Department of Anaesthesia
University Hospital Hairmyres

19th October 2024

Departmental response to the RCOA draft AA Scope of practice 2024 document.
This response has been agreed to by nineteen of our twenty one anaesthetic consultants.

Overview

University Hospital Hairmyres is a small DGH with orthopaedics, vascular, general, urology and ophthalmology surgical specialties. It has five fully trained AAs ranging from 15 years to less than one year in post. Our AAs rarely if ever work on a 2:1 basis with consultants, so they are always well supervised. We are pleased to report that they are a very dedicated group of individuals, who have become an integral part of the anaesthetic teams and that we have had no safety issues or any significant complaints against them. We also have AiTs of all grades, but do not have enough to cover all out of hours service commitments which don't requiring senior staff. We feel that our AAs have had a positive impact on medical anaesthetic training, allowing AiTs to be freed up for the most valuable training opportunities and this is reflected in our trainee feedback, which is very good.

The royal college states it is responsible for standards within anaesthesia in the UK and this would presumably include professionalism. We are therefore disappointed that the college has not felt it necessary to address the unprofessional behaviours of a small minority of it's members who have conducted a smear campaign against the AA health care workers as a group. The college must be aware that social media is awash with malicious slurs, deliberate misinformation and ugly, threatening language directed towards the AAs and those that speak out in support of AAs. This has had a very negative impact on AA morale and no doubt future recruitment. There are likely probity and bullying issues from some individuals and we are surprised that the college has not warned their members that they are possibly in breach of the GMC's guidance on good medical practice. Unfortunately, this nasty and vocal smear campaign of a small group of anaesthetists, including college members, has been successful in whipping up a hysteria towards AAs and other MAPs. This has influenced this Scope of Practice document by your own admission at the outset of the document. It has also fed into the public arena damaging the AA reputation and our specialty as a whole. It is worth pointing out that there are doctors who are frightened to speak up at meetings or to go on social media in support of AAs, because they know they will almost certainly suffer abuse. There is clearly a major problem when this is the case and the college to their discredit have shown little if any leadership in this regard.

Your document states that the RCOA have had to respond to the views of their members and the survey conducted about AAs and obviously these things cannot be discounted. However, the views of a very vocal minority and a survey do not constitute evidence that AAs cause issues of safety,

have negative impacts on medical training or reduce the quality of service. Our own experience in NHSL is that none of this is the case. Most of the anaesthetists in your survey either hadn't worked in a hospital with AAs or had rarely done so, but this group were still willing to give them the most negative response. We think this demonstrates an ignorance on their behalf, undoubtedly influenced by social media. Those that had actually worked regularly with AAs had a more positive view.

Your survey had a major focus on AiT training, highlighting concerns that they have a negative impact on training, but where is the evidence? On a local level, evidence of negative impact on training would surely be highlighted in trainee feedback, or at ARCPs and we are not aware of this being the case. Similarly training committees finding any evidence of this would take issue with departments. Again we are not aware of this being the case. On a national level it would seem extremely unlikely that the small numbers of AAs, less than 200, throughout the UK could have any significant impact on training.

It is worth pointing out that although training junior doctors is a necessary and important part of what the NHS does, it is not it's main function. NHS Boards and anaesthetic departments, in conjunction with training committees, have to balance training and service commitments. We believe that the college and trainees need to be cognisant of the balance between training and service needs, particularly in the current climate of financial constraint and increased demand.

Much of the negative opinion towards AAs, particularly from trainees, has occurred after NHS England's poorly judged announcement of funding for a large increase in AA numbers. This inevitably created an angry backlash from trainees who are struggling through the competitive training process. Scotland was planning a more cautious expansion, however we are now impacted by the subsequent fallout, including this scope of practice document. The vast majority of Scottish AAs work in DGH hospitals, which do not have sufficient numbers of AiTs to fill the out of hours workload without also negatively impacting daytime AiT training. Unlike England we do not or rarely use AAs to do 2:1 working. We have found that the AAs can improve theatre efficiency and reduce some of the out of hours work for trainees, therefore freeing them up for daytime training opportunities. Interestingly, NHS England was one of the major stakeholders helping to create this scope of practice document, but despite Scotland's different experience of AAs there was disappointingly no Scottish body involvement.

<u>Specifics</u>

We take issue with the draft scope of practice limitations on the nerve blocks within the remit of qualified AAs. While we agree the priority should always be to train AiTs, there are many times when there are no trainees available to take the training opportunity. There are ample opportunities in our department for AAs to be doing blocks. Some AAs are extremely proficient at a particular block and this can and should be used as a resource to train AiTs and even consultants. We consider the reasoning behind the limitations are poorly thought out and don't stand up to scrutiny. The RCOA and the RA-UK have not quoted any evidence that AA practice in regional anaesthesia is unsafe in any way. Competency is what is important for a block procedure, not what title is on a name badge. There are blocks that are inherently safer that a FIB block and competency that is more easily achieved than a spinal. It therefore appears that the RA-UK and the RCOA have set arbitrary limits, which are clearly there to discriminate against AAs. It should be for individual departments to decide what blocks are necessary and determine competency within existing local governance. Competency and safety can be demonstrated by documentation of training, audit of practice and local

governance. We therefore suggest that the limitations on blocks are unnecessary and should be removed or significantly relaxed.

