West Suffolk Hospital Anaesthetic Department

21st October 2024

To Whom It May Concern,

I am writing on behalf of the Department of Anaesthesia at West Suffolk Hospital, Bury St Edmunds. As a Trust that has been an early adopter of Anaesthesia Associates, we fully support the need for updating the 2016 AA Scope of Practice as the profession evolves and matures. However, upon reviewing the RCoA's recent draft proposal, we are left disappointed and concerned. The restrictive nature of the proposed scope could negatively impact patient care, service delivery, and the wellbeing of both physician anaesthetists and AAs.

The narrow scope outlined in the proposal seems driven by professional protectionism rather than any evidence of harm. The draft proposal's restrictions appear to stem from anecdotal concerns about patient safety, based on RCoA member surveys. However, these concerns lack robust evidence. The 2014 Cochrane review found no clear evidence differentiating the safety of physician versus non-physician anaesthesia providers, and we are unaware of any more recent data that contradicts this. Our local practice supports these findings, and we strongly encourage the committee to adopt a more evidence-based approach. We strongly urge the College to reconsider and review the scope based on a more balanced and inclusive approach.

Internationally, non-physician anaesthesia providers have been safely and successfully integrated into anaesthetic services. Trusts in the UK that have adopted AAs have similarly experienced success, benefiting patients, services, and staff alike. The opportunity for AAs to contribute to UK practice should not be dismissed, and it is essential to build on the successes of those currently utilising AAs.

Contrary to opinions cited in the draft scope of practice, our Trust has found the experience of working with AAs overwhelmingly positive. Operating under a 2:1 supervision model, AAs are recognised as indispensable team members, contributing significantly to safe and effective patient care while supporting physician anaesthetists.

Furthermore, AAs have enhanced, not reduced, training opportunities for AiTs, contribute to teaching and training, and have active roles in management and QI activities. The proposed changes threaten to undermine these established benefits, creating inefficiencies and hindering the NHS's ability to meet growing demands. It is well acknowledged that the anaesthesia workforce must expand, and this burden

should not rest solely on physician anaesthetists. AAs, like midwives in obstetrics, should be integrated as essential partners in providing safe and effective care.

The restrictive nature of the draft document would limit AAs' practice below their training and experience levels. NAP7 shows that the median experience of practicing AAs is nine years. Before imposing such stringent limitations on a highly trained group of professionals, the College must provide robust, evidence-based justification.

While we acknowledge the differences in knowledge breadth and depth between physician anaesthetists and AAs, the ceiling for AAs' development must be reconsidered, and their skill set re-evaluated. Clear guidance on demonstrating necessary training and progression should be outlined nationally. The current draft does not support career development, offering little real progression and proposing static supervision levels that are neither practical nor conducive to retaining highly trained professionals.

We propose the following revisions to the scope of practice:

On qualification:

- AAs should operate under local supervision with a 2:1 ratio, with immediate clinical assistance available when required.
- AAs should manage ASA 1-2 patients in a range of specialties, excluding paediatrics (under 16) and obstetrics, with the option to complete further competency assessments for specialised modules supported by the RCoA.
- Local supervision for general and neuraxial anaesthesia in the specified case mix.
- AAs should be allowed to practice skills acquired during training at supervision level 1-2a (2:1 model).
- For areas outside the defined scope, 1:1 supervision (level 1) should apply.

Post qualification:

- Continued 2:1 supervision with progression to more complex cases (ASA 3+) based on experience, appraisal, and revalidation.
- Nationally agreed specialty modules should be available for AAs to develop specialist interests or independent practice, aligned with the AiT curriculum and undertaken based on service needs and individual interests.
- National guidance should align with the AiT curriculum, allowing training up to the equivalent level of Stage 1 but at supervision level 2b (e.g., regional anaesthesia).

- Subspecialty packages, in consultation with units, should be offered for cardiothoracic and neuro-anaesthesia, enabling career progression or specialisation.

We recognise the concerns raised by some regarding the scope of AA practice. However, the College must uphold professionalism and protect individuals' right to practice without fear of harassment. Instances of abuse or online harassment based on individuals' roles or beliefs are unacceptable and should be met with a zero-tolerance policy. The College must take a clear stance on this issue and support organisations in identifying and addressing inappropriate behaviour in line with Good Medical Practice.

In conclusion, the limitations outlined in the proposed scope of practice are not justified by the evidence and are impractical for delivering the level of care required by the NHS. The restrictive nature of the draft threatens to marginalise a highly skilled group of professionals, potentially undermining their future role. We strongly urge the RCoA to reconsider these restrictions and adopt a more flexible, evidence-based approach that allows AAs to fully contribute to patient care and service delivery.