to enhance patient safety and mitigate risks
***R:* This pilot believes it is possible to define roles but that the economic modelling does not support PA with ophthalmic multidisciplinary teams as a viable option at this time**
L: Address concerns regarding the impact of PAs on medical training opportunities for resident doctors
***R:* This pilot did not identify any work done by a PA that would impact on training of resident ophthalmic doctors but the pilot did note trainer fatigue across training of all AHPs within eyecare services. The pilot suggests that trainer time should be focused on established AHP and doctors within eyecare services.**

Leng Report Projections and Workforce Planning:

The NHS Long Term Workforce Plan targets 10,000 PAs by 2036/37, but the Royal College of Physicians (RCP) advocates for a slower rollout due to medical community concerns.
***R:* This pilot cannot endorse the rollout of PA within ophthalmology at this time.**
L: The review will inform updates to the workforce plan in 2025, reflecting changing healthcare needs
***R:* This pilot will await these updates and the RCOphth will respond accordingly.**

Leng Report Regulation and Safety:

L: The RCP supports regulation to ensure patient safety, including fitness-to-practice procedures for PAs

***R:* This pilot was not able to comment on this but supports this statement.**

L: Data from UMAPs[10] shows PAs and AAs provide safe, effective care with minimal involvement in serious incidents (3 out of 14,000 cases across 40 NHS trusts)

***R:* This pilot had no reports of serious incidents, but no PA worked without supervision. There were no reports of patient complaints regarding treatment or interactions with PAs in this pilot.**

Leng Report Stakeholder Feedback:

The British Medical Association calls for renaming the PA role to clarify its distinction from doctors and demands stricter supervision protocols

***R:* The patient voice within this pilot strongly supported this and expressed that the name was confusing. Correct introduction of all healthcare providers to visually impaired patients was emphasised in this pilot in addition to patients being empowered to ask what the clinician they are seeing is trained to do.**

L: UMAPs emphasises the positive contributions of PAs in reducing appointment backlogs and supporting chronic disease management

***R:* There were no findings in this report to support this in the four trusts that had PAs in this pilot scheme.**

Leng Report Challenges Highlighted:

L: Concerns about unsafe substitution of doctors by PAs and its impact on patient care

***R:* The feedback from the membership of RCOphth and other stakeholders supported these concerns. This report did not find that PAs could replace ophthalmologists and indeed found that tasks suggested for PAs should be carried out by ophthalmic AHPs as they were more experienced and economically more viable.**

L: Negative mental health impacts reported by 96% of MAPs (PA) due to perceived hostility in their working environment

***R:* Disappointingly this was also found in this pilot with three of our four PAs reporting hostility in their working environment.**

Leng Report Upcoming Developments:

L: The RCP plans to publish draft guidance on safe supervision and an interim scope of practice for newly qualified PAs by December 2024

***R:* This pilot could not support the RCOphth publishing an equivalent. The RCOphth plans to leave the framework and scope of practice used for the pilot on the website**.

L: The Leng Review's conclusions are expected in spring 2025, shaping future deployment strategies for PAs and AAs across the NHS

***R:* The RCOphth will await this and respond accordingly.**

Appendix **A**

Membership of the Working Party

- Sarah Mailing, *Lead for Project, Chair of Training Committee*
- Sarju Athwal, *Consultant Ophthalmologist*
- Adonis El-Salloukh, *OTG Chair*
- Sunil Mamtora, *Fellow to PA Project*
- Alex Tytko, *Director of Education, Training & Events Department*

Appendix **B**

Project documentation

Documents	Short descriptive
Documents to trusts	Application pack
PA Pack	List what the documents were that we gave the PAs
Course programmes	Timetables of the 4 courses the PAs attended
Course feedback	Feedback received from those attending
Webinars attended	List of webinars that PA Fellow put on for the PAs
Surveys	The surveys that were dent for the beginning, mid-term and at the end of the pilot

Appendix **C**

Key concerns raised by membership and how they were addressed

a. Initial lack of consultation and transparency

- Members were surprised by the sudden announcement of the PA pilot and felt the College had not adequately consulted them beforehand.
- How it was addressed: The College acknowledged this concern and committed to improving transparency through structured stakeholder meetings and increased email communications.

b. Clarity of PA roles and impact on training

- Members raised concerns about how PAs would be integrated into the workforce and whether their presence would reduce training opportunities for ophthalmologists.
- How it was addressed: The College uploaded further documentation to the website regarding the pilot and emphasised that the purpose of the pilot was to establish the viability of the PA role in ophthalmology, and to assess for any potential impact on training opportunities.

c. Initial issues with webinar engagement

- Some members found that registration for the webinar was closed prematurely, making it difficult for them to participate.
- How it was addressed: After complaints, the College promptly reopened registration and later committed to ensuring better communication of future events and registration deadlines.

