Royal College of Anaesthetists consultation on the draft Anaesthesia Associate Scope of Practice 2024

Name of individual / group	
Position (if applicable)	
Date	

Description and role of the AA

Organisation A

- It should be clear that AAs are not doctors from outset and are not independent anaesthetic practitioners.
- It would be more appropriate if they were regulated by the HCPC as under GMC the assumption would be they are medically qualified by public and patients.
- A robust curriculum framework / assessment process needs to be in place post qualification to evidence maintaining capabilities and achieving additional competencies that may allow any other scope of practice.
- Working 2:1 supervision model in theatre list is not safe for patients or practical for list efficiency, and only adds additional burden of responsibility to any supervising consultant/ autonomous practicing anaesthetist.
- Statement that AAs provide safe and valuable patient care is not clearly evidenced. There are limited benefits to patients and wider anaesthetic team within scope of practice and takes more effort and time to navigate and extract what they can do.
- Statement that AAs are not taking place of trainees or consultants we would not agree with.

Organisation B

Organisation B welcomes the RCOA's continued engagement with its members to build consensus on supporting the training and practice of Anaesthesia Associates (AAs). Organisation B acknowledges the need for qualified anaesthetists to provide the necessary training and supervision for this workforce and is committed to collaborating with anaesthetists and employers to achieve this. We agree that the potential impact on the training of anaesthetists must be considered and support the proposals for training impact assessments and related processes to ensure that anaesthetists in training are not disadvantaged. This principle, however, should apply equally to all training health professionals, and Organisation B cannot support prioritising one group's training at the expense of another.

While Organisation B supports the principle of ensuring clarity regarding staff roles and job titles for patients and colleagues, we question whether the proposed approach effectively achieves this goal.

Organisation B is concerned about the principle of the RCOA as a non-statutory body setting out to restrict the practice of any healthcare professional as it is a departure from any existing form of clinical governance in the UK and it is not clear how this would work. It is noted that all three health care regulators in the UK are explicit in describing a scope of practice as not being a list of permissible tasks but is instead defined by a professional's

ability to evidence knowledge, skills and experience to perform a task safely. The GMC has recently re-emphasised this position as it applies to AAs and PAs as well as doctors. It is not clear therefore where an advisory scope of practice will sit within the governance structure which is the responsibility of employers. This will require legal advice.
There is no evidence that a defined list of permissible tasks contributes meaningfully to patient safety which is recognised as highly complex field of interacting systems and is no longer focussed on individual fault. There is a risk that a defined list of tasks could be taken as a list or permissions or expectations of an AA regardless of their training, knowledge or experience. This may be why no such approach is taken with other health care professionals or the regulators.
The principles outlined in the consultation regarding supervision and the progression of skills development are useful and could inform the career development framework for AAs. This structured approach could be one of the most valuable contributions the RCOA could offer in supporting the appropriate development of AAs to meet local service demands.
However, the proposed time-based progression of skills acquisition is inconsistent with modern healthcare curricula, which are competency-based. Practitioners should advance according to their demonstrated learning and abilities, which will vary by individual and location. Imposing arbitrary time frames for progression, as suggested in this document, seems inappropriate.
It is to be welcomed that the document recognises that some existing AAs may have skills out with the proposed scope in this paper and agrees that such individuals be permitted to continue to deliver these roles within appropriate, existing clinical governance structures. This will avoid potential challenge under employment law which prevents an employer from materially changing an employee's role without their input and consent. It does however raise the question why new AAs cannot also be allowed to develop these skills as long as appropriate clinical governance is in place. This would appear to be counter-intuitive and open to challenge.
It is also unclear why the proposals categorically prevent new AAs from performing peripheral blocks, other than Fascia Iliac Blocks (FIBs). No specific safety concerns are outlined, and this restriction seems inconsistent with current practice, where advanced practitioners, podiatrists, and other HCPC-regulated professionals perform peripheral blocks. A clearer explanation of the rationale for excluding AAs from this role, even after appropriate training, would be beneficial. This highlights a broader concern regarding the practicality and sustainability of defining rigid role limitations.
In conclusion, this document could be very helpful in progressing the safe development of AAs as part of the health care workforce in [this region]. Organisation B supports further development of the proposals to adopt a more flexible, competency-based approach to skill acquisition, in line with modern curricula and current clinical and regulatory processes.

Principles guiding capacity to support AAs

- **Organisation A** We recognise need to give clear guidance in draft document and attempt to define scope of practice but we only support 1:1 model of supervision involving clinical anaesthesia and sedation.
- There is concern of negative impact on trainees. Training will be negatively impacted by expansion and prioritisation of training of AAs.

- Some AAs have better access to specialty lists (regional anaesthesia / block rooms even though not in scope of practice) that may be designated as lower risk and undertaken at 2:1 supervision model. However such lists are vital part of anaesthesia curriculum at all stages.
- Consultant Anaesthetists already have supervising responsibilities to anaesthetists in training from CT1- St7 and need to provide 2:1 model of supervision as part of anaesthetic curriculum. They should not be forced to supervise AAs as 1:1 or 2:1 if they choose not.
- Although document indicates AAs can work 24/7 they don't as level of supervision is impossible to achieve. This gives AAs greater day time opportunities than anaesthetist in training who work 48hr/ week average with onerous OOH rotas for much less salary.

