General Medical Council

Anaesthesia associate registration assessment (AARA) content map engagement report

Contents

Introduction

From November 2022 to January 2023, we sought feedback on the draft content map for the new anaesthesia associate registration assessment (AARA). The draft map had been developed with contributions from relevant organisations such as the Royal College of Anaesthetists (RCoA), Association of Anaesthetists (AoA), Association of Anaesthesia Associates (AAA) and Higher Education Institutes (HEIs).

The AARA is the means by which, in future, qualified anaesthesia associates (AAs) will demonstrate their readiness to practice in the UK. It is set at the level of a newly qualified AA and will comprise of:

- an applied knowledge test, set and delivered by the GMC; and
- an assessment of clinical skills undertaken during the course of study using workplace-based assessment (WPBA) and quality-assured by the GMC.

The AARA content map sets out the core knowledge, skills and behaviours needed for UK practice. The knowledge test and clinical skills assessment will derive from the content map and be set at a level reflecting the expectations of a newly qualified AA entering their first role in the NHS. We would expect AAs to develop their skills further after qualification and this document should not be used to limit their development.

We published the PA and AA generic and shared learning outcomes and the revised AA curriculum in September 2022 and this content map for the AARA is the final part of the education framework. Course providers will use the revised AA curriculum that has previously been published and the AARA content map, as a guide when designing their course. This would cover the course and any assessments. We'll check that they've done this appropriately through our quality assurance activities.

Course providers will need to make sure that any students joining from September 2023 follow a course aligned to this new framework. The AARA will be implemented in summer 2025, when the first cohort of students following this framework begin to graduate.

Engagement overview

The respondents were asked to read the content map and then answer questions about whether they thought the content map:

- would ensure patient safety is the first priority
- would help to meet service, patient and workforce needs
- is deliverable
- is clear and easy to use

- includes the right content.

They were also asked for their views on the proposed format of the AARA.

Details of the questions and the statistics are in Annex A.

Key findings

We received a total of 63 direct responses to the questionnaire which included:

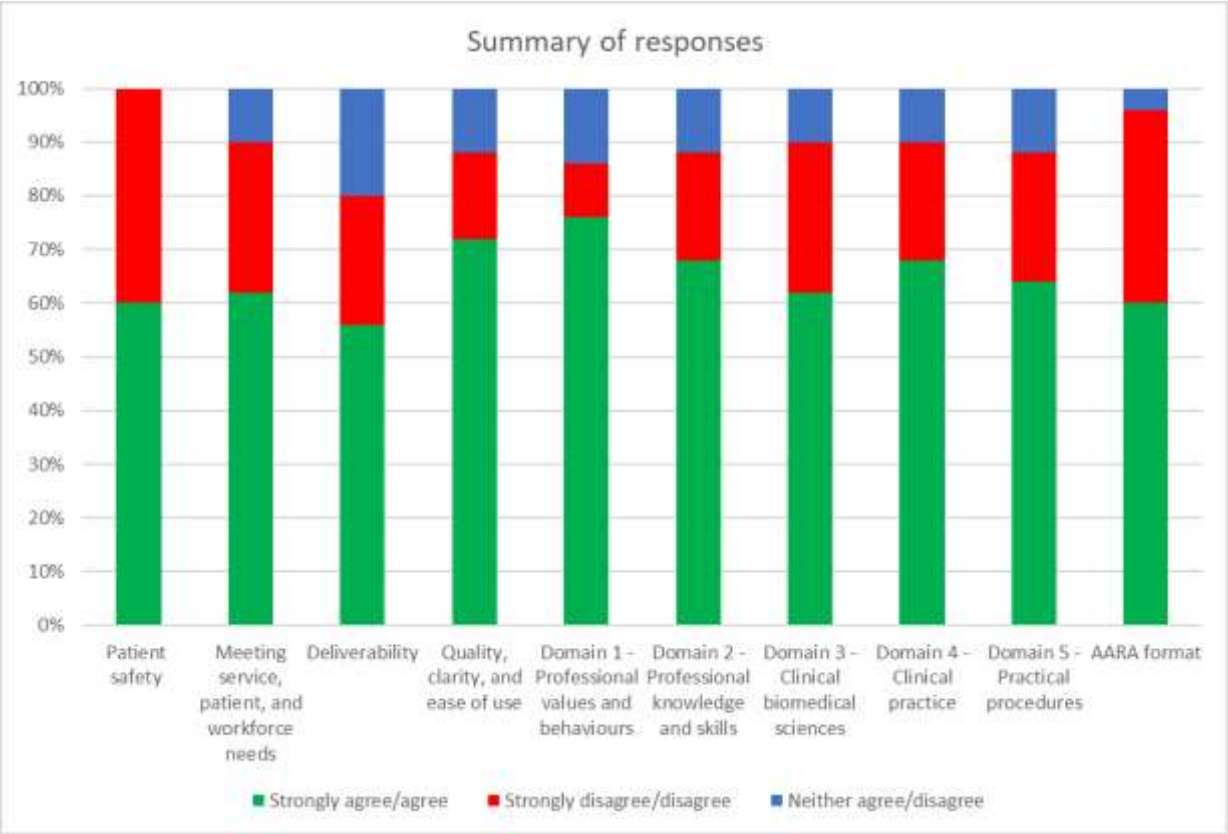
- 11 responses from organisations, including bodies representing AAs, anaesthetists, AA education providers, NHS organisations, arm's length bodies and patients.
- 52 responses from practising AAs, student AAs, doctors, other healthcare professionals and individuals. Of these, 13 individuals used their response to express opposition to the existence of the AA role, rather than engaging with the questions asked about the AARA. Those responses have been noted but are excluded from analysis of the specific questions reported here.