Timeline of key events

Since the initial concerns were raised in September 2023, The College has made structured efforts to engage members and address concerns through a series of scheduled meetings:

- **7 December 2023:** Follow-up meeting between College representatives and OC members to discuss feedback from the webinar.
- **9 December 2023:** Meeting between OC and the OTG to discuss specific trainee concerns regarding the PA pilot.
- **26 February 2024:** The College hosted a follow-up webinar to provide further updates on the pilot.
- **24 July 2024:** First meeting of the PA pilot working group, including the Chair of Training, OC Chair, OTG Chair, and Pilot Trainee Lead.
- **18 September 2024:** Follow-up PA pilot working group meeting.
- **10 October 2024:** High-level follow-up meeting with the President, Chair of Training, Chief Executive, a College representative, and the OC Chair.
- **20 November 2024:** Further PA pilot working group meeting to discuss findings and future direction.

Appendix **D**

Summary of surveys for clinical supervisors

Pre-programme

To begin with there was overall general optimism regarding the role of the physician associate (PA) and how they might be able to develop clinical skills in the same way that nurses have done in our unit in the eye casualty. Suggested other roles included glaucoma monitoring and the delivery of intravitreal injections. There were however concerns raised with some saying that they did not feel that there was a role within the department. Concerns were raised about the challenge of developing ophthalmic knowledge in a short period of one year only compared to other allied health professionals who spend many years developing their skills and knowledge within ophthalmology. A recurrent theme was a lack of clarity on what a PA is and what they can do.

Suggested roles in which the PA could be used were scribing, although concerns were raised that this role was not appropriate considering the remuneration that the PA received. It was a common concern that PAs seemed to have a deficiency in their medical knowledge.

Mid-programme

At the middle of the programme multiple concerns were raised by clinical supervisors about a perceived lack of basic knowledge, communication skills, time keeping and examination skills.

Concerns were raised about a significant amount of time and effort being invested into the training of a particular PA but this not transpiring into a meaningful improvement in clinical skills.

At another unit it was explained that the PA has been used as a receptionist rather than a member of the medical team providing direct clinical care. Some positive comments were noted about how, although a particular PA has been motivated and enthusiastic, the role had not added as much as hoped. In another unit the role of the PA was described as a very positive experience: the individual PA here was described as ambitious and was encouraged to apply for medicine. At another unit the PA was described as a useful general assistant. The PA in this department had been trained to undertake video slit-lamp examinations at a virtual imaging hub to support senior imaging technicians. Multiple comments did specifically say that they felt that the PA had not offered a good return on investment. This PA was thought to practise at the level of a medical student part way through their studies.

Post-programme
One department commented that, although the PA was able to deliver intravitreal injections, this was the only thing that they had seemed to manage due to a poor level of clinical skills. It was felt that the time spent on training within the department had not been a valuable use of resources. Specific concerns were raised about this particular PA with comments about attitude, lack of clinical acumen, timekeeping, missing sessions and inability to develop.

In another unit, it was felt that it would take significantly longer than a year to develop the necessary skills to be clinically valuable.

Appendix **E**

Results of the Ophthalmologists in Training Group (OTG) trainee survey on the Royal College of Ophthalmologists Physician Associate pilot scheme

Shahanaz B Ahmed
Adonis El Salloukh

Executive summary

Between September and December 2024, the Ophthalmologists in Training Group (OTG) carried out a survey into the impact of physician associates (PA) recruited onto the Royal College of Ophthalmologists' pilot scheme. The survey aimed to assess the impact of training, training opportunities and experience, taking into account PA roles, supervision experience and workflow efficiency.

Thirteen residents from the four sites involved in the pilot scheme took part in the survey.

