Royal College of Anaesthetists

Planning the introduction and training for Anaesthesia Associates

Considerations for your Anaesthetic Department

AfPP PROGRESSING SAFER SURGERY
The Association for Perioperative Practice

AAA
Association of Anaesthesia Associates

CODP
College of Operating Department Practitioners

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FOREWORD

This guidance is designed to assist NHS trusts and health boards that are considering introducing and training anaesthesia associates. It may also be useful to departments that already employ anaesthesia associates and wish to review their existing processes.

Our aim is to provide a practical, step-by-step guide to all stages of the process, from initial stakeholder consultation and assessment of training capacity to delivery and evaluation of training. Underpinning all these considerations is a focus on patients' needs and patient safety.

The guidance replaces the 2016 edition, *Planning the introduction and training for physician's assistants (anaesthesia)*. This updated guide better reflects the current requirements of the anaesthesia associate role, patients' needs, and the factors departments should consider before introducing the role to the anaesthetic team. We are mindful of the forthcoming regulation of anaesthesia associates and will update the guidance when regulation is implemented in 2024 as well as in response to other relevant developments.

In developing this guidance, we have sought to address the questions most asked by trusts/health boards, anaesthetic departments and the wider anaesthetic community. The information is structured in three sections, planning, preparation and implementation, with a useful summary of key recommendations for each. It also includes frequently asked questions, a description of the anaesthesia associate role upon qualification, template job description and a guide to the principles of undertaking a training capacity assessment within your anaesthetic department.

We are grateful to colleagues and other stakeholders whose advice and insight has been invaluable in helping us update the guidance. Our consultation has included clinical leaders, training networks, and anaesthetists of all grades including those in training, anaesthesia associates and patient representatives. The guidance is supported by the RCoA and the Board of the Association of Anaesthesia Associates. We thank everyone who has contributed their time and expertise. We hope you find this guidance helpful.

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INTRODUCTION

The Royal College of Anaesthetists (RCoA) has developed this document to provide guidance for departments who are considering the introduction of anaesthesia associates (AAs) into their anaesthetic teams. In addition, it is intended that this guidance will be used as a resource for those departments that have already commenced the training and employment of AAs. This is a live document which will be subject to updates as required, including upon regulation of AAs and as the AA role develops. This guidance replaces the 2016 document *Planning the introduction and training for physicians' assistants (anaesthesia)* which was a revision of the Department of Health publication: *A toolkit to support the planning and introduction of training for Anaesthesia Practitioners*.[1]

The anaesthetic workforce is under considerable strain.[2,3,4] The RCoA's *Medical Workforce Census 2020*[5] revealed a shortfall of 1,400 anaesthetists, which is estimated to prevent over one million operations and procedures from taking place per year. Due to factors such as an ageing and growing population, and increasing demand for surgery, the shortfall is expected to grow to 11,000 by 2040.

While AAs may be able to help fill some of the anaesthetic workforce gap, there is also a need to expand the numbers of consultant and SAS anaesthetists by increasing the number of anaesthetists in training (AiT) places. This will provide anaesthetic teams with the full breadth of experience and expertise to deal with the cases that they face. Any expansion of the AA workforce must be in addition to, not instead of, expansion in anaesthetic doctors. The RCoA has advocated, and will continue to push, for more funding for AiT places.

Since the inception of the anaesthesia practitioner programme in 2002, the AA (previously referred to as physicians' assistants (anaesthesia) – PA[A]s) profession has inevitably undergone some developmental changes. In 2019 it was announced that the General Medical Council (GMC) would act as the regulatory body for AAs, and with that comes specific professional requirements and standards to which the profession must adhere and comply.

This document aims to help individual departments of anaesthesia determine how AAs might usefully augment their anaesthetic services, and provide an understanding of the considerations and steps required before introducing AAs.

The guidance is structured around three stages:

- **PLANNING**. How to determine the need for the role, obtain support and secure the funding. How to ensure appropriate local stakeholder involvement.
- **PREPARATION**. How to commission a training programme from a higher education institute (HEI). How to recruit student AAs or check the registration status of qualified AAs. How to establish local clinical governance arrangements.
- **IMPLEMENTATION**. How to deliver AA training within your department. How to safely develop the scope of AA practice and supervision, supporting the student AA and ensuring safe practice.