Additionally, there were five organisations who didn't answer the questionnaire directly but did provide a summary of their feedback. Their comments have been noted and considered.

Responses were received from across the UK. Of the 11 organisations, five said they were UK-wide, three from England, and one from each of Scotland, Wales and Northern Ireland.

Of the individuals who responded to this question and engaged with the questionnaire, one indicated they were from the UK, 32 were from England, six were from Scotland and one from Wales. Three respondents identified as having a disability. Gender, where provided in individual responses, was male (23) and female (14). Ethnic origin, where provided in individual responses, was white (29), Asian or Asian British (4), black or black British (1), other ethnic group (1).

For the questions asking whether the content map met the given statement, there was overall support with 56% to 76% of 50 respondents stating they strongly agreed or agreed. The questions that scored lower related to the format of the AARA and how that impacted patient safety. The chart below summarises the responses:



Main themes

We received many comments, which have all been reviewed. They can be summarised into several themes:

- The format of the AARA – there were divergent views about the use of WPBA to assess clinical skills. 60% of respondents agreed or strongly agreed with this proposal, 38% disagreed or strongly disagreed and 4% neither agreed nor disagreed. Those that disagreed generally said that an OSCE would be more appropriate. Some commented that AAs should sit the Fellowship of the Royal College of Anaesthetists exams.
- Knowledge levels – several respondents felt they weren't descriptive enough.
- Level of detail – several respondents felt there was not enough detail in the content map or information about how skills would be assessed.
- Prescribing – AAs cannot prescribe currently and some respondents questioned whether they needed to know about prescribing in much detail. Conversely some respondents queried whether there should be more pharmacology in the content map if AAs are to be able to prescribe in the future.

- Simple peripheral nerve blocks – there were some concerns about whether all student AAs would or should have the opportunity to practise peripheral nerve blocks.
- Practical procedures – some respondents felt some of the procedures in domain 5 should be in different categories, particularly arterial lines.
- Comments about individual capabilities.

How we responded

We compiled all the comments and suggestions from respondents, discussed them with the development group and drafted a new version of the content map with agreed suggested changes included.

Where appropriate, as agreed by the development group, the following changes have been made:

- Knowledge levels – a more detailed description has been drafted.
- Knowledge levels of capabilities – some of these have been amended based on feedback.
- Added pacemakers and implantable cardioverter defibrillators (ICDs) to the other equipment monitoring section of domain 3.
- Changed wording of 'special populations' to 'specific populations' to make the language more inclusive.
- Rephrased some of the capabilities to make them clearer.

Where we haven't made changes, we have responded to the themes raised, explaining our rationale.