The key findings included:
- Respondents did not feel PAs had a positive impact on their training
- Respondents had a neutral response to whether PAs had a negative impact on their training opportunities
- PAs were involved in a variety of roles during the pilot, including scribing, helping with tasks arising from clinics or eye casualty including administration and chasing results, performing intravitreal injections and conducting consultation in casualty and clinics

- Respondents overall felt that PAs had no impact or reduced workforce efficiency in the roles they performed
- Supervision experience was fairly limited, however mostly neutral. One respondent felt supervision was time-consuming due to the PA's lack of background knowledge in medicine and ophthalmology
- More than 60% of respondents feel there is not a role for PAs in ophthalmology. Many respondents commented on the availability of other healthcare professionals (allied healthcare professional and foundation year doctors) who have more relevant background and training and can perform the roles undertaken by PAs during the pilot scheme.

The main limitation of the survey was the low number of participants. The reason for this is that there were four PAs taking part in the pilot, at four hospital sites for a maximum of 12 months, limiting the number of trainees who will have worked with a PA.

This survey only analyses the experience and views of residents. It is important to also understand the views and experiences of physician associates themselves and other stakeholders working within ophthalmology.

Introduction

The Royal College of Ophthalmologists (RCOphth) initiated a pilot scheme to assess the potential role of physicians associates (PA) in ophthalmology[1]. The pilot scheme ran from November 2023 for a period of 12 months. Four PAs took part in the pilot scheme across four sites: Stoke Mandeville Hospital (Buckinghamshire Healthcare NHS Trust), Bristol Eye Hospital (University Hospitals Bristol NHS Foundation Trust), Leighton Hospital (Mid-Cheshire Hospitals NHS Foundation Trust) and St James's University Hospital (The Leeds Teaching Hospitals NHS Trust).

The main aim of the pilot scheme was to identify if there is a role for PAs in ophthalmology, and to define a scope of practice with patient safety as the primary focus[2].

Methods

The Ophthalmologists in Training Group (OTG), the trainee body representation at the College, undertook a survey to assess:

- The impact of PAs on ophthalmic specialist training across the four sites
- The impact of PAs on workforce efficiency
- Trainees' views on how or whether the PA role could be improved.

The survey focussed on four key areas:

1. impact of PAs on training opportunities and experience
2. resident experience of supervision of PAs
3. roles carried out by PAs within the pilot scheme
4. impact of PAs on workforce efficiency.

An electronic survey was distributed to residents at pilot sites through their local OTG representative between September and December 2024.

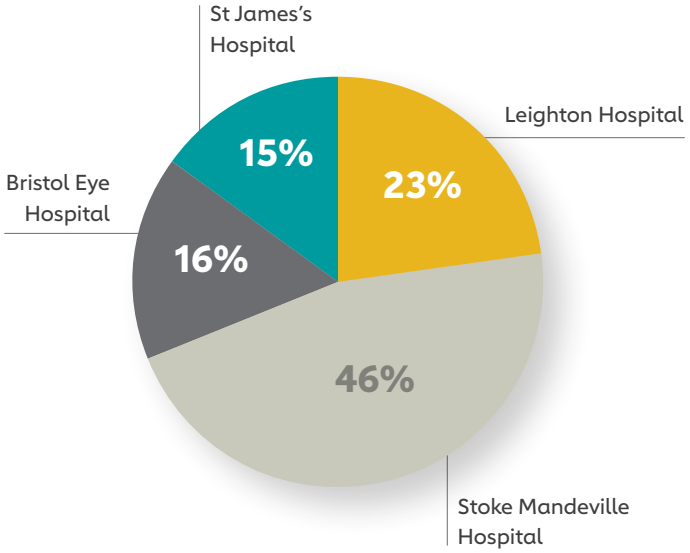
Qualitative and semi-quantitative analysis was carried out thereafter.

Results

Demographics

Thirteen residents who worked at sites with PAs responded to the survey. Residents from all pilot sites were represented (Figure 1) and there was a good distribution of stage of training, except for the lack of ST1 level residents (Figure 2). At the time of responding, PAs had been working in the department for between four and 12 months.