Formal registration of AAs is vital and we continue to work actively with the GMC to facilitate this. It is expected that statutory regulation for AAs will commence in the second half of 2024. As with all employees within an NHS hospital, clinical governance remains the responsibility of the employing hospital, which is vicariously liable for their practice.

Although there is an overlap of activities undertaken with other healthcare practitioners such as nurses, physician associates and operating department practitioners (ODPs), the delivery of anaesthesia to patients should be undertaken only by those who have undertaken a formal anaesthetic training programme. This means physician anaesthetists (including AiTs, locally employed doctors, SAS doctors and consultants) and AAs. Where anaesthesia is delivered by an AA, they will work under the supervision of a consultant or other autonomously practising anaesthetist.

While the introduction of AAs may seem complex, this document systematically details each of the

stages, providing the core information and guidance required. Examples of experience gained from existing sites with AAs are included in the appendices and are intended to facilitate the introduction of this role.

KEY RECOMMENDATIONS

Planning

- **Discuss**
  - Establish a core group to provide training and ongoing support for AAs.
- **Assess training capacity**
  - Undertake a training capacity assessment (planning should progress only when training capacity has been agreed).
- **Gather evidence**
  - Prepare a draft paper outlining the potential local risks and benefits.
- **Engage with stakeholders**
  - Establish monthly meetings for key stakeholders with terms of reference.
- **Develop a business case**
  - Consider who, or which committee, needs to approve the development of the business case during the initial proposal, developing case and final case.
- **Develop an action plan**
  - Generate an action plan to introduce training for student AAs with agreed timescales and responsibilities.

Preparation

- **Source funding**
  - Funding must be sourced at the beginning of the process. Use the national resources and funding offerings available.
- **Recruitment**
  - Identify a local human resources (HR) policy to highlight the appropriate sources of recruitment.
- **Clinical governance arrangements**
  - AAs should be managed and governed by the anaesthetic department. Hold early discussions to seek advice on the expectations for your organisation.

Implementation

- **Training student AAs**
  - Student AA's training must be based on the AA curriculum. Any serious variation puts at risk the national transferability of the qualification.
- **Obtain feedback**
  - Set up robust arrangements for obtaining feedback during the first year of the training programme and conduct a formal review process of the training of AAs.

1 PLANNING

Determine the need for the role, obtain support and secure the funding

1.1 Key supporting information
1.2 Initial discussion
1.3 Gathering evidence
1.4 Wider discussion of the proposal with key stakeholders
1.5 Organisational development planning for operating theatres
1.6 Business case
1.7 Outcome agreement of the business case

For the introduction of AAs into your hospital to be successful, it is important for all those involved to be clear about the reasons behind the initiative, what is required of them and what support will be available.

Successful training requires a firm commitment from the existing anaesthetic department to provide consistent high-class teaching over the entire duration of the AA training course and beyond, into service delivery as postgraduate practitioners.

1.1 Key supporting information

Anaesthesia associate curriculum

In 2022, the RCoA published the draft AA curriculum:

- AA curriculum[6]

At the time of writing, the three higher education institutions (HEIs) offering the AA course, with either a postgraduate diploma or an MSc, are the University of Birmingham, University College London and Lancaster University Medical School. Other HEIs may be prepared to set up or reinstate courses should demand increase. Information as to the teaching and educational facilities required can be obtained from the appropriate course administrator. Before accessing the course, some students will be required to develop their knowledge and skills via university modules or the Accreditation of Prior Learning process (APEL/APL) to prepare them for entry.

Further details about the AA courses and eligibility requirements are available on the individual HEI websites:

- University of Birmingham[7]
- University College London[8]
- Lancaster University Medical School[9]

Key websites

Information and publications relating to the AA role can be found on the RCoA website.[10]

Other useful websites are:

- Association of Anaesthesia Associates[11]
- Association of Anaesthetists[12]
- Association for Perioperative Practice[13]
- British Anaesthetic & Recovery Nurses Association[14]
- College of Operating Department Practitioners[15]
- Department of Health & Social Care[16]
- General Medical Council[17]
- NHS England (formerly Health Education England)[18]
- NHS Employers[19]
- Patient Voices at Royal College of Anaesthetists[20]

1.2 Initial discussion

Initial discussions on the introduction of AAs should focus on patients' needs, patient safety and the capacity of these practitioners to help the organisation deliver its service in the future. Potential concerns and queries from colleagues should be addressed from the start of the process.

