Royal College of Anaesthetists

Extraordinary General Meeting of the Royal College of Anaesthetists

Tuesday 17 October 2023

Member briefing

Introduction

The Board of Trustees has called this extraordinary general meeting (EGM) in response to a requisition, including six resolutions, that has been proposed by individual College members with the support of more than 0.75% of the membership.

The purpose of this briefing document is to help members to consider the resolutions proposed and to make informed decisions.

In our responses to the resolutions, we have sought to provide some useful context and to highlight some of the potential implications of the proposals being made.

Enhancing the voices of the membership

In our five-year strategy, launched in 2022, we set out a strong commitment to ensuring the voices of our members are heard on important issues. Then, at AGM in December 2022, we changed our governance to allow members to requisition a meeting for a vote on a particular topic. This is the power that has been used by members to call this EGM, and it is possible to use the same power to propose resolutions for debate and vote at our annual general meeting (AGM) each year.

In line with our values, we seek to be just and fair in our democratic processes and open and responsive to the conversations that members want to have. We encourage as many of our members as possible to attend the EGM or to use their proxy vote – another new member power that enables the membership to vote in their own time rather than at the time prescribed by the Trustees – so that the full range of viewpoints can be heard.

Our charitable responsibilities

As set out in the College's governance, the six resolutions proposed by members are advisory to Council, which means they are not binding on the College even if they are passed by the required simple majority. Instead, Council members and then ultimately the Board of Trustees must carefully consider the outcomes of each resolution – even those that align with current College policy – before agreeing any further action.

As the College is a charity, its Trustees have a duty to ensure delivery of its objectives while making sure the College is carrying out its purposes for the public benefit. Trustees will have to apply that principle in their consideration of the outcome of the advisory resolutions at this EGM.

The College's charitable objects set out in our Charter are to:

- advance promote and carry on study and research into anaesthesia and related subjects and to disseminate the useful results of any such research
- educate medical and other appropriately qualified healthcare practitioners to maintain the highest possible standards of professional competence in the practice of anaesthesia for the protection and benefit of the public
- further instruction and training in anaesthesia both in the United Kingdom and overseas; and
- educate the general public in all matters relating to anaesthesia.

These objects underpin everything we do. They guide the Board of Trustees and Council, the majority of whose members are democratically elected from the membership by the membership, in the decisions they make and their leadership of the College.

This EGM provides an opportunity, across a range of important topics, for the College's membership and leadership to consider together what best serves the specialty, the College, its members, the wider NHS, patients and the public not only now but for many years to come.

We look forward to seeing and hearing from you at the EGM on 17 October.

Resolutions

1 Member resolution on the proposed expansion of anaesthesia associates

The Council is advised to ask the Clinical Directors network to pause recruitment of AAs until the proposed RCoA Survey and Consultation is complete and the impact on doctors in training has been assessed and reviewed.

The Council is advised to ask the College Tutors (CTs) and Regional Advisors (RAs) to ensure that doctors-in-training are given priority over AAs in their exposure to training opportunities. If CT/RAs find that is not the case then they should feed this information back to the Training Department, in order that the training capacity of that hospital be reviewed.

Supporting statement from the proposer

We recognise the dedication and personal contributions made by individual Anaesthesia Associates (AAs) across the NHS.

We note with concern the proposed 10-fold expansion of the AA workforce, as outlined in the NHS Long Term Workforce Plan published in June. We believe this expansion is misplaced and that further expansion of AAs would not be in the best interests of trainees or patients.

We further note the College's recent workforce report, stating that *"...unless urgent action is taken, the UK will be 11,000 anaesthetists short by 2040"*. In overtly supporting the proposed expansion of AAs, in a financially constrained NHS, the College is actively hindering the urgent action required.

Consultant anaesthetists have key roles in all areas of perioperative practice, and have undergone a more rigorous, broad and prolonged training. An expansion of AAs would implicitly lead overall to a less-skilled workforce, something that is completely at odds with the College's charitable aims. In contrast, the protection and benefit of the public, a cornerstone of its objectives, are best met by a replete and well-trained workforce.

Resolution proposed by: Dr Danny Wong

College Council and Board of Trustees response

Anaesthesia Associates (AAs) are practitioners working under the supervision of an autonomously practising anaesthetist.

We recognise the strength of feeling among our members regarding NHS England's proposed expansion of the number of AAs, to an estimated 2,000 by 2036/2037. Indeed, we have advised NHS England against rapid over-expansion given the current lack of evidence about the potential impact on anaesthetic training and other factors.

Furthermore, NHS England has confirmed that the AA expansion plan set out in the NHS Long Term Workforce Plan is aspirational and that they are keen to work with the College to grow and assess the evidence base around AAs. NHS England also acknowledge that modelling over 10–15 years is inherently difficult and will need to be continually refreshed to assess progress and assumptions.

We agree that training opportunities for anaesthetists in training must be prioritised and have asked that College Tutors inform the College of any concerns about their department's ongoing capacity to train anaesthetists in training. We will shortly finalise and publish our updated guidance for departments who employ or are considering introducing AAs, which includes a requirement to undertake a training capacity assessment and principles for how that assessment should be undertaken.

Since the introduction of AAs, the College's role has been to provide leadership and guidance on their education, training and professional standards. This is consistent with our responsibility to safeguard standards in anaesthesia, including through the education of medical and other appropriately qualified healthcare workers (as set out in our Charter).