***Figure 1:* Site of training of survey participants at time co-working with physician associate**



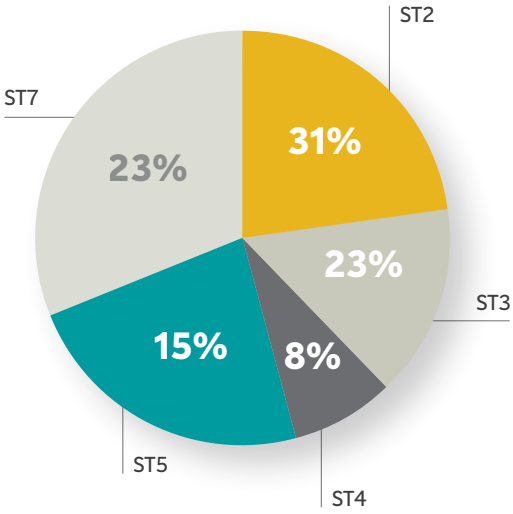


***Figure 2:* Stage of training of resident at time of response to survey**

Ten responders (77%) had worked directly with the PA during the pilot, while three (23%) worked at pilot sites but did not have direct clinical activity with PAs.

Impact on training opportunities

Residents were asked to respond to the following two statements using an 11-point Likert scale where 0 was strongly disagree and 10 was strongly agree:

- **Statement 1:** Physician associates have had a positive effect on my training opportunities
- **Statement 2:** Physician associates have had a negative effect on my training opportunities

Figure 3: **To what extent do you agree with the following statement?**

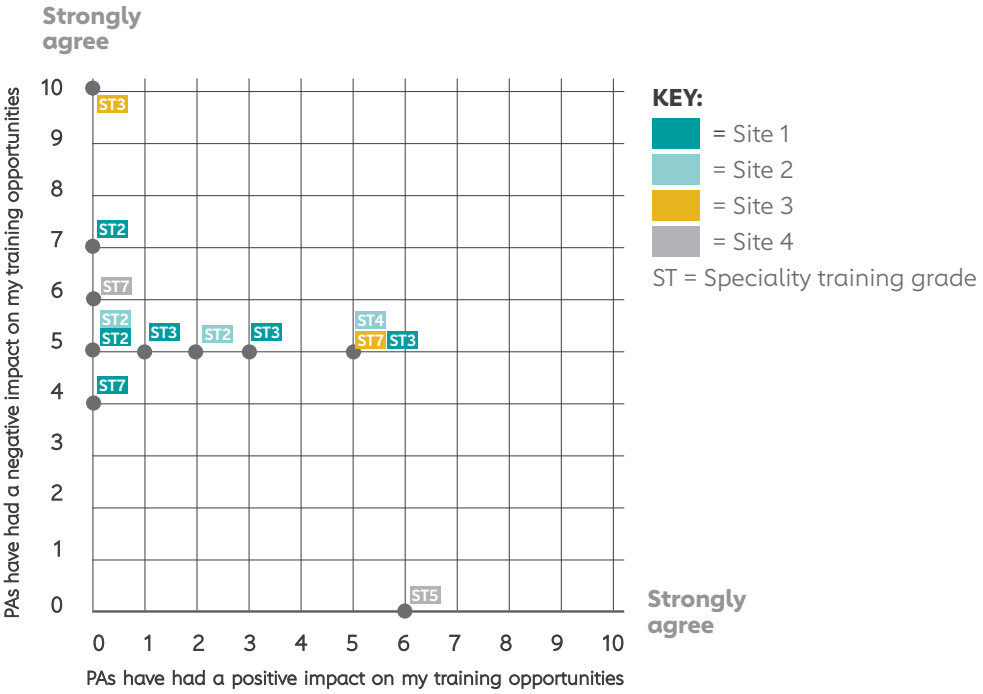


Figure 3: Resident responses on agreement with statements regarding whether PAs have had a positive impact on their training (horizontal axis) and negative impact on training (vertical axis). Specialty training (ST) grades of the participant are documented against scores. Coloured boxes are used to depict the training site of the responder, with the same colour indicating same unit of work.

Results are summarised in Figure 3. Regarding statement 1, all trainees gave scores of between 0 and 6, with a mean score of 2. No trainee felt that the presence of a PA had a positive impact on their training.