WPBA and how skills will be assessed

We have considered these responses but still feel that WPBA is appropriate for this profession. It offers more fidelity over the student AA's action in practice and will not only assess the technical and clinical competence of the student AA but also their interaction with patients and colleagues, allowing their professional behaviours to be assessed. The AA course is akin to an apprenticeship with on-the-job training, providing a workplace-based learning programme. WPBA offers greater authenticity and opportunity for detailed assessment as AAs spend the majority of their time in the workplace, with extensive clinical exposure and access to patients. We believe that assessing their clinical skills in real-time will provide greater authenticity than a simulated OSCE.

In addition to passing the AARA knowledge test and WPBA, student AAs will still need to pass their AA qualification. Assessment arrangements for AA qualifications will be specified by the Higher Education Institute (HEI) within the limits of the new AA curriculum. The curriculum is

clear that the AARA is not a substitute for a course provider's own programme of assessment, which should incorporate formative and summative assessments, enhance learning, and determine the learner's attainment of curriculum outcomes.

The GMC will provide standards and guidance to HEIs and employers on WPBA and will define what needs to be assessed and how. Training will be provided to assessors, together with information about the tools that should be used to make the assessments.

We have set up a working group, consisting of representation from the RCoA, AoA, AAA, the HEIs running AA courses and employers. The working group is developing the WPBA which will be based on Entrustable Professional Activities for AAs (EPA(AA)s) and are similar to those used in the Initial Assessment of Competence for trainee anaesthetists. They have been made specific for AAs, reflecting their scope of practice and supervision levels. There are five EPA(AA)s that a student AA must achieve to pass their WPBA: pre-operative assessment, general anaesthesia, procedural sedation, peripheral regional anaesthesia, spinal anaesthesia. Each EPA(AA) has been defined with key capabilities and limitations. Further information on the WPBAs will be published at a later date.

Knowledge levels

We've reviewed the knowledge levels and provided more detailed descriptions as to what the knowledge levels mean. They have been redefined as:

- **Comprehensive:** A thorough working knowledge of the subject matter, applied in the context of a newly qualified AA, as specified in the RCoA Anaesthesia Associates Curriculum. Able to apply this knowledge across all settings relevant to their role, and able to seek clarification where required. An understanding of the limits of their knowledge, and when to seek advice.
- **Broad:** A rounded understanding of the subject matter in overview. Able to describe the relevant key information and apply it in practice at the level of a newly qualified AA, as specified in the RCoA Anaesthesia Associates Curriculum. An understanding of the limits of their knowledge, and when to seek advice.
- **Basic:** A general awareness, with an understanding of key principles and risks which could impact patient safety. An understanding of the limits of their knowledge, and when to seek advice.

Level of detail

A content map is intended to be high level and sets out the areas that could be tested in the AARA. It concentrates on the professional skills, knowledge and behaviours that are essential for safe practice. We do not feel there needs to be any more detail in the map. However we will

provide more detail about how clinical skills will be assessed when information about WPBAs is published.

Prescribing

AAs cannot currently prescribe. If prescribing is introduced in the future, we will update the content map accordingly. In the meantime, AAs need to understand the principles of prescribing appropriate pain relief or anti-biotics post-surgery and be able to administer drugs safely.

Simple peripheral nerve blocks

Although AAs will not be trained to the level of independent practice, they would have exposure to nerve block procedures. Examples will be provided in the guidance for WPBAs.

Practical procedures

The practical procedures in domain 5 are identical to those listed in the AA curriculum. The AA curriculum has previously been through an engagement process and been finalised and published. We have therefore not made any changes to domain 5 in the AARA content map to ensure these two documents remain aligned.

Out-of-scope comments

There were also some comments that were out of the scope of this engagement:

- The value of the role of the AA.
- Impact on trainee anaesthetists – several respondents felt that there should be more investment in training anaesthetists instead of AAs and that training AAs could impact on the training of doctors.
- Accountability and supervision – there was some concern about who has accountability, the AA or the supervising doctor.
- Background of student AAs and course length – some respondents thought the course should only be available to those with a healthcare background and that two years is not sufficient time to learn the relevant knowledge and skills.