Delivering this role does not prevent us from taking an evidence-informed approach to AAs or advocating for a change of policy on AAs if supported by evidence. We have recently conducted a member survey about AAs and are in the process of commissioning an independent review of the international evidence about AAs and their overseas equivalents. The findings from both will form the basis for further consultation with members and patient groups.

If we find evidence of negative impacts on issues such as anaesthetic training, patient safety, or service efficiency we will put these points to NHS England and national governments in robust terms. We will also bring a discussion and vote to our AGM in 2024, once our evidence gathering stage is complete and regulation has been implemented. **We will do this whether this resolution is passed or not.**

We encourage members to consider the potential risk of this resolution:

- requesting a pause in recruitment of AAs may be viewed by NHS England as incompatible with the College fulfilling the long-standing leadership role outlined above. If this responsibility is ceded to another body with much less expertise in anaesthesia and related training, education, safety and quality issues, the College (and its members) will have little influence.

We do not oppose this resolution and will seek to act on it if passed by a simple majority.

Additional context

This resolution makes reference to our member survey about AAs, which was open from 21 August to 20 September 2023. The anonymous survey was administered on our behalf by Research by Design, an independent research company. Research by Design will undertake analysis of the survey responses and provide a report to the College which we will publish and share with members.

Medical education and training for anaesthetic doctors is and will remain the College's priority and primary focus. We believe that anaesthetic training places must be increased, both in the short term to address the current bottleneck at ST4 level and in the long term at CT1 and across the entire anaesthetic medical training pathway. This expansion is essential to address workforce shortages and we will continue to advocate for this at the highest levels.

We remain fully committed to supporting AAs currently working in the NHS or in training. We have a duty of care to them as individuals and a responsibility to maintain service provision for patients. It would be unethical to withdraw this support and we note that the resolution does not ask us to do that.

We have shared a near final draft of the 2023 edition of our guidance for departments who employ or are considering introducing AAs because it is useful reference for members ahead of the EGM, but please note that this is subject to final amendments ahead of its official publication.

Additional briefing about the AA role is included in Appendix 1.

2 Member resolution on the supervision of anaesthesia associates

The Council is advised to amend the Guidelines for Provision of Anaesthetic Services (GPAS) the Anaesthesia Clinical Services Accreditation (ACSA) and other relevant College documents to make it clear that local opt-outs from the College's position on the supervision of AAs are not approved by the College.

Supporting statement from the proposer

We note and reaffirm the current stated College position that AAs should always be supervised by a named and readily-available Consultant Anaesthetist, and consider that this requirement is inviolable. We believe that individual hospitals should not unilaterally waive this requirement. We also believe that if it is necessary for AAs to work outside their initial scope of practice (as currently defined in Appendix E: AAGBI and RCoA Executive Summary: Scope of Practice for a PA(A) on qualification), then they should be directly supervised by a Consultant, physically present in theatre throughout (Level 1), and that this requirement should be inviolable.

We believe that this is essential to maintain the highest possible standards of professional competence in the practice of anaesthesia.

Resolution proposed by: Dr Danny Wong

College Council and Board of Trustees response

We agree that adequate supervision of anaesthesia associates (AAs) is crucially important. The scope of practice for AAs upon qualification – including supervision arrangements – is set out in our draft 2023 guidance for introducing AAs.

Any area of practice that differs from the scope of practice upon qualification is known as an enhanced role. **We do not currently support enhanced roles for AAs until statutory regulation is in place.**

However, enhanced roles for AAs do exist within some trusts. These roles are supported by local governance arrangements – a provision that is acknowledged in the Guidelines for Provision of Anaesthetic Services (GPAS). Services supported by enhanced roles may often have been in place for many years and in some cases are understood to function well for the benefit of patients. The need to maintain these services will have to be taken into consideration alongside the need for adequate supervision, and evaluation of patient care.

Through this EGM process and our own member engagement, we understand that members have legitimate concerns about supervision of AAs and about the lack of a scope of practice beyond qualification. We will continue to take steps to address those concerns. Our current work in this area includes:

- establishing a working group to develop a scope of practice for enhanced roles outlining safe supervision levels, to take effect when regulation is in place. We will ensure the working group has representation from all relevant stakeholders, including anaesthetists in training
- conducting a series of surveys of AAs, clinical leaders and the membership to gain further information about how AAs are working and the views of the membership.

In addition we will:

- engage with NHSE and university AA course providers to try and ensure a consistent understanding of supervision levels
- request that clinical leaders pause in the development of enhanced roles for AAs.

We do not oppose this resolution. If passed by a simple majority the Council and Board of Trustees will seek to act on it whilst taking into consideration their duty to ensure the College carries out its purposes for the public benefit.

Additional context

We support statutory regulation of anaesthesia associates, which is due to be implemented in 2024. We have always seen regulation and the establishment of consistent standards as essential patient safety requirements. This is now even more pressing and we will continue to push for regulation to be implemented at the earliest possible opportunity.

The current scope of practice for AAs defines what they can do upon qualification. Our position has always been that we will develop a comprehensive and clearly defined scope of practice beyond qualification, to take effect when regulation is in place.

We are setting up a working group with representation from stakeholders including, but not limited to, anaesthetists in training and other members, training network representatives, clinical leaders, the Association of Anaesthetists, the Association of Anaesthesia Associates, PatientsVoices@RCoA, and the GMC.

We have shared a near final draft of the 2023 edition of our guidance for departments who employ or are considering introducing AAs because it is useful reference for members ahead of the EGM, but please note that this is subject to final amendments ahead of its official publication.

Additional briefing about the AA role is included in Appendix 1.