Regarding statement 2, scores of between 0 and 10 (with 11 trainees giving a score of 5 or higher) were received, with a mean score of 5. The trainee consensus is relatively neutral on this statement, although two trainees felt their training was negatively impacted by the PA (scores of 7 or more).

There does not appear to be a strong correlation of responses to stage of training, however, whereas some senior trainees (ST4+) responded neutrally to the question regarding positive impact on training, all junior trainees actively disagreed with this statement. The two participants from both sites two and four have quite differing responses.

Overall trainees were more in agreement with statement 2 compared to statement 1, that is, they felt that PAs had a more negative impact on their training than a positive impact on their training. The only reason provided for PAs having a positive impact on training was performing administrative tasks and scribing notes. Reasons provided for a negative impact on training included time required supervising PAs and seeing simpler cases, leaving a more complex mix of patients in clinic for doctors.

Residents were asked to provide free text reasons for their responses. These are presented below:

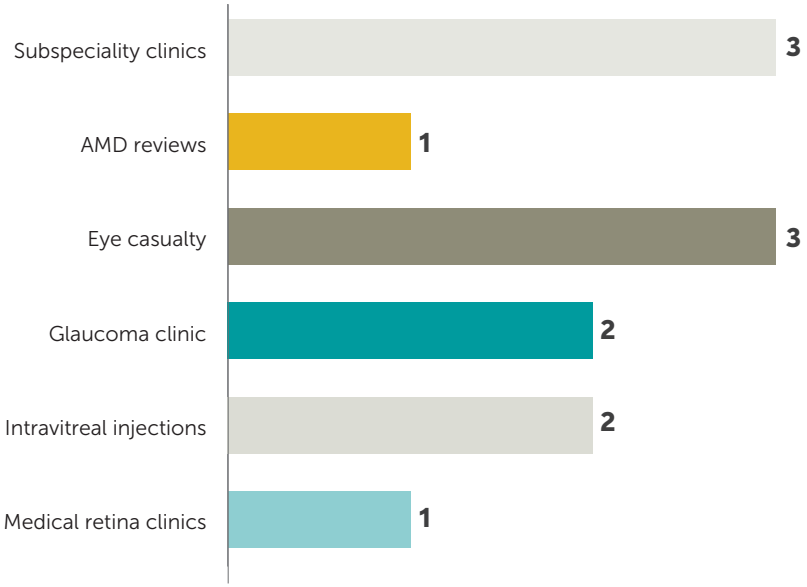
- "I work closely with the PA in our department for neuroophthalmology. He has been very helpful with admin work/typing notes. He's engaging and helpful. This role however could be filled with an fy1/2"
- "No benefit in training as the PA is not taking on service provision element that would have lowered my workload. Supervision is time consuming and takes away time I would have spent teaching observers/medical students/pre reg optoms"
- "They have not affected my training in any way at present, not positively or negatively"
- "Not been here long enough/had enough interaction with her to meaningfully know – I don't know what she does or, what she could do/how she could be used."
- "I personally would find it handy if PAs were capable of reviewing notes before clinics and marking them up for drops oct fields etc but this is not what happens. I think she is supernumerary rather like a junior trainee or F2"
- "Taking opportunities, adding to the ANPs and optometrists and orthoptists in extended roles which leaves fewer opportunities for everyone. Making eye casualty sessions more difficult as no longer varied case mix left for doctors. Having to supervise without being given a choice"
- "No negative"

Roles carried out by PAs

We surveyed the areas of ophthalmology in which PAs were assigned roles during their pilot period (Figure 5). There is a wide range of clinical areas in which PAs undertook their roles including subspecialty clinics, emergency eye departments and intravitreal injection clinics.

Of note, other options were provided. From the survey responses, no PA undertook clinical roles in diabetic retinopathy only clinics, virtual clinics, on calls, cataract surgery theatre lists or ward work for ophthalmology inpatients.