Response to out-of-scope comments

The role of the AA and impact on trainee anaesthetists

It is important to remember that AAs are not anaesthetists and are not expected to perform the same role. They are clinically trained practitioners that work within an anaesthetic team under the direction and supervision of a supervising anaesthetist. Qualified AAs train to care for adult patients in a hospital operating theatre. AA training does not include care of patients in paediatrics or obstetrics, or other highly specialised settings although they may acquire the relevant skills and knowledge to care for these patients following qualifications, through appropriate CPD, development and assessment. They will always work under supervision, even once qualified.

The AA role is now established within many NHS hospitals and the Department of Health and Social Care have already made the decision to introduce statutory regulation. They have said 'Strengthening the future NHS workforce remains one of the government's top priorities. Anaesthesia associates (AAs) and physician associates (PAs) are already a valued and integral part of the multi-disciplinary healthcare team, but they have the potential to make an even greater contribution. Regulating these professions will help to increase the contribution AAs and PAs can make to the United Kingdom's (UK) healthcare, while keeping patients safe.'

Accountability and supervision

AAs are clinically trained healthcare professionals, who work under supervision alongside doctors and provide medical care as an integral part of the multidisciplinary team in community, primary or secondary care. During and beyond qualification in their roles, AAs develop their skills through on-the-job experience under the day-to-day supervision of appropriately qualified and experienced clinicians. Supervising doctors make an important contribution to the AAs that they oversee.

AAs should be supported to develop their roles and responsibilities through appropriate delegation of tasks and responsibilities. When delegating care to an AA, supervising doctors must be satisfied that the person providing care has the appropriate qualifications, knowledge, skills and experience to provide relevant and safe care for the patient. If the care is delegated in line with the principles set out in GMC guidance, then the supervising doctor is not accountable to the GMC for any actions (or omissions) of the AA. However the doctor remains responsible for the overall management of the patient.

There is no one size fits all for supervision and it is important for supervising doctors and AAs to work together to establish the level of supervision appropriate for them. This may vary from task to task, patient to patient and over time. Newer members of the team or more recently qualified AAs will require much more support than experienced individuals.

In order to support doctors in this role, we have put together this advice which is drawn from key principles from our professional guidance; insights from those with experience of acting as supervisors; and wider work undertaken by others.

Background of students and course length

Course lengths and entry requirements are determined by the relevant HEIs. The GMC doesn't prescribe these requirements. Our role will be to approve the AA curriculum and make sure HEIs are delivering this and meeting the outcomes required.

Annex A – about the engagement and questionnaire

Why engage?

We are working to our standards for the design and maintenance of postgraduate medical curricula Excellence by Design (EBD). One of the requirements of EBD is that the developer of the curriculum being presented can demonstrate that they have sought feedback on their curriculum from key stakeholders.

The feedback is not just a requirement of the standards, but also an essential step in developing the product, and towards achieving buy-in for the AARA.

Who did we engage with?

Medical education organisations who have an interest in AA education: the four departments of health, other UK healthcare regulators, the four statutory education bodies, postgraduate training organisations, medical royal colleges, medical schools and AA course providers. Also interested are organisations representing employers, trainers, doctors, AAs, patients, nurses and other healthcare professionals. It was also open to anyone else who saw the survey on the GMC website.

We drew up a list of these organisations with contacts and they are detailed in Annex B.

How did we engage?

- Emailed the contacts in the identified organisations listed above.
- Encouraged recipients to share the link to the survey.
- Targeted generic inboxes at the organisations listed.
- Promoted the survey on the GMC website.
- Asked collaborative partner organisations to promote the survey on their websites.
- Promoted the survey through the MAPs Community of Interest.

The questionnaire

We asked respondents to help make sure that the AARA content map:

- meets our standards
- ensures patient safety is the first priority

- helps to meet service, patient and workforce needs
- is deliverable
- is high quality, clear and easy to use
- embeds fairness
- contains the right content
- is the right format.