The following are possible topics for consideration during initial discussions:

- What are the service and organisational workforce needs for anaesthesia?
- How is the current service affected by recent or planned policy changes?
- Can the performance targets be met with the current workforce?
- Can the current level of service to patients be maintained and improved where appropriate?
- Can the appropriate level of training be maintained for AiTs?
- What options are available to deliver the service in the future?

Before starting this process, ensure that anyone involved in the discussions is using the same definition of AAs and their role on qualification, and that this is based on national criteria (see Appendix E).

The following questions need to be asked:

- How can AAs be integrated in the workplace?
- What is the initial job plan for AAs to assist in the delivery of anaesthesia services?
- Will the theatre layout allow for the appropriate levels of supervision?
- What will be the impact on the wider anaesthetic team?
- What are the benefits and challenges of introducing this role?
- What changes are required to realise these benefits and how to address any challenges?
- What workforce changes would be needed if AAs are not introduced into your department and are these achievable?

KEY RECOMMENDATIONS

Before proceeding, ensure that there is a core group within the anaesthetic department to provide training and provide ongoing support for AAs. Clinical directors and college tutors should be involved in, and support, discussions to introduce student AAs.

It is important that these questions are resolved to ensure alignment as the business case progresses. For more information please see the Frequently Asked Questions in Appendix A.

Anaesthetists in training

Since the introduction of the AA role in 2004, there have been consistent questions about how the training and presence of AAs will affect AiTs. There have been several papers that specifically look at this, the first being the Association of Anaesthetists' report on the role in 2011.[21] A second paper describes a qualitative investigation into the demographics and scope of practice of AAs in the UK in 2017, and the experience of working together as an anaesthetic team.[22] More recently, in 2023, a survey was conducted of UK AiTs on their experiences and perceptions of working with AAs.[23]

It is important to recognise that student AAs, unlike novice anaesthetists, will need immediate supervision throughout their training. We suggest that clinical directors planning the introduction of AAs within a department should understand that level 1a–1b supervision (supervisor presence in theatre) will be required throughout their training period.

We recognise that this extra requirement for 1:1 training may impact consultants already providing level

1 supervision to CT1 and ACCS (Acute Care Common Stem) anaesthetics trainees. In addition, some departments may have separate arrangements to train other healthcare workers in anaesthetic skills such as anaesthetists on return-to-work programmes, ACCPs (advanced critical care practitioners) and medical students. It is therefore crucial that a **training capacity assessment** is carried out to ensure that there is capacity to take on AAs and that there will be no deleterious effects on anaesthetists in training (AiTs). This will show whether there is sufficient capacity to provide the required levels of supervision and access to appropriate clinical cases to meet curricular training requirements for AiTs and student AAs.

The underlying principles for undertaking a training capacity assessment can be found Appendix F. This will be a locally defined process requiring identification of regular, spare training list capacity with appropriate 1:1 supervision, above and beyond that allocated to anaesthetists in training. The business case should clearly provide assurances that last-minute movements of AiTs will be held to the minimum. The training capacity assessment should be carried out by the college tutor, clinical director and consultant lead for AAs alongside both the RCoA regional advisor (anaesthesia) and head of school for the relevant region, to ensure the introduction of AAs will not affect curricular training opportunities for AiTs. Organisations employing AAs should directly inform the regional advisor and head of school of the number of AA posts agreed and keep them updated as to the progress once appointed. AA course providers will require confirmation that student AAs can be adequately trained. Consultants training AAs will need to understand the training curriculum and capability assessments to meet the requirements of the GMC to undertake this training. The training itself will require the same recognition in job planning as that required for an educational supervisor role for AiTs.

Other areas of good practice that have been identified include:

- AAs being aware of their role in supporting AiT education
- AAs being flexible in accommodating their rota to meet AiTs' needs as required
- AAs in established extended/expanded roles facilitating training opportunities for AiTs
- AAs being involved in the induction of new AiTs to a department where the AAs' experience and continuity can help familiarise new trainees with the department.

Factors attributed to fostering good professional relationships and successful integration of the AA role include:

- having more than one AA employed/training in a department
- having a designated consultant lead responsible for AAs
- AAs being managed and governed by the anaesthetic department
- AAs being included in the department's audit, teaching programmes and social activities.