The curriculum for AAs includes training in the use and placement of arterial lines. It is therefore unfathomable that the SoP would not allow them to place arterial lines for phase 1 of practice and then a department would have to demonstrate a need for this in phase 2. We feel this limitation should be taken out of the SoP completely. Similarly, direct supervision for performing spinal anaesthesia even by phase 3 seems to be unnecessary overkill.

The SoP would limit the AAs, so that they could only preoperatively assess patients under direct or close supervision even in phase 3. The AA curriculum has a major emphasis on preoperative assessment and preparation, and they are extensively assessed on it. It is our experience they are very competent and consistently do it diligently, more so than many medical staff. We therefore fail to see why a consultant would need to be within two minutes recall and in the theatre suite for them to undertake this. There is no physical intervention at this point in the patient pathway, so close supervision in the majority of cases makes no sense. We do not use 2:1 working, which may require closer supervision and clearly more complicated patients and those undergoing more major surgery would require more senior input. We think that the limitations on preoperative work should be altered to local or distant supervision depending on the particular circumstances.

In University Hairmyres Hospital, we do not use AAs as overnight cover, however they do work some daytime weekends and some evenings, covering our out of hours emergency theatres on rotas which include trainees, helping to keep their rotas compliant. They are never doing theatre work without consultant supervision, and their presence helps turnover. The SoP states, in section 3.9, that AAs can work out of hours, including overnight, however section 2.1 states that in the NHS England guidance, AAs cannot "be used as replacements for doctors on any on call rota". Without our AAs contributing to out of hours commitments, either AiTs would need to do more out of hours work reducing their Monday-Friday daytime training. The college SoP should clarify what out of hours work is acceptable, eg weekend daytime, or else it can leave this for local boards to decide. If AAs cannot take part in some of the out of hours work this will have a particular impact on the small –medium sized departments, which are not gifted with large trainee numbers. At the same time, it will likely have no impact on the larger hospital departments that have greater numbers of trainees and pointedly also greater representation on national bodies, including the RCOA.

The draft SoP states that with 2a supervision the supervisor must be in the theatre suite rather than just available within two minutes. While we can see that there may be a need to remain in the theatre suite in larger hospitals, our DGH does not require this. The geography of our hospital means that we are easily within two minutes recall from surgical wards or from offices. Each consultant and AA has a dedicated DECT phone for quick communication. If we were to follow the SoP to the letter, then we would not be able to go to a ward to review a patient, significantly limiting our efficiency. We have the same practice for trainees who are often less experienced than our AAs. We are therefore of the view that this should be relaxed to two minutes recall, without the need to stay in the theatre suite, where hospital layout and communications allows.

<u>Career development</u>

There is no doubt that the introduction of this scope of practice in its current iteration will impact negatively on the ability of qualified AAs to progress within the role. The transition aims to reduce the impact on patient services and on anaesthetic departments, but will lead to a backwards move for many AAs, reducing their clinical activity and ability to be involved in many aspects of

anaesthesia which they have safely and competently been involved with for many years. This will directly affect the AA workforce morale and the ability to retain this highly trained staff group.

It is probable that the restrictive transitional arrangements will mean that newer AAs can't progress through the phases nor develop extended roles. This will lead to two tiers of AAs, which has the potential to contravene employment law. The SoP also has not taken into account that AAs are on Agenda for Change contracts, which determine their progression and banding.

The GMC stated at the recent AAA Conference that the SoP will be a guidance document only, and there will be no issues with fitness to practice if qualified AAs continue to work outside of this scope of practice, within local established governance arrangements, if complaints are made with reference to working outside of the scope – this needs to be confirmed to give assurance to AAs and to the departments they work in.

Example of impact the SoP would have on our service: At a weekend an AA is covering the emergency theatre, which includes the emergency vascular service for a large population of Scotland. The anaesthetic consultant has gone home as the emergency list has finished. An ruptured AAA presents to ED and the anaesthetic consultant has been called in. Currently, the AA does a preoperative assessment and helps prepare the patient for theatre (potentially including placement of an arterial line). They help prep theatre and draw up drugs prior to arrival of the consultant. None of this would be acceptable according the draft SoP, as the AA would not do able to do anything until closely supervised after the arrival of the consultant. This is clearly unhelpful and is likely to have a detrimental impact on patient outcomes.

Summary

This scope of practice, if adhered to in its current iteration, would set arbitrary limits on the AA role. It would make the role less attractive, with less hope of career development, therefore leading to issues of recruitment and retention. The evidence that AAs are unsafe, poor value for money or indeed obstructing AiTs training is not there. Many of the limitations this SoP puts on their practice are inconsistent and arbitrary. We think that the college, rather than showing leadership, has jumped on the 'bash the AAs' bandwagon created by a small, vocal group who are determined to end the AA role. We feel that your draft Scope of practice should be significantly revised to reflect the valuable role that AAs undertake in a modern team based approached.

Specific areas we would seek changes:

Phases 1 – Exclusion of insertion of arterial line should be removed.
Phase 1 – Exclusion of spinal anaesthesia should be removed.
Phase 1,2, 3 - Relaxation of the limitations on nerve blocks they can perform.
3.6 & 4.10 Consultants just require to be within a two minute recall, not necessarily in theatre suite.
Phases 1,2,3 -Immediate or close supervision shouldn't be a requirement for preoperative assessment.
Phases 1,2,3 -Immediate or close supervision shouldn't be a requirement for preparation for anaesthesia.
Phase 3 - Immediate supervision shouldn't be required for spinal anaesthesia.