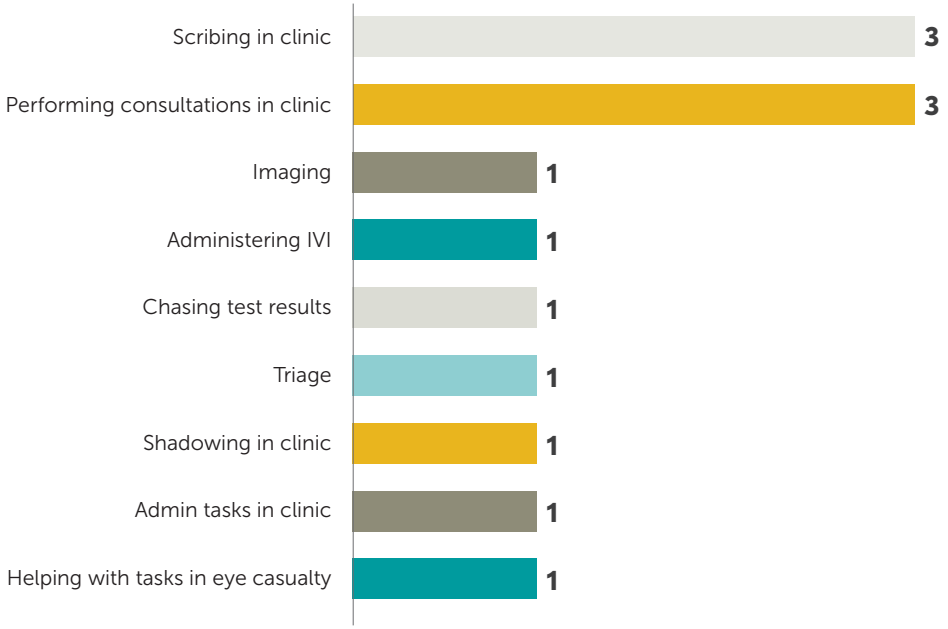
Figure 5: **Clinical areas to which physician associates were assigned to during the pilot period**



The survey also asked about specific activities and tasks undertaken by PAs within these clinical areas (Figure 6). The most common roles performed by PAs were scribing in clinics and performing consultations in clinic, each of which PAs undertook across three sites.

Other roles provided as options in the survey, but were not performed by PAs according to responders include administering treatment (other than intravitreal injections), consenting patients and working in operating theatres.

***Figure 6:* Roles undertaken by physician associates at the four sites involved in the pilot scheme**



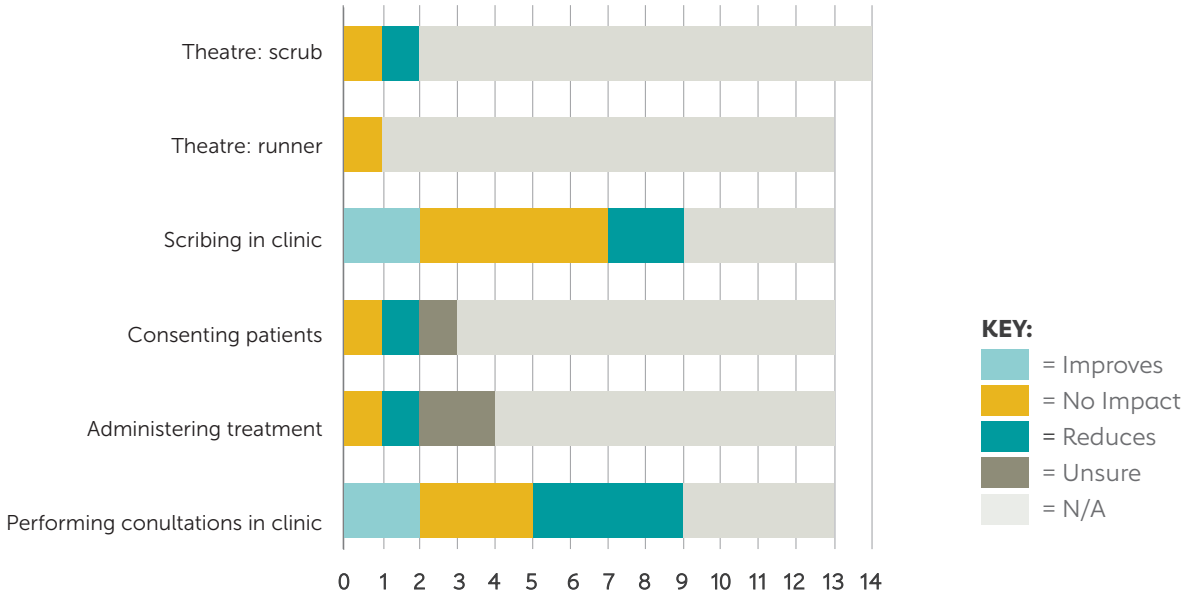
In the previous question regarding impact of PAs on training, two responders commented that some tasks can be undertaken by a Foundation Year doctor. On assessing the responses here, roles such as scribing in clinic, chasing test results, administrative tasks or helping with tasks in eye casualty could be undertaken by a foundation year doctor. It is important to note however, that not all units will have access to a foundation year doctor. In one unit, the PA undertook shadowing in clinic. We assume that this would not be a long term role for PAs, but may be used for training.