The questions in the questionnaire were:

- Patient safety - Upon satisfactory completion of a course that follows this content map, newly qualified AAs will be able to work safely and competently in their defined area of practice and be able to manage or mitigate relevant risks effectively (state to what extent agree or disagree, with comments).
    - 30 (60%) strongly agreed or agreed with the statement. 20 (40%) disagreed or strongly disagreed.
    - Of the 11 responses from organisations, ten agreed or strongly agreed with the statement and one disagreed. Of the 39 responses from individuals, 20 agreed or strongly agreed with the statement and 19 disagreed or strongly disagreed.

- Meeting service, patient, and workforce needs - Overall, this content map will help ensure that the AAs of the future can fulfil service, patient and workforce needs appropriate to their profession (state to what extent agree or disagree, with comments).
    - 31 (62%) strongly agreed or agreed with the statement. 14 (28%) disagreed or strongly disagreed and five (10%) neither agreed nor disagreed.
    - Of the 11 responses from organisations, all of them agreed or strongly agreed with the statement. Of the 39 responses from individuals, 20 agreed or strongly agreed with the statement, 14 disagreed or strongly disagreed and five (10%) neither agreed nor disagreed.

- Deliverability - Course providers will be able to meet all the expectations set out in this content map in a high-quality, two-year training programme (state to what extent agree or disagree, with comments).
    - 28 (56%) strongly agreed or agreed with the statement. 12 (24%) disagreed or strongly disagreed and ten (20%) neither agreed nor disagreed.

- Of the 11 responses from organisations, nine agreed or strongly agreed with the statement and two neither agreed nor disagreed. Of the 39 responses from individuals, 19 agreed or strongly agreed with the statement, 12 disagreed or strongly disagreed and eight neither agreed nor disagreed.

- Quality, clarity, and ease of use (state to what extent agree or disagree, with comments).
  - The AA registration assessment content map is clear, and easy to use
    - 36 (72%) strongly agreed or agreed with the statement. Eight (16%) disagreed or strongly disagreed and six (12%) neither agreed nor disagreed.
    - Of the 11 responses from organisations, all agreed or strongly agreed with the statement. Of the 39 responses from individuals, 25 agreed or strongly agreed with the statement, eight disagreed or strongly disagreed and six neither agreed nor disagreed.
  - It is clear what students need to achieve to satisfy the requirements of the content map.
    - 36 (72%) strongly agreed or agreed with the statement. Ten (28%) disagreed or strongly disagreed and four (8%) neither agreed nor disagreed.
    - Of the 11 responses from organisations, ten agreed or strongly agreed with the statement and one neither agree nor disagreed. Of the 39 responses from individuals, 26 agreed or strongly agreed with the statement, ten disagreed or strongly disagreed and three neither agreed nor disagreed.

- Equality, diversity, and inclusion - We'd like your views on the potential impact of this content map on people who share protected characteristics under the Equality Act 2010 (comments only).
    - All comments received about equality, diversity and inclusion felt there were no issues or any adverse impact on protected characteristics.

- Domain 1: Professional values and behaviours - The high-level learning outcomes, capabilities and required knowledge levels listed in domain 1 are appropriate to the AARA (state to what extent agree or disagree, with comments).
  - 38 (76%) strongly agreed or agreed with the statement. Five (10%) disagreed or strongly disagreed and seven (14%) neither agreed nor disagreed.

- Of the 11 responses from organisations, all agreed or strongly agreed with the statement. Of the 39 responses from individuals, 27 agreed or strongly agreed with the statement, five disagreed or strongly disagreed and seven neither agreed nor disagreed.

- Domain 2: Professional knowledge and skills - The high-level learning outcomes, capabilities and required knowledge levels listed in domain 2 are appropriate to the AARA (state to what extent agree or disagree, with comments).
  - 34 (68%) strongly agreed or agreed with the statement. Ten (20%) disagreed or strongly disagreed and six (12%) neither agreed nor disagreed.
  - Of the 11 responses from organisations, ten agreed or strongly agreed with the statement and one neither agreed nor disagreed. Of the 39 responses from individuals, 24 agreed or strongly agreed with the statement, ten disagreed or strongly disagreed and five neither agreed nor disagreed.

