Date 21/10/24

Response from the Association of Anaesthesia Associates to the Consultation on the Draft Anaesthesia Associate Scope of Practice 2024

The Association of Anaesthesia Associates welcomes the opportunity to respond to the consultation on the draft Anaesthesia Associate (AA) Scope of Practice 2024. Over the last 20 years, AAs have become integral members of anaesthesia teams across the UK, offering vital support and enhancing the flexibility and resilience of anaesthesia services. As highly trained professionals delivering anaesthesia under supervision, AAs bring a complementary skill set to the workforce, increasing capacity to meet patient care needs.

Given the current shortage of anaesthesia providers, which is contributing to the delay of an estimated one million surgeries annually—and with projections showing this could rise to 8.25 million by 2040[1]—it is essential to create a blended workforce that aligns professional skills and competencies to patient needs. AAs are a workforce designed to expand capacity and utility, not replace existing roles. The scope of practice should reflect the value and potential of skilled professionals like AAs, rather than restrict their development and contribution to care.

While the draft scope of practice includes several principles that we fully support, there are key areas that require further consideration to ensure the profession's future and uphold the best standards of patients care.

[1] RCoA - The Anaesthesia Workforce: UK state of the nation report, February 2022

Charlton House, 32 High Street, Cullompton, Devon, EX151AE email: info@anaeshtesiateam.com tel: +44 (0) 7952873378

Points of Agreement

- **Supervision:** We support the principle that AAs should be supervised at a 1:1 or 2:1 ratio in clinical settings, ensuring patient safety and upholding the highest standards of care.
- **Accountability:** As regulated professionals[2], AAs are accountable for their actions and are required to work within the boundaries of their competencies, a principle we fully uphold.
- **Phased Approach Based on Experience:** We agree with the proposed phased approach for newly qualified AAs, which includes a 3-6 month preceptorship period before transitioning to a 2:1 working ratio. This structured transition supports the development of AAs as they move from direct to close supervision, allowing supervisors to assess team readiness. Phase 2 also reflects preparedness for AAs to manage patient emergence from anaesthesia under close supervision.

Areas of Concern

Despite contributing to the clinical reference group, we are concerned that AAs and their representatives were excluded from the core writing group responsible for drafting this document. This exclusion has led to an overemphasis on limitations rather than a focus on what AAs can safely and effectively achieve with appropriate support frameworks.

- **Threat to the Viability of the Profession:** The proposed draft threatens the viability of the AA profession by presenting a narrow scope that imposes overly complex and undeliverable stipulations on employers.

[2] AAs are not currently regulated. The GMC will be the regulator of AAs from 13th December 2024.

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- **Creation of a Two-Tier Profession:** The proposed draft risks establishing a two-tier system within the AA profession, creating disparities based on length of service. This contradicts the principles outlined in the NHS Agenda for Change terms and conditions, which promote equality of access to career progression opportunities for all staff.
- **Phased Approach Should Focus on Ability, Not Time:** While we support a phased approach, we believe that progression should be based on individual skills and competencies rather than a fixed timeline. This rigidity risks hindering the development of capable practitioners. It in no way accounts for the already established Medical Associate Professions (MAPs) documents developed by NHSE such as the 'Core Capabilities Framework' (NHSE 2020).
- **Lack of Progression from Phase 2 to Phase 3:** The proposed draft does not offer sufficient opportunities for professional development for AAs. After five years of practice, there are no further skills that can be developed in a clinical setting apart from CVP line insertions. This does not demonstrate a meaningful career pathway or enable AAs to meet the requirements for appraisal and CPD required for statutory regulation.
- **De-skilling of Professionals:** The transitional arrangements outlined in the draft scope of practice risks de-skilling AAs and reducing the availability of essential patient services. By placing undue restrictions on the tasks AAs can perform, the proposed draft actively undermines their ability to contribute effectively to patient care and workforce provision of anaesthesia services.
- **Contradiction of NHS Values:** The draft scope of practice contradicts the NHS Constitution's commitment to maintaining high standards in patient care. By limiting the scope of practice for AAs, it undermines the profession's ability to contribute to sustainable healthcare services. Removing AAs from established

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anaesthetic teams, where they are already fully integrated, would destabilise anaesthetic care provision.

- **Balancing Training with Patient Care:** We fully support the need for anaesthetists in training (AiTs) to gain the clinical exposure required to develop their skills. However, it is essential to remember that patients are not merely training opportunities—they are individuals in need of timely care. While it is crucial for AiTs to access training, this should not come at the expense of delivering care for patients. A well-integrated workforce that includes AAs can strike this balance effectively by increasing flexibility and continuity within teams.

Conclusion

We understand and fully support the need to assure patients, supervisors, and the wider healthcare team of the safety and effectiveness of AAs in clinical practice. We remain committed to working collaboratively with stakeholders to achieve this goal. However, this draft scope of practice falls short in supporting the structured development of AAs as a profession. A scope of practice should focus on training, development and governance, ensuring safe practice while promoting professional growth. Blanket restrictions on development are counterproductive.

It is important to note that no patient safety incidents have been reported in relation to AAs in practice. Concerns that have been raised are largely based on unfamiliarity with the role and misinformation around its utility and purpose. The scope of practice should, therefore, focus on fostering better understanding and trust in AAs, rather than restricting their potential contribution to workforce and patient care.

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In conclusion, the draft scope of practice, as it currently stands, does not reflect the full potential of Anaesthesia Associates to enhance anaesthesia services in the UK. By overly restricting our role, it undermines both patient care and the sustainability of the profession. We believe this scope of practice cannot be implemented in its current state. We call for a more balanced and collaborative approach that supports structured professional development, values the vital role AAs play within healthcare teams, and aligns with the overarching values of the NHS.

We look forward to continuing to work with relevant stakeholders to ensure the safe, effective, and sustainable integration of AAs within anaesthesia teams, while maximising our contribution to patient care.

Sarah Massey

AAA President

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