Workforce efficiency

This section of the survey evaluated perceived impact of PAs on workforce efficiency by residents. It does not take into account objective measures of output or efficiency

We asked responders on the impact they feel PAs have on workforce efficiency in a variety of roles. In most roles, some trainees felt PAs reduced workforce efficiency. Only in two roles did some trainees feel PAs improved workforce efficiency: scribing in clinic and performing consultations in clinic, however for both greater numbers of responders felt they had a neutral or negative impact on workforce efficiency. With regards to performing consultations in clinic, more residents felt PAs reduced workforce efficiency than improved efficiency. Regarding impact of workforce efficiency when performing consultations in clinic, this is likely to be influenced by PA experience and background.

***Figure 4:* perceived impact by residents of PAs on workforce efficiency in different clinical roles**



Trainees were asked to provide free text reasons for their answers. These are summarised below:

- "Potential to be useful for scribing, but their knowledge is lacking"
- "It's helpful having someone in clinic to scribe/do the paperwork, speeds things up. Not taking away from training opportunities because they have not been asked to step up further than this (from what I have seen). Again, helpful to have but seems overzealous to hire someone at that banding when a fy1/nurse specialist could do the same job"
- "Decreased efficiency. It would be more useful to hire additional specialist optometrists and ophthalmic imaging staff who are already experts in their field and could do the job that the PA is doing without the additional training and supervision requirements."
- "The PA is not used in the headcount so I cannot say that it has directly affected the department but if they were to be counted then it would negatively affect the department. They do not see many patients (perhaps one in all of casualty). They cannot prescribe so then come to the doctors to prescribe."
- "Unclear as yet – she is like a student really"
- "I don't think having a PA has made a noticeable difference in the workforce efficiency"
- "Not a big impact"

Overall, some trainees felt PAs could improve workforce efficiency by scribing, but this depends on having some background in the field in order to complete the task. Extrapolating from experience, we suspect this mainly involves knowledge of medical and ophthalmology terminology, but also members of the multidisciplinary team within ophthalmology as well as other hospital specialists.

The main reasons provided by residents for PAs reducing workforce efficiency included lack of knowledge and/or training which means PAs require supervision to perform their roles as well as the lack of ability to perform some tasks (prescribing is given as an example). Therefore doctors may need to put in significant time in supervising PAs and completing tasks on their behalf, which may be disruptive to their own flow of work and reduce their output.

Of note, one responder felt that there are other health professionals who could take on roles assigned to PAs during the pilot without the need for the same level of additional training and supervision.

Supervision of PAs

We asked about trainees' experience of supervising PAs. Five trainees (38.5%) have had experience supervising PAs. Four (80%) of these trainees spent one to four hours per week supervising PAs and one trainee spent less than one hour a week supervising a PA. Trainees were asked to describe their experience of supervising PAs. Free text comments from survey respondents are below:

- "Not enough background knowledge in ophthalmology or medicine at all, need to explain everything in details multiple times and would have been faster if I had done those tasks myself"
- "Neutral but took opportunities away from others eg prereg optoms, international observers"
- "Couple of eye case clinics but they barely saw any patients"
- "Pleasant individual. Well meaning. Cannot comment on competence or scope of her practice really as not known fully"

A handful of trainees have had experience of supervising PAs. Supervision of more junior residents and other allied healthcare professionals is part of the training to become an ophthalmologist. One trainee commented on supervision taking more time due to the lack of background knowledge. Other trainees described more neutral experiences.

Role of PAs in ophthalmology

We asked residents for their opinion on PAs in their current roles, as described earlier, and whether there was scope to improve the role of PAs in these areas. Responses have been included below.