3 Member resolution on information for patients

The Council is advised to ratify as a professional standard the need to inform patients, when applicable, that an AA could be involved in their care, that an AA is not a registered medical practitioner, and who their responsible Consultant Anaesthetist is.

Supporting statement from the proposer

We believe that patients should be informed preoperatively when an AA could be involved in their care, be made aware that an AA is not a registered medical practitioner, and be told who their responsible Consultant Anaesthetist will be. This is a key plank of the College's charitable aim of educating the public in all matters relating to anaesthesia. NICE guidelines, as we were recently reminded in Parliament, make it clear that the onus is on the individual professionals to properly explain their role to patients, especially if there is a likelihood of this not being automatically understood.

Resolution proposed by: Dr Jan Hansel

College Council and Board of Trustees response

The principle that anaesthesia associates (AAs), like all healthcare workers, should be open and honest about their experience, qualifications and role when talking to patients is incorporated into the GMC's Good Medical Practice (GMP 66), the 2024 edition of which will apply to AAs once they are regulated by the GMC.

This principle is also included in both the current and forthcoming editions of our guidance for introducing AAs to departments. Our patient representative group, PatientsVoices@RCoA has previously been consulted on this issue and supports the College's position that patients must be appropriately informed of who will be managing and overseeing their care.

Additionally, to avoid any unintended confusion for patients, we will work with our ethics committee and others to produce supplementary guidance about how members of the anaesthetic team should introduce themselves and the titles they should and should not use.

We support statutory regulation of anaesthesia associates, which is due to be implemented in 2024. This is now even more pressing and we will continue to push for regulation to be implemented at the earliest possible opportunity.

This resolution reflects current College policy and we do not oppose it. We will seek to act on it if passed by a simple majority.

Additional context

The GMC's Good Medical Practice sets out the professional values and behaviours expected from doctors. This includes a requirement to act with honesty and integrity and a stipulation that: *"You must always be honest about your experience qualifications and current role."* (GMP, 66). In terms of establishing and maintaining partnerships with patients, the relevant standard relates to sharing with patients the information they will need to make decisions about their care. This includes a responsibility to explain *"who is responsible for each aspect of patient care..."* (GMP, 49c).

Good Medical Practice does not currently apply to AAs as they are unregulated, but once regulation is implemented they will be bound by the same standards. The GMC confirmed this when it published the 2024 update of Good Medical Practice, which will come into effect on 30 January 2024. The points cited above are also present in the updated edition.

Both the current and forthcoming editions of our Guidance for introducing and training anaesthesia associates state: *"The protocols for obtaining patient consent for treatment by AAs are no different to those for any other healthcare professional. AAs must make their role clear to patients and be prepared to answer questions pertaining to their training, experience and supervision."*

We note that as currently drafted this resolution could imply that it is the responsibility of the consultant anaesthetist to inform patients that an anaesthesia associate will be involved in their care. If this resolution is passed, we will discuss with the proposer how this could be practically implemented to remain within the spirit of the GMC's Good Medical Practice. Similarly, it is not clear what the term 'professional standard' means in the context of this resolution but if passed we will clarify this and act accordingly.

Additional briefing about the AA role is included in Appendix 1.

4 Member resolution on rotational training

The Council, together with the Education, Training and Examinations Board, is advised to fully consider the personal impact of rotational training, to work with the relevant stakeholders to reduce the need for any short-term placements of under 1 year except in situations where experience cannot be gained without rotating (eg cardiothoracic anaesthesia), and to present a report on their progress at the College Tutors Meeting in June 2024.

Supporting statement from the proposer

We acknowledge that the impact and effects of short-term rotational training for doctors in training posts has changed over the last 20 years.

Such placements may create a sense of isolation and transience, affecting morale and workplace cohesion. Unfamiliarity with local processes and protocols is a hindrance to doctors in maintaining the highest possible standards of professional competence, which is one of the College's charitable objectives. Furthermore, unfamiliarity with the educational needs of individual doctors on short-term placements has, anecdotally, resulted in preferential allocation of valuable educational opportunities to permanent staff.

Short-term placements may have significant and detrimental consequences on the family life of doctors, especially those with caring responsibilities and health issues.

We consider that more could be done to ensure that the importance of stability and the educational and personal benefits offered by longer placements are taken into account when considering the need for breadth of experience.

Resolution proposed by: Dr Ramey Assaf

College Council and Board of Trustees response

We share the concerns raised regarding the impact of short rotations on the health and wellbeing of anaesthetists in training.

We have been considering this issue for some time and believe there is a unique opportunity now that the 2021 Anaesthetics Curriculum has been established, to work with heads of schools, training programme directors and regional advisors to review rotations and the way in which training is delivered within different regions.

We will continue this work, informed by our members' views. We will establish a working group to look first at the rationale for rotational training, including its value as an educational tool. The working group will also consider the current structure of rotations and the reasons for it, whether service reconfiguration could be delivered to support better training and the potential risks and benefits of that.

We will also work with regional advisors, training programme directors and heads of school to better understand the regional differences in the impact of rotational training on anaesthetists in training. We will report on this work at the College Tutors meeting in 2024.

We note that decisions on rotational training are not solely in the gift of the College.

This resolution aligns with ongoing work by the College and we do not oppose it. We will seek to act on it if passed by a simple majority.

Additional context

In addition to establishing a working group on rotational training, we seek to coordinate where possible with other relevant organisations working on this issue at local, regional and national level.

Appendix 2 provides some additional information about rotational training in the context of the 2021 Anaesthetics Curriculum.