Principles underpinning the clinical supervision of AAs

- **Organisation A** The criteria needed to fulfil conditions to facilitate a 2:1 model are appropriate but are impossible to fulfil, implement, police, and adhere to without compromise to patient safety.
- 2:1 supervision model will only add to waiting times, negatively impact theatre efficiency, and poor team work.
- For the clinical supervisor a 2:1 model will only add to stress, burden of responsibility and burn out.
- Each theatre must have an operating department practitioner (ODP) or equivalent for 2:1 model. In [this region] we do have not an ODP as part of the anaesthetic team.. We have trained anaesthetic nurses or theatre nurses who have upskilled to help the anaesthetist. They would not be willing/ or is it appropriate to take on any responsibility as part of 2:1 model
- Provision of Sedation has all the risks of anaesthesia and usually in isolated areas around hospital. We agree 1: 1 model must be maintained for any procedural sedation.
- AAs can have a role working alongside anaesthetic consultant/ autonomous practicing anaesthetist who work long days in theatre with early starts, may work without breaks and anaesthetising increasing high risk, aged, complex patients.

The practice of clinical supervision of AAs

- **Organisation A** Very few consultant anaesthetists / autonomous practicing anaesthetists would be willing to undertake the additional responsibility and work load of a 2:1 model of supervision for AAs as part of job plan and clinical practice.
- Conditions to facilitate 2:1 model are impossible to guarantee and therefore breach patient safety.
- Appropriate trained medical qualified anaesthetist should be employed to undertake work in a separate theatre not AAs.

- Planning from pre-op assessment to ensure patient selection suitable for AAs would require too much additional work with little gain.
- Last minute changes to list would lead to stoppage on both theatre lists as supervisor needs to be involved in preop care leading to further theatre inefficiency.
- Sedation can have more inherent risks than general anaesthesia and 1:1 model should always be in place. Deep sedation should excluded from document.
- AAs are not qualified to undertake paediatric practice. There is no curriculum post qualification to gain paediatric skills therefore it should be excluded from practice even as 1 :1
- Patients should be told if an AA is allocated to anaesthetise them have the right to request a medically qualified anaesthetist.
- Non-direct anaesthetic duties may be possible such as POA but this assumes a level of knowledge equal to that of a medical qualified doctor.

Post-qualification phases of practice

- **Organisation A** There is an assumption in draft document that post qualification progression of capabilities and extended role is proportional to "time-served".

- Document indicates assessment by the clinical lead for AAs to demonstrate progression however there is no post qualification curriculum / framework to map progression too. What assessment tools are utilised, what are the standards?
  There is no framework for annual review of competence.
  Who provides training of assessors/ supervisors?
  Are they required to be a recognised trainer with GMC?

- The progressive to 2:1 supervision (phase 1, 2 and 3) proposed is far beyond what we expect of anaesthetists in training who have to clearly demonstrate summative achievement of defined capabilties and assessment milestones mapped to RCoA training curriculum. This is unrealistic scope of practice.

- In [this region] a small number of PA(A)s were trained in 2000's in one department . The training programme was abandoned after 2 rounds of enrolment with a total of 6 trained. From our experience we do not agree with the statement that after 4 years majority of work would be under a 2:1 model of supervision. Again this is much more than expected of medical qualified anaesthetist in training and is concerning. A 1:1 model has been maintained with our small cohort of PA(A) in [this region] . They have engaged in extended duties in helping with allergy clinic and admin support.

Aspects of anaesthetic practice that are included in the scope of practice and those that are excluded

- **Organisation A** Safe prescribing/ administration of controlled drugs or otherwise remains responsibility of supervisor. A 2:1 model makes it very difficult to maintain responsibility and puts supervisor at risk and liability if any issue.
- We would disagree with any proposal to amend current legislation to allow AAs greater authority for prescribing and administration of anaesthetic and controlled drugs.

Plan for transition to 2024 Scope of Practice for AAs post qualification

Organisation A Transition to the 2024 scope for all phases should be immediate in the interests of patient safety.

Overarching reflections and any other comments

- **Organisation A** The document has given clear criteria and conditions needed to be in place to facilitate progress to a 2: 1 supervision model for clinical anaesthesia which is very appropriate. For the most part these are almost impossible to assure on a daily basis within any anaesthetic service with patient safety being the overarching concern. This will give leverage to any consultant supervisor or autonomously practising anaesthetist to maintain 1:1 model of supervision.

- There is not enough educational governance around post qualification assessment / curriculum and maintenance, progression and acquirement of capabilities other than time-served basis beyond the draft 2023 AA curriculum. There needs to be much greater detail on standards and accreditation of qualifications, and progression of capabilities, as well as ongoing assessments of knowledge and skills.

- The AA role to be safe and within scope, makes it financially unviable (particularly given salary). There is no advantage in expanding the numbers of AA as there is no impact on workforce planning deficits required for the delivery of anaesthetic services 24/7 currently and on projections needed for anaesthetic services in the future.

- A much safer, more flexible, efficient, sustainable solution would be to increase the number of anaesthetic training posts, and subsequently consultant anaesthetic and autonomously practicing anaesthetist positions.
- There are no difficulties in recruitment of medically qualified doctors to anaesthetic training with bottle necks at Ct1 and St4 and at least 3:1 applicant to training post ratio.
- RCoA member consultation overwhelmingly agreed that AAs are detrimental to the delivery of anaesthetic training.