To minimise any potential issues for possible rota clashes/opportunities with AiTs, further recommendations include:

- regular contact between the clinical lead for AAs and college tutors to identify the potential for increased training opportunities and investigate any areas of concern that could arise for either group
- regular contact between the clinical lead for AAs and staff responsible for rota allocation to minimise any potential rota clashes and maximise experience potential for both groups
- dynamic monitoring of AA rota allocation by either the clinical lead for AAs or a lead AA, to ensure that continuity of service and adequate levels of supervision are maintained
- where expansion/extension/service development of the role is proposed, part of this development should investigate how the application could be a resource of teaching and training for the department in the future.

In 2023, NHSE published a commissioned study by the Yorkshire and Humber Academic Health Science Network (YHAHSN)[24] into the impact of the two associate professions, namely the AAs and physician associates. Their findings were, overall, positive regarding patients and service provision, with a positive impact on the training of healthcare staff including AiTs. However, feedback from some AiTs indicated that they worried that recruitment of AAs would have a negative impact to

training and future job opportunities. Given the increase in the number of student AAs and the increase in anaesthetic training numbers announced in 2023, it is clear that continuous monitoring of the training needs of all learners is necessary within a department.

KEY RECOMMENDATIONS

A training capacity assessment should be carried out by the college tutor, clinical director and consultant lead for AAs, alongside the RCoA regional advisor and head of school. Planning should only progress when training capacity has been agreed by all parties.

1.3 Gathering evidence

Evidence of current workforce challenges should be gathered and mapped to show the impact of the AA role on maintaining and improving services. This may require additional reconfiguration of services to make best use of the role, taking into account existing trained and non-trained staff and their requirements, training capacity, the complexity of the patients requiring anaesthetic services, acuity, site distribution of the service and the access to high dependency unit (HDU)/intensive therapy unit (ITU) facilities. Effective scoping and planning are essential in this initial process and may be different in each hospital.

Flexibility: enabling increased flexibility and continuity to anaesthesia teams

The scope and complexity of anaesthesia are such that anaesthetists are integral to the delivery of high-quality care across the whole of the perioperative pathway. With an aging population and higher levels of sickness requiring more complex treatments, the pressure on all grades across the specialty has become more intense and demanding. As highlighted in the RCoA's *The Anaesthetic Workforce: UK State of the Nation Report 2022*[4] there is an anticipated shortfall of anaesthetic consultants and SAS doctors coupled with an ageing workforce that is unsustainable in the long term. The AA role has the potential to increase the flexibility of physician anaesthetists, and provide an element of continuity within the department to support all grades of medical staff within anaesthesia.

The introduction of AAs can add to the overall anaesthetic team mix, giving consultant anaesthetists greater scope for delegation. This can lead to increased availability of consultant presence across a greater scope of clinical and administrative areas. In turn, this allows them to work flexibly and reactively to ongoing challenges presented to the team.

With appropriate supervision, trained AAs can support other members of the anaesthesia team for service (consultant) or teaching (trainees) and allow for more senior anaesthetists to participate routinely in out-of-theatre activities usually attended by AiTs.

This development has the potential to improve both the staff experience and patient care. Despite the AA workforce remaining small in recent years (currently the role accounts for around 1.5% of the anaesthesia workforce), some qualitative research and case studies have highlighted local initiatives where the role has shown positive examples of service improvement and benefit for both staff and patients.[22,24,25,26]

Examples of these improvements have included:

- shorter patient waiting times for a medical anaesthetic opinion in pre-admission clinics
- improved flow in theatres with increased flexibility in rotas and fewer cancellations
- enabling staggered admissions for patients on the same day of surgery
- improved efficiency in theatre utilisation, with increased turnover of patients and less 'downtime'
- faster resolution of problems in patients' postoperative pain
- more immediate response by senior medical staff for attendance to 'outreach' patients
- less waiting time for out-of-theatre procedures such as vascular access and sedation for minor procedures
- multiple theatre working with 2:1 supervision of AAs which can release more senior anaesthetic staff for service provision
- development of new services, for example, regional anaesthesia, sedation and vascular access
- potential for greater opportunities for senior clinicians to provide tuition to AiTs
- continuity for induction of new members of staff to the anaesthetic department
- improved wellbeing in the anaesthetic team due to the addition of team members, where workforce shortages are a contributory factor to stress and burnout.[27]

Increasing capacity in teams

Supervision of two AAs during the maintenance phases of anaesthesia can allow the supervising anaesthetist to oversee two theatres. The efficiency of this team will depend on the length of the cases and

the number of theatres being run by a team. Clinical audits from units employing AAs have demonstrated that theatre efficiency can be improved using this model.