5 Member resolution on national recruitment for doctors in training

The Council is advised to:

- make necessary enquiries in order to acquaint itself with the reasons for the delay in publishing the SIR report, and discuss its findings
- consider whether there is any evidence, on the basis of the report, that HR records were not kept clearly and accurately, whether or not adequate auditing and benchmarking systems were in place, and whether or not staff had the necessary knowledge, skills and training to carry out their roles
- consider whether or not it still has confidence in the leadership and senior management of the Anaesthetic National Recruitment Office (ANRO).

Supporting statement from the proposer

We note with great concern the findings of the multiple systematic failures, as described in the Significant Incident Report (SIR) of December 2021, and the considerable delay and reluctance in releasing this report. Ensuring that the best candidates are appointed into training posts, and that HR processes are as good as possible, are prerequisites for ensuring the highest possible professional competence. The College also has a public duty, in the light of the privileged and confidential information that it holds, to ensure that any breaches of the GMC's Good Medical Practice and Leadership and Management for all Doctors are acted upon.

Resolution proposed by: Dr Richard Marks

College Council and Board of Trustees response

The recruitment process run by the Anaesthetic National Recruitment Office (ANRO) has significant impact on doctors' careers and personal lives and we share the great concern expressed by members regarding its systemic failures.

The Significant Incident Report into errors that occurred in recruitment in autumn 2021 (published in July 2023) was discussed at Council in September 2023, alongside the report into errors that affected CT1 recruitment in February 2023. These reports will be the subject of further discussion at Council's November meeting. The discussion will include consideration of a report of progress against the recommendations and will cover the points raised in the resolution. Minutes of both meetings will be published on the College website in due course.

ANRO is an administrative team based within the West Midlands Deanery. Recruitment is overseen by Regional Deans and the NHSE national recruitment team and ultimately the Medical and Dental Recruitment and Selection Committee (MDRS) on behalf of the four Statutory Education Bodies (SEBs).

We believe that ANRO is itself the recipient of poor support from MDRS/NHS England, and that its performance is a result of inadequate resourcing and support. This is evident in the recommendations of the incident reports, and the fact that MDRS/NHSE have only recently agreed to provide additional resource following sustained pressure from the College.

This resolution aligns with ongoing work by the College and we do not oppose it. We will seek to act on it if passed by a simple majority. In addition, we will continue to make representations to NHS England and MDRS regarding their inadequate support and resourcing for ANRO.

Additional context

In July 2023 NHS England Workforce Training and Education (NHSE WTE formerly HEE) published its report of a Significant Incident Review into serious issues that affected anaesthetic CT1 and ST3 recruitment in autumn 2021. At the time the errors occurred, the College called for an urgent review and action to stabilise recruitment and was subsequently represented on the review team.

The review was completed in December 2021 and although the College argued very strongly for the findings of the report to be published upon completion, it was only published in July 2023 in response to a freedom of information request. In the intervening period, the College continued to hold ANRO and the MDRS to account to ensure sufficient safeguards were in place to continue to deliver recruitment.

In August 2023, NHS England published its report of a review into two errors that affected anaesthetics CT1 recruitment in February 2023. The College was represented on the review group and we are grateful to the applicants who shared their experience with us at the time. We used this feedback to demonstrate to NHS England the impact of the errors and to push for the increased resource given to ANRO at the time to be sustained. We also advocated for greater oversight of the recruitment process and for ANRO to report back to the incident review group on its progress against the recommendations.

Recruitment and its processes should be a top priority for NHS England and must be adequately resourced, with due care given to every doctor who applies. We will continue to represent our members' views in conversations with ANRO and NHS England about recruitment.

Appendix 3 provides some additional context on anaesthetics recruitment.

6 Member resolution on regional recruitment

The Council is advised to set up a group, together with any other stakeholders it sees fit, which may include the Academy of Medical Royal Colleges, to investigate whether a centralised national recruitment centre is in the best interests of our specialty, to explore the legal and practical possibilities of recruitment at a regional level, and to present a report on their findings in due course.

Supporting statement from the proposer

We believe a strong case can be made for recruitment at a regional or local, rather than national level, using the present metrics for assessment. Benefits may include local consultant buy-in and better information and choice for applicants.

Resolution proposed by: Dr Richard Marks

College Council and Board of Trustees response

We have listened to the concerns of members about national recruitment. Equally, we have heard from members who oppose a return to a regional system. We therefore welcome this resolution as an opportunity to gauge the views of the wider membership.

We have taken early steps to ascertain the interest of other stakeholders in working with us to consider the relative benefits of regional recruitment. While the appetite so far has been limited, we will formally approach stakeholders, including the Academy of Medical Royal Colleges, to join a working group to consider this issue.

We note that it would be difficult for the College to explore the possibilities of a return to regional recruitment without the involvement of other parties.

We do not oppose this resolution and will seek to act upon it if passed by a simple majority.

Additional context

Recruitment for anaesthetists in the UK is a complex process involving several stakeholders.

- **The Medical and Dental Recruitment and Selection (MDRS) Committee of NHSE** is a Committee of Deans and Education leads within NHS England overseeing specialty recruitment across various medical and dental specialties. MDRS represents the four statutory education bodies for the UK's four nations (NHS England Workforce Training and Education (NHSE WTE), NHS Education Scotland (NES), Health Education and Improvement Wales (HEIW) and the Northern Ireland Medical and Dental Training Agency (NIMDTA)).
- **ANRO (Anaesthetics National Recruitment Office)** is housed within the West Midlands Deanery team and provides services for the delivery of national recruitment in anaesthetics. The ANRO team work alongside the NHSE WTE national recruitment team to deliver recruitment with input from the RCoA Recruitment Committee. ANRO is part of NHS England and is responsible for overseeing the national recruitment process for various levels of anaesthesia training.
- **The Royal College of Anaesthetists (RCoA)** is the professional body responsible for setting standards for anaesthetists, including those in training in the UK.