- Domain 3: Clinical biomedical sciences - In domain 3, the four areas of clinical biomedical sciences listed and their capabilities and required knowledge levels are appropriate to the AARA (state to what extent agree or disagree, with comments).
  - 31 (62%) strongly agreed or agreed with the statement. 14 (28%) disagreed or strongly disagreed and five (10%) neither agreed nor disagreed.
  - Of the 11 responses from organisations, nine agreed or strongly agreed with the statement, one disagreed and one neither agreed nor disagreed. Of the 39 responses from individuals, 22 agreed or strongly agreed with the statement, 13 disagreed or strongly disagreed and four neither agreed nor disagreed.

- Domain 4: Clinical practice - In domain 4, the areas of clinical practice listed and their capabilities and required knowledge levels are appropriate to the AARA (state to what extent agree or disagree, with comments).
  - 34 (68%) strongly agreed or agreed with the statement. 11 (22%) disagreed or strongly disagreed and five (10%) neither agreed nor disagreed.
  - Of the 11 responses from organisations, all agreed or strongly agreed with the statement. Of the 39 responses from individuals, 23 agreed or strongly agreed with the statement, 11 disagreed or strongly disagreed and five neither agreed nor disagreed.

- Domain 5: Practical procedures - The practical procedures and level of knowledge listed in domain 5 are all appropriate to the AARA (state to what extent agree or disagree, with comments).
    - 32 (64%) strongly agreed or agreed with the statement. 12 (24%) disagreed or strongly disagreed and six (12%) neither agreed nor disagreed.
    - Of the 11 responses from organisations, ten agreed or strongly agreed with the statement and one neither agreed nor disagreed. Of the 39 responses from individuals, 22 agreed or strongly agreed with the statement, 12 disagreed or strongly disagreed and five neither agreed nor disagreed.

- AARA format - The stakeholder working group propose that the AARA should consist of an applied knowledge test and workplace-based assessment (state to what extent agree or disagree, with comments).
    - 30 (60%) strongly agreed or agreed with the statement. 18 (36%) disagreed or strongly disagreed and two (4%) neither agreed nor disagreed.
    - Of the 11 responses from organisations, ten agreed or strongly agreed with the statement and one disagreed. Of the 39 responses from individuals, 20 agreed or strongly agreed with the statement, 17 disagreed or strongly disagreed and two neither agreed nor disagreed.

- Other feedback (comments only).

Annex B – Contact list for engagement

General Medical Council

Primary representative group	Secondary representative group	Representing (organisation)	Country	Source of contact and action
Employers	Other individual employers		UK-wide	We emailed a survey link to those who had registered with our Community of Interest and indicated they fell into one of these categories
Trainers/educators	Individual trainers	None	UK-wide	
Doctors	Individual doctors	None	UK-wide	
Doctors	Individual students	None	UK-wide	
AAs	Individual AAs	None	UK-wide	
AAs	Individual student AAs	None	UK-wide	
SEBs	English SEB	HEE	England	We emailed a survey link to all members of the GMC MAPs external advisory group
SEBs	Welsh SEB	HEIW	Wales	
SEBs	Scottish SEB	NES	Scotland	
Departments of health	English government	England	England	
Departments of health	Welsh government	Wales	Wales	
Departments of health	Northern Irish government	Northern Ireland	Northern Ireland	
Departments of health	Scottish government	Scotland	Scotland	
Employers	Collective employers	NHS employers	England	
Doctors	Collective doctors	BMA	UK-wide	
AAs	Collective AAs	AAA	UK-wide	
Patients	Various patient groups		UK-wide	We identified a specific individual and emailed them directly asking them to respond to the survey and to share it with relevant colleagues and other contacts
Royal colleges	College representing AAs	RCOA	UK-wide	
Royal colleges	Collective colleges	AoMRC	UK-wide	
Anaesthetists	Collective anaesthetists	AoA/AA	UK-wide	
Regional training administrations	HEE regional offices	Each individual regional office	UK-wide	
Healthcare regulators	Nurses	NMC	UK-wide	
Healthcare regulators	Allied healthcare professionals	HCPC	UK-wide	
Course providers	Individual course providers	Each individual course provider	UK-wide	We emailed a survey link to representatives from UoB, UCL and Lancaster Medical School
AAs	Collective student AAs		UK-wide	UoB and UCL sent a survey link to their students