General Medical Council

21 October 2024

Dr Fiona Donald

Chair of the Anaesthesia Associate Committee

Royal College of Anaesthetists

Sent by email: engage@rcoa.ac.uk

Regent's Place
350 Euston Road
London NW1 3JN

Email: gmc@gmc-uk.org
Telephone: 0161 923 6602

gmc-uk.org

Chair
Professor Dame Carrie MacEwen

Chief Executive and Registrar
Charlie Massey

Dear Fiona

Thank you for sharing the RCoA's draft anaesthesia associate (AA) scope of practice guidance. I'm grateful to have been given an opportunity to comment prior to its publication. We have now reviewed the documents and I have provided our views on various aspects of the guidance below.

We welcome this draft guidance and appreciate the pressures that the College is facing as a result of some strongly held views around how AAs can be safely deployed in anaesthetic departments. We also welcome the commitment by the College to review the guidance on a three-year cycle.

Overall, we think that, with some refinement, the draft guidance could be helpful to AAs, their supervisors and employers, and will also provide a level of reassurance to patients and the public. The document is clear and well-structured, and we hope the final version will prove a useful reference for AAs and the anaesthetic departments that employ them. We also welcome the recognition within the document that an individual professional's scope of practice is likely to increase with experience.

We are also grateful to the College for ensuring that the proposed scope of practice aligns with the AA curriculum, as this was a key concern that we fed back throughout the drafting process.

We do have some concerns about the guidance that I will outline further and that I hope will be helpful for the College to consider when drafting its final version.

Scope of practice

We think that the tables in the guidance setting out the proposed phases of AA scope of practice based on level of experience represent a solid foundation to build on, and we welcome that describing them in this fashion allows for an increase in scope over time. However, we are concerned that the contents of each table represent an insufficiently flexible approach to individual scope that could have the effect of inhibiting professional development for AAs and unnecessarily limit the contribution that suitably trained AAs could make to the NHS workforce. Ultimately, these limits could have consequences for

the viability of the profession, with impacts for employers as well as the very small number of course providers currently operating in the UK, so it is critical that they be clearly based on evidence.

We note that the proposed transitional arrangements for existing AAs with five or more years of clinical experience (set out on page 18, section 3 of the document) in essence make provision for these AAs to continue to operate outside the College's recommended scope, while more recently qualified AAs would be permanently prohibited from practising at this level. While we are supportive of managed local flexibility for experienced AAs, we think this approach risks criticism of perceived unfairness, and it is not clear whether enforcing such an arrangement would put employers at risk of legal challenge. It could also open the College to challenge around the patient safety justification for what is a relatively rigid and restricted scope of practice.

We hope that the College can address this issue prior to releasing the final version of its guidance, ideally by including additional flexibility for all experienced AAs to extend their scope of practice beyond that defined in Phase 3, provided their clinical supervisor is assured that they are trained and competent to do so.

Supervision

Setting out expected levels of supervision in clear terms may be helpful for anaesthetic departments that have not previously employed AAs. However, as with the sections of the guidance dealing with scope of practice, we are concerned that the requirements as drafted could be perceived by some employers as overly restrictive and so we think the guidance could benefit from allowing a degree of discretion for employers to be able to determine appropriate levels of supervision within their own departments.

Ensuring that AAs are appropriately supervised is, of course, vital to ensure patient safety. We would therefore suggest that, where your guidance covers supervision requirements, it reflects our own guidance on supervision, leadership and delegation.

Our updated clinical governance handbook sets out our expectation that organisations who employ AAs should make appropriate arrangements for their deployment and supervision. We have also published a range of guidance explaining our expectations of supervisors and the people they supervise that will apply to AAs once they are regulated by us:

- *Good medical practice*
- *Leadership and management for all doctors*
- *Delegation and referral*

When it comes to good supervision, there isn't a one-size fits all approach. AAs and their named supervisors should agree a level of supervision appropriate to each individual's skill level, experience, role and the nature of the task.

It is particularly important to be clear about these issues when discussing where overall responsibility for a patient's care lies. For example, section 4.2 of your guidance states that 'Overall responsibility for the anaesthesia care of the patient rests with the clinical supervisor.' While this is accurate, without the additional context provided by our guidance on supervision and delegation we worry that such language could reinforce the erroneous narrative we have seen play out in some quarters that supervising doctors will always be held responsible for decisions or mistakes made by those they supervise. As with other professionals that doctors supervise and work alongside in multi-disciplinary teams, doctors are not accountable to us for the decisions and actions of PAs and AAs, provided they have delegated responsibility in line with the standards and guidance set out above.

Matters of employment

In seeking to place requirements on employers, we did wonder whether the guidance might in places go beyond the College's remit. For example, in sections 2.4.3 and 2.5, and section 3D on page 18, the guidance outlines the need to ensure the employment of AAs does not negatively impact on a department's ability to train anaesthetists in training, SAS anaesthetists and locally employed doctors. While ensuring high quality training in anaesthesia is an undeniably important issue and will of course be a priority for the College, we question whether guidance on the scope of practice of a different profession should in any way focus on the impact on doctors' training rather than on how to ensure safe and high-quality care for patients. We would also like to understand why the proposal is to measure the impact of employing AAs on doctors' training when we understand this is not the approach taken for other roles within the multi-disciplinary team. This is particularly pertinent given the number of AAs working in the health service is very small (approximately 190 in total) compared to the number of consultant anaesthetists currently in practice or those in anaesthetic training – approximately 14,000 in total. NHS England's Long Term Workforce Plan seeks to increase AA numbers to a relatively modest total of 2,000 by 2035. It also sets out the ambition to double the number of medical school places and that increase should be reflected in an increase in the number of doctors working and training across all specialties.

Similarly, we would like to understand whether the following sentence in section 2.4.1 refers to anaesthetic departments as institutions or to individual members of the anaesthetic team: 'This assurance should include confirmation that the department of anaesthesia is willing and able to support the training and employment of AAs.' If it is the former, then we question whether this line needs to be in the guidance as it appears somewhat superfluous. If it is the latter, we question the

proportionality of this measure given this is not the approach taken for any other roles in the anaesthetic team.

Non-medical prescribing (NMP)

Finally, page 17 of the guidance states that 'The GMC will clarify their view on AAs who have gained NMP status through other professions (nursing etc) and their ability to use that qualification while working as an AA.' We are currently waiting for clarity from the Department of Health and Social Care and NHS England on the legal position in this regard so would request the guidance be amended to reflect that. Alternatively, the College may wish to seek the views of the Department directly.

Thank you again for the opportunity to comment on this guidance. I hope you find this feedback helpful, and we look forward to seeing the final version before it is published.

Yours sincerely

Charlie Massey