Appendix 3 expands on the responsibilities of these organisations in relation to recruitment and provides additional context on relevant factors such as distribution of posts, fill rates, workforce planning and the rationale for national recruitment.

Appendix 1
Anaesthesia associates

Background

Anaesthesia associates (AAs), formerly known as physician assistants (anaesthesia), were introduced in 2004 and are a part of the medical associate professions (MAPs) group, alongside physician associates and surgical care practitioners.

AAs work within the anaesthetic team under the supervision of an autonomously practising anaesthetist (such as a consultant or SAS doctor), supporting the provision of safe anaesthetic and perioperative patient care. Qualifying as an AA requires successful completion of a two-year, postgraduate AA training programme from an accredited provider, following either a minimum of three years as a registered healthcare professional (eg nurse or operating department practitioner) or completion of a biomedical/life science degree.

The AA role is designed to complement the work of medically qualified anaesthetists, supporting them to deliver anaesthetic care for patients and assisting with the overall service requirements of the department. AAs are an additional member of the anaesthetic team and are not a replacement for medically qualified anaesthetists.

Regulation

In 2019, the Department of Health and Social Care (DHSC) announced that the General Medical Council (GMC) was to become the regulator responsible for the regulation of AAs and Physician Associates (PAs). The decision for the GMC to become the regulators of AAs and PAs was the outcome of a DHSC consultation in 2017 and scoping exercise.[†]

Earlier this year, the DHSC launched a 12-week public consultation[‡] on the draft legislation for the regulation of AAs and PAs in order to make any necessary amendments before laying the order before parliament, and it is now expected that regulation of PAs and AAs will commence in the second half of 2024 at the earliest.

In preparation for regulation, the GMC has published a range of documents including the professional standards and learning outcomes that AAs will be required to adhere to upon regulation.[§] The GMC is also developing an AA registration assessment (AARA), which will be implemented after regulation begins and all qualified AAs will be required to successfully pass (in addition to their training programme assessments) in order to apply to register with the GMC and practise.

The College has long advocated for extending regulation to AAs and welcomes regulation of this role. Regulation is an essential patient safety requirement, it is vital to ensure that healthcare professionals are held to a high standard professionally with a consistency in skills, training and the level of public protection and patient confidence.

Proposed expansion of AAs

Although AAs have existed since 2004, the AA workforce has remained relatively small with approximately 160 AAs on the Managed Voluntary Register held at the RCoA. Currently, NHS England (NHSE) is providing a national funding offer in England until April 2024 (which includes a consistent salary support offer for student AAs, a contribution towards tuition fees and educational supervision in the workplace). This was for up to a combined total of 120 students across NHSE regions in 2022–2023 and 187 students in 2023–2024. Following this, NHS England's Long Term Work Force Plan announced plans to expand AA numbers by an estimated 2,000 by 2036/2037. NHS England acknowledges that this number is aspirational and actual expansion will be demand led. In the period leading up to regulation NHSE are keen to work with the College to assess the evidence base and to refresh modelling assumptions.

[†] assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/777130/maps-consultation-report.pdf

[‡] gov.uk/government/consultations/regulating-anaesthesia-associates-and-physician-associates/regulating-anaesthesia-associates-and-physician-associates

[§] gmc-uk.org/pa-and-aa-regulation-hub

The College has advised NHS England against over-expansion of anaesthesia associates given the current lack of evidence about the potential impact on anaesthetic training and other factors. Following the publication of the NHS Long Term Workforce Plan many members have expressed concern about the impact AAs may have on their training and working lives.

In consultation with members and other stakeholders, the College has been working to ensure that there are sufficient safeguards put in place across this programme of regulatory reform. In our upcoming revised, guidance document, Guidance for introducing and training anaesthesia associates (2023), we have added a requirement for departments to undertake a training capacity assessment when considering introducing student AAs. This is to establish whether departments have the capacity required to maintain the appropriate levels of training and supervision for anaesthetists in training and train student AAs, ensuring there will be no negative impact on training opportunities for anaesthetists in training. This will require sign off by the college tutor and clinical director, with involvement from the regional advisor (anaesthesia) and head of school.

Supervision

AAs work under the supervision of an autonomously practising anaesthetist at all times, as stated in RCoA's *Guidelines for the Provision of Anaesthetic Services (GPAS), Anaesthesia Clinical Services Accreditation (ACSA),* and the *2021 Guidance for supervision arrangements*.

AAs must have a named, supervising physician anaesthetist who will be responsible for entrusting responsibility to the AA and devising and agreeing an anaesthetic plan with the AA.

At the point of qualification, AAs work under supervision at levels 1b and 2a (and sometimes 1a), as stated in the AA curriculum and the upcoming guidance for introducing AAs. Student AAs must always be supervised at level 1a or 1b. These levels of supervision are specific to AAs and differ from the supervision levels in the 2021 anaesthetics curriculum, because the AA training and supervision requirements differ from those of an anaesthetist in training.

1a	**Supervisor present in theatre throughout and required to assist case with proactive involvement**
1b	**Supervisor present in theatre throughout and available to assist reactively when needed**
2a	**Supervisor in theatre suite, available to guide aspects of activity through monitoring at regular intervals**

Introduction to patients

The protocols for obtaining patient consent for treatment by AAs are no different to those for any other healthcare professional and patients must always be informed as to who is delivering their care.