Facilitating service reorganisation

Service reorganisation is a key aspect of the current health service agenda. Workforce planning can be notoriously problematic in anaesthetic departments. Some departments may find that the introduction of AAs is a viable way to maintain or enhance services.

Enhanced clinical teaching

Employing AAs may enhance AiT training because they can free up AiTs from repetitive service theatre lists. This gives them more opportunity for consultant-led training. Furthermore, the trained AA can be added in a rota to lists to prioritise the greatest teaching opportunities for AiTs. AAs have the potential to ensure that AiTs' teaching and curriculum requirements are met.

Supervision and the role of the AA on qualification

The role of the AA on qualification, based on the competencies and capabilities that they have achieved during their training, is included as Appendix E. AAs must work within an established anaesthetic team with a named supervising anaesthetist who should remain in the theatre complex at all times. The supervising anaesthetist may be an autonomously practising anaesthetist as defined in the *Guidelines for the Provision of Anaesthesia Services (GPAS)*,[28] such as a consultant or SAS doctor. Clinical supervision of student AAs (excluding those who are returning to work after a period off) may be a role for AiTs in stage 3 of the CCT in the anaesthetics training programme, should they wish; however, this should not be mandatory and they should not feel pressured to do so. This would still require consultant supervision within the 2:1 model of practice.

Integrating a new practitioner into a team takes time. It is understood that, in many hospitals, AAs with further experience and training have extended their practice beyond the level on qualification; however, as there is no national approval process of extended practice, it is especially important that the clinical governance of such arrangements be carefully addressed at a local level. The RCoA will develop and publish a comprehensive and clearly defined scope of practice beyond qualification for AAs, seeking input from a wide range of stakeholders.

AAs can enable flexible working and continuity within a team but cannot be employed to substitute for vacant medical posts. AAs should have an agreed job plan, which may include activities across the perioperative patient pathway such as anaesthetic assessment clinics.

NHSE has appointed one AA ambassador to each region in England. These ambassadors are experienced AAs who can be a valuable source of advice to departments. Currently, no equivalent role exists within the three devolved nations. Further information can be found in Appendix D.

KEY RECOMMENDATIONS

Prepare a draft paper outlining the potential impact of introducing the AA role and circulate it to all stakeholders for comment.

1.4 Wider discussion of the proposal with key stakeholders

After approval within the anaesthetic department, a draft paper outlining the AA role should be circulated to all stakeholders for comment. The document should confirm that:

- there is wide engagement of the theatre team
- the rationale for the proposal is sound
- all the options are described
- there is engagement of stakeholders outside the immediate theatre environment.

All staff who will either be working directly with or have potential to interact with AAs should be consulted where appropriate.

Detailed discussions should be held with key stakeholders within theatres and the executive team of the hospital or healthcare organisation. Staff in the workforce/deanery should also be made aware of the proposal. Suggested key stakeholders include:

- the anaesthetist clinical lead
- the local expert in anaesthesia education
- lead AA/consultant lead for AAs
- the clinical/medical director – for clinical leadership
- the director of medical education
- college tutor and AiT representative(s)
- the theatre manager/director of operations – to understand theatre staffing and rostering
- the director of finance – to consider financial backing and future investment planning
- the director of human resources – for understanding current HR policies
- the education and learning manager – for training and education expertise
- patient representatives – for the patient perspective and public transparency
- staff representatives – to consider the impact on staff
- the clinical governance/risk management lead – to ensure patient safety through the development of protocols for the role
- the head of school – for oversight of training across the region.

A small working party should be established to consider the issues around establishing training for the AA role. An important consideration is the effect that training AAs may have on overall training requirements and capacity within the anaesthetic department. This will require administrative/project management support, strategic planning and local governance.

A clinical lead for AAs should be formally identified with the expectation that working with student AAs will have an educational component. Some organisations have found appointing a qualified, lead AA useful, to assist with the teaching, and provide support to student AAs and their integration into a department.

KEY RECOMMENDATIONS

Establish monthly meetings to progress the training, with terms of reference for key stakeholders.