- "I don't think so. Allowing procedures (such as minor surgery) to be performed would definitely take away from already limited training opportunities"
- "I don't think PA adds anything to the ophthalmology department as everyone in the department has their own specialist area/trained specialty including our imaging team/optom/orthoptists etc and PA has no trained experience in any of these areas. It is unnecessary addition to the department and does not improve efficiency any all instead may slow things down."
- "I frankly don't see a role for PAs in ophthalmology. Our existing allied health professionals (specialist nurses, optometrists, orthoptists and imaging staff) perform all the roles that are outlined above (within the potential scope of a PA) already and there are formal training pathways, and regulatory mechanisms for these staff members already."
- "Honestly, the PA has no idea about how to get trained which is unfair on them. They may have had ideas of what they wanted to gain but do not know how to go about it. There is no formal programme, apart from one speciality the PA is not getting trained with SMART objectives. It appears they are lost in the department. There is no ownership for them and thus they are not learning skills which you would expect a nurse practitioner to have learnt by this time. The intentions are mostly good but the infrastructure is lacking"
- "Doing ward work."
- "As I have said; they should be managing and directing nurses to be controlling patient flow effectively – ie reviewing the clinics – marking up patients for drops/oct/fields – capable of checking for an RAPD etc. I have not been at this unit long but I'm not clear on what our PA does but it doesn't seem to be driving any efficiency – to be clear that's no criticism of the individual but I don't see how her timetable is delivering increased productivity for the unit"
- "They would be most helpful as a scribe or helping with admin tasks from clinic or eye casualty."
- "Not sure not been closely working with them"

Finally, participants were asked if they feel there is a role for PAs in ophthalmology.

Eight participants (61.5%) feel there is no role for PAs in ophthalmology. Reasons included:

- "No, I do not. Ophthalmology already has a varied AHP workforce with greater experience and training to help with efficiencies."
- "No. I think our current complement of allied health professionals (optometrists, orthoptists, nurses, imaging staff) are already performing all the roles that have been suggested that PAs could do"
- "Currently I can not see a role for PAs in ophthalmology as we already have a multi-disciplinary team with consultants, trainees, staff grade doctors, optoms, orthoptists, ANPs"
- "No. We have plenty of AHPs who are able to do supportive roles or minor procedures to help the efficiency of the department. I think it would be much more work if I had to supervise a PA in clinic or doing any procedures. They would be helpful only to help with admin or scribe in busy clinics, however I realise they would like not be happy to be restricted this way in their scope of practice."

Two participants (15.4%) feel there is a role for PAs within ophthalmology. Reasons included:

- "Of course there is a role for PAs. How can we accept nurse practitioners or other allied health professionals but not PAs. They just need direction and training"
- "In dealing with inpatients and undertaking clerical tasks"

One participant did not respond to this question and one participant did not feel they could make a conclusion based on their experience.

Conclusions

Limitations of this survey include the small sample size. Although we do not have the total numbers of trainees who worked alongside a PA to calculate proportion of responders, as four sites were involved in the pilot for a maximum of 12 months, we suspect this is the main reason a small percentage of ophthalmologists in training would have been eligible to take part in the survey. A spread of training grades responded to the survey from all four sites. Feedback was received that some residents did not respond to the survey as they had no interaction with the PAs and therefore did not feel able to complete the survey.

The survey evaluated the impact of PAs in certain roles, however this may vary according to site of work, the supervising clinician and clinical sessions, therefore the results may have limited generalisability. This survey provides an overview of experiences of current trainees working at sites involved in the pilot scheme. Qualitative analysis was performed to understand experiences of residents and their reasons for responses provided.

To summarise, no trainee felt that their training opportunities were positively impacted by the presence of a PA in their workplace. Trainees were generally neutral on the question of any negative impact of PAs on their training opportunities, except for two out of 13 trainees who reported their training was negative impacted by the presence of a PA in their department. The overall consensus was that PAs did not improve workflow efficiency for the rest of the team and that roles performed by PAs could be performed by existing healthcare professionals including allied health professionals, rather than introducing a new role in existing departments.

If PAs remain part of the ophthalmology workforce, we would recommend re-evaluating the impact of the role on training opportunities and trainee experiences in one to two years, particularly with the introduction of the new ophthalmic specialist training curriculum.

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