AAs must make their role clear to patients and be prepared to answer questions pertaining to their training, experience and supervision, as stated in our guidance for introducing AAs and the GMC's Good Medical Practice, which will apply to AAs once regulation has been implemented.

We continue to work with PatientsVoices@RCoA to ensure their voice is incorporated into our work, with patient representation on the Anaesthesia Associate Founding Board and all associated working groups and committees.

Scope of practice

On qualification, the AA will be trained to core competencies in the AA curriculum, which is aligned to the GMC's Physicians Associate and Anaesthesia Associate Generic & Shared Learning Outcomes and the professional standards in Good Medical Practice. The updated scope of practice for AAs on qualification is in the draft 2023 guidance for introducing AAs.

The GMC will look to the College, as the professional body responsible for the speciality of anaesthesia in the UK, to develop the scope of practice and clinical standards for AAs. We are setting up a representative working group to develop a comprehensive and clearly defined scope of practice, which will be subject to consultation with a wide range of stakeholders including our members. We have also undertaken survey work into the roles AAs currently undertake to inform this work.

Guidance for the introduction of anaesthesia associates

The College has recently revised its existing guidance for introducing AAs, which includes the considerations and processes that departments should take when considering introducing AAs, as well as principles of undertaking a training capacity assessment. We have shared a near final draft of the 2023 edition of the guidance because it is useful reference for members ahead of the EGM, but please note that this is subject to final amendments ahead of its official publication.

Appendix 2
Rotational training in the context of the 2021 Anaesthetics Curriculum

The 2010 Anaesthetics Curriculum and training programme was based on the concept of 'spiral learning'. This meant that basic principles learnt and understood were repeated, expanded and further elucidated as time in training went on; this also applied to the acquisition of skills, attitudes and behaviours. There were essential units of training which anaesthetists in training returned to at each level, as well as specialist areas of practice that were introduced from Intermediate Level onwards. This meant that time spent in specialist area blocks of practice had to be undertaken twice, often necessitating frequent rotations to tertiary units where these training opportunities were available.

In introducing the 2021 Anaesthetics Curriculum, the College used the opportunity to try and improve training for anaesthetists in training. The data at the time of development showed that more than 40% of CT2s did not complete core training and move into ST3 after two years. Pressure to pass the FRCA Primary exam and a desire to gain further anaesthetic experience (especially in obstetrics) were cited as particular stressors in the College's Welfare and Morale Report published in 2017.

Alongside this, the report also indicated that three-month and six-month rotations were felt to be too short, resulting in anaesthetists in training feeling unsettled professionally and personally. Some respondents reported adverse outcomes at ARCP relating to a lack of protected training time, particularly with short rotations during intermediate/advanced modules, and the fact was highlighted that support networks took some time to grow and more frequent rotations could impede the development of anaesthetists in training. These issues are addressed in the 2021 curriculum.

To an extent, 'spiral learning' is still a concept in the 2021 Anaesthetics Curriculum and rotations ensure adequate clinical exposure and experience to ensure fulfilment of all key capabilities and GPCs required at each stage of the curriculum. However, as it has been developed in a non-surgical specialty way, anaesthetists in training are only required to undertake single blocks of neuroanaesthesia, cardiac anaesthesia and ICM during Stage 2, which should reduce the need for frequent rotations and may lead to better experience and increased confidence in these areas of specialist practice. Introducing this change also aimed to address the inconsistencies in the way these areas of practice at the higher and advanced levels of the 2010 Anaesthetics Curriculum had been delivered, particularly around lengths of placements in these areas across the UK.

The nature of broad-based general training promotes flexibility and more opportunities, at the senior levels of training, for independent practice and development of the full range of knowledge, skills, behaviours, and attributes needed to practice as a consultant anaesthetist in the NHS.

Appendix 3
Anaesthetics recruitment

The Royal College of Anaesthetists is the professional body responsible for the specialty throughout the UK. We are the third largest medical royal college in the UK by membership. With a combined membership of more than 24,000 Fellows and Members, we ensure the quality of patient care by safeguarding standards in the three specialties of anaesthesia, intensive care and pain medicine.

Recruitment for anaesthetists in the UK is a complex process involving several stakeholders. Below, we list the key organisations and their roles.

1 **The Medical and Dental Recruitment and Selection (MDRS) Committee of NHSE** is a Committee of Deans and Education leads within NHS England overseeing specialty recruitment across various medical and dental specialties. MDRS represents the four statutory education bodies for the UK's four nations (NHS England Workforce Training and Education (NHSE WTE), NHS Education Scotland (NES), Health Education and Improvement Wales (HEIW) and the Northern Ireland Medical and Dental Training Agency (NIMDTA)). The responsibilities of MDRS are to:

   - ensure equitable and fair standards in the delivery of recruitment across all medical and dental specialities in the UK
   - take ultimate UK-wide responsibility for the operation of national recruitment in the UK on behalf of the statutory educational bodies
   - include representatives from various organisations, including BMA junior doctor representatives, the General Medical Council, National Institute for Health Research, Royal College recruitment representatives, and the Academy of Medical Royal Colleges representatives.

2 **ANRO (Anaesthetics National Recruitment Office)** is housed within the West Midlands Deanery team and provides services for the delivery of national recruitment in anaesthetics. The ANRO team work alongside the NHSE WTE national recruitment team to deliver recruitment with input from the RCoA Recruitment Committee. ANRO is part of NHS England and is responsible for overseeing the national recruitment process for various levels of anaesthesia training. Its main responsibilities include:

   - management and delivery of policies and procedures from the point of job advertisement to job offer
   - coordinating and delivering recruitment efforts in collaboration with local education offices and recruitment leads
   - providing feedback to the RCoA Recruitment Committee on fill rates, appeals, complaints and quality improvement measures.

3 **The Royal College of Anaesthetists (RCoA)** is the professional body responsible for setting standards for anaesthetists, including those in training in the UK. The College has the following responsibilities with regard to recruitment:

   - ensure the functioning of a Recruitment Committee to act on behalf of the College, the specialty and Council in setting policies, and maintaining standards for recruitment
   - ensure that the recruitment office have all specialty standards in place to deliver recruitment
   - provide clinical expert knowledge and input to the recruitment process
   - set, agree and communicate the person specification for entry into the specialty
   - advise on the appropriate assessment tools, methodology and process for recruitment
   - provide the specialty and prospective candidates with information regarding the recruitment process
   - select the chair of the RCoA Recruitment Committee who then represents the College as a stakeholder to external organisations, including NHS England (formerly known as HEE), ANRO, and the Medical and Dental Recruitment and Selection (MDRS)
   - to advise external stakeholders, but not to manage or control the recruitment process or set the number of training places.

Distribution of posts

Training posts are distributed and allocated across the UK by the statutory educational bodies and should be based upon a number of factors:

- training needs and capacity
- patient needs
- government or national policy
- other socio-economic factors.

The College, alongside other professional bodies and stakeholders, provides feedback and advice (usually via the Lead Dean for Anaesthetics) for the appropriate number and spread of posts. The College's position is based upon feedback from trainers, projected future patient demand, workforce needs, and planning for a sufficient number of anaesthetists for the future.

NHSE review and set how posts are distributed across England. The College works through the Boards in Scotland Wales and Northern Ireland respectively to influence decision making, where there is good collaboration between the SEBs, the College and local STCs.

The College generates its own workforce data to help national bodies and stakeholders make informed decisions about the development of the anaesthetic workforce. The College publishes this information for members and stakeholders alike:

- Workforce census (2020) – the most contemporary review of the size, shape and profile of the anaesthetic workforce (2022 update currently being analysed)
- Anaesthetic workforce summary – a high-level summary of the structure of the anaesthetic workforce in 2019
- Workforce data pack (2018) – This document provides an analysis of the anaesthesia workforce situation in the UK at the time and was developed to support anaesthetists to engage in local level workforce discussions
- Workforce Census (2015) – the 2015 census was a comprehensive review of the anaesthetic workforce at the time and was the first report that outlined that the CfWI workforce projections were not sufficient for the future demand. It also highlighted issues such as the ageing workforce and the contributions of SAS Doctors.

College data has consistently shown that there is a need to increase training numbers in order to produce more anaesthetists in the UK to meet patient demand. From our analysis, we have developed a series of positions in relation to the anaesthetic workforce; these include:

The sources of data presented supports the following key recommendations of the College.

- **Specialty anaesthesia training numbers must be increased in the light of future demand** projections, most notably from the College's own research and Health Education England's work conducted by the CfWI.
- **Core anaesthesia and/or ACCS (Anaesthesia) training posts must be increased** to ensure sufficient supply to fill specialty training programmes (noting that at present there is a bottleneck at ST4).
- SAS and trust-grade doctors make up 22% of the trained anaesthesia workforce and are likely to increase as a proportion, with the largest cohort aged between 40 and 54 years. While retirement plans will vary, as is the case with consultants, SAS Doctors must be considered when conducting national and regional workforce planning.
- The College supports an increase in the intensive care medicine workforce. However, any expansion must not occur at the expense of anaesthesia training numbers. This is a joint RCoA and FICM position.

Fill rates in national recruitment

Anaesthetics has not always been able to achieve 100% fill rate at recruitment. Data from 2018 shows a pattern of recruitment where the specialty was not able to achieve 100%. There were areas across the UK where <100% was a common recruitment outcome. The tables below review historical fill rate data for the UK in 2018.

National recruitment – August 2018

Region	Places	Accepted	Fill Rate
Health Education East Midlands	32	20	62.50%
Health Education East of England	12	12	100.00%
Health Education Kent, Surrey and Sussex	26	26	100.00%
Health Education North East	25	17	68.00%
Health Education North West	40	40	100.00%
Health Education South West	20	20	100.00%
Health Education Thames Valley	10	8	80.00%
Health Education Wessex	7	7	100.00%
Health Education West Midlands	17	17	100.00%
Health Education Yorkshire and the Humber	24	17	70.83%
London Recruitment	83	83	100.00%
Northern Ireland	10	10	100.00%
Scotland	48	37	77.08%
Wales	20	19	95.00%
Total	374	333	89.04%

National Recruitment – February 2018

Region	Places	Accepted	Fill Rate
Health Education East Midlands	9	9	100.00%
Health Education East of England	4	4	100.00%
Health Education North East	17	12	70.59%
Health Education North West (Mersey)	4	4	100.00%
Health Education North West (North Western)	18	18	100.00%
Health Education South West	14	14	100.00%
Health Education Thames Valley	3	3	100.00%
Health Education Wessex	8	8	100.00%
Health Education West Midlands	18	16	88.89%
Health Education Yorkshire and the Humber	14	11	78.57%
London Recruitment	24	24	100.00%
Northern Ireland	5	2	40.00%
Scotland	10	5	50.00%
Wales	10	9	90.00%
Total	158	139	87.97%

This resulted in the College making the increase in recruitment fill rate a specific priority for the future of the specialty. The College took a programme approach working at national, regional and local levels to establish the reasons and develop plans to improve recruitment. These included:

- regional engagement sessions
- national workforce planning and modelling working alongside the advisory boards
- national meetings with CMOs and workforce leaders
- creation and establishment of an undergraduate framework and medical leads network
- exploration of national recruitment with a single unit of application
- Listening events across the UK.

Workforce planning

Anaesthetists play a critical role across many healthcare settings. The College has stated that anaesthetics is a medically led specialism and therefore no additional surgical lists can take place without increasing anaesthetic workforce capacity.

Anaesthetists are already at the centre of the establishment and delivery of perioperative care through multi-professional teams, supporting the NHS's ambitions of better joined-up and patient centred care. Still more must be done to realise the full potential of anaesthesia as a key player in the delivery of these ambitions.

Workforce Census data from the RCoA has outlined that the workforce is not growing at a suitable rate to support the current and future demands of patients and the nation.

Workforce Context

The State of the nation report published in 2022 reported that:

- demand for healthcare services continues to rise due to factors such as the growing and ageing UK population
- urgent action is required to prevent the looming shortfall of 11,000 anaesthetic staff by 2040, which would prevent 8.25 million operations from taking place per year
- the number of SAS anaesthetists, almost a quarter of the anaesthetic workforce, has barely increased since 2015
- there has been a decline in the number of newly-qualified anaesthetists over recent years (from 569 in 2013 to 373 in 2019, a 34% reduction)
- the 50 plus age group is now 39% of the workforce meaning that this group will be expected to retire in the next 5–10 years
- supply of anaesthetists is constrained by inadequate training places, an aging workforce, and poor retention – driven by issues such as pension taxation
- first steps to address the issue should be increasing anaesthetic training places and pension taxation reform.

The NHS cannot continue to function effectively without an anaesthetic workforce which is healthy, adequately staffed (across all grades and roles), well supported and valued.

Respected, valued, retained

In October 2021 The College published the report Respected, valued, retained – working together to improve retention in anaesthesia, investigating the factors affecting retention in anaesthesia and possible solutions to improve retention at individual, employers and systems level. The report also found that:

- 1 in 4 consultants and 1 in 5 SAS anaesthetists planned to leave the NHS within five years
- around 1/3 of the anaesthetic workforce may be working less than full-time within five years
- around 1/3 of respondents said that COVID-19 made them less inclined to stay working in the NHS
- anaesthetists are at higher risk of fatigue and burnout due to the nature of the role and the pressures of managing patients while still maintaining emergency services and supporting the elective backlog recovery.

Why national? The benefits of running national recruitment

Addressing regional imbalances: national recruitment allows the NHS to strategically distribute posts across various regions, ensuring that areas with shortages of healthcare personnel receive adequate staffing. This helps to address disparities in healthcare access and quality between urban and rural areas. This planning should be done with the short- and the long-term workforce, patient and service need in mind; as well as balancing the capacity to train and the throughput of anaesthetists in a programme. This is a complex process and the College has been advocating for an increase in the national number of anaesthetic training places to increase the number of anaesthetists overall. We also work hard to ensure that all available posts are advertised for each round.

Efficient use of resources: national and centralised recruitment can optimise the allocation of resources from the central office perspective and from across Colleges and faculties. It can ensure multiple IT systems are not used across specialties and allows the greatest amount of flexibility for candidates if they want to apply for multiple specialties in a single round of recruitment.

Improving diversity and increasing opportunities: recruitment in anaesthetics is delivered across the four nations in three units of application:

- England and Wales
- Northern Ireland
- Scotland.

This creates flexibility for how posts can be preferenced by applicants for a given recruitment round. For example, an applicant would be able to preference a training place in the South West (Peninsula and Severn), Wessex and Wales as potential locations to train. Likewise, an applicant in the North of Scotland could also preference East of Scotland and West of Scotland if they wished. This process offers flexibility to appointable applicants willing to relocate for a post or if they have personal ties to more than one region. This ensures that opportunity of diversity in terms of background and regionality can be improved across the UK.

Recruitment is made better if it is face to face?

National recruitment has always been difficult to deliver, particularly for large specialties like anaesthetics. The pandemic meant that online recruitment was the only option open to the UK, and this transition was brutally swift for all concerned, but particularly for applicants to quickly adjust the way in which they approached recruitment. We are still yet to fully appreciate the system-wide disruption this caused, particularly when looked at through the lens of differential attainment in medicine. However, moving online did offer the opportunity to move away from some long-standing difficulties with national recruitment:

- **workload and time constraints:** face-to-face recruitment processes required our medical colleagues to make significant time available to deliver the recruitment process and be at a recruitment venue. This sometimes required assessors and applicants to travel sizeable distances to attend venues incurring cost (accommodation, travel, venue costs and logistics) and impacting the environment. This was particularly burdensome for busy clinicians with limited availability due to their demanding work schedules
- **travel and scheduling issues:** face-to-face recruitment often required candidates to travel to specific locations for interviews, which could be impractical, time-consuming, and costly, especially for those residing far from urban centres or medical institutions. Face-to-face recruitment processes could be prone to delays due to scheduling conflicts across the UK and with external events, no-shows (applicants or assessors for adverse circumstances), or other unforeseen circumstances. This could hinder the hiring process and affect the timely filling of posts.

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