Links should also be made with AA ambassadors and local healthcare organisations that may have experience in training AAs (see Appendix B for the AA register and Appendix D for further information about AA ambassadors).

1.5 Organisational development planning for operating theatres

Traditionally, anaesthesia staffing in theatres follows the model below with doubling up for training or due to complex cases.

THEATRE 1	THEATRE 2	THEATRE 3
Consultant/SAS + ODP or anaesthetic nurse	Consultant/SAS + AiT + ODP or anaesthetic nurse	AiT with distant supervision + ODP or anaesthetic nurse

When assessing the need for AAs, consider how they will function in the team once they are qualified at the end of their course. An AA can give greater flexibility to the ways that staff can be employed within theatres, and the models below provide some examples of the different set-ups that can be used when working with AAs. These models are examples of how a qualified AA can work, not a student AA. Student AAs are required to train under a 1:1 supervision model with the consultant or other autonomously practising anaesthetist.

Model 1 Using the AA to improve theatre output and efficiency

THEATRE 1
Consultant/SAS **AA** + ODP/anaesthetic nurse

The AA can provide additional support to the consultant, as required, throughout complex procedures or in emergency situations. This includes supporting the consultant in setting up complex cases or support for same-day and staggered admissions. In this way, theatre throughput can be increased by consultants and AAs working together to minimise downtime between cases. The AA may provide additional skilled supervision in the recovery room for specific patients. There must be a dedicated trained assistant, that is, an ODP or equivalent, in every theatre in which anaesthesia care is being delivered.

Model 2 Employing the AA to improve theatre teaching

THEATRE 1
Consultant/SAS + AiT **AA** + ODP or anaesthetic nurse

Employing the AA can allow the consultant time to undertake competency-based teaching (for example, blocks and epidurals) while maintaining continuity of patient care.

Model 3 Using the AA to support long and complex surgical cases

THEATRE 1

Consultant/SAS

AA

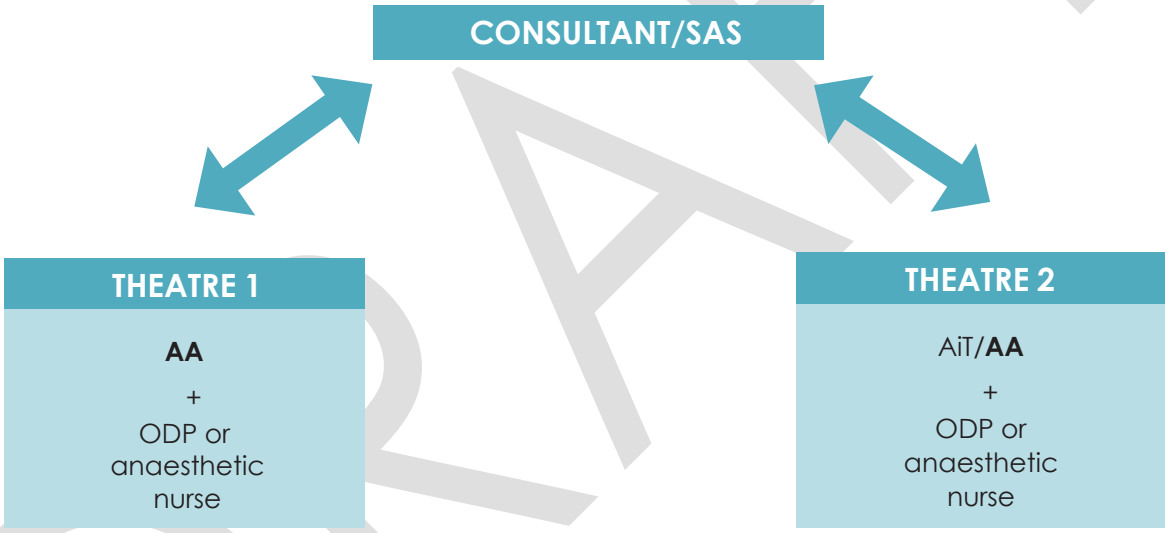
+

ODP or anaesthetic nurse

AAs can provide support to the lone anaesthetist undertaking long cases and, where appropriate, allow for rest breaks.[29] This is in line with *Flexible working: Raising the standards for the NHS*,[30] *NHS People Plan 2020/21*[2] and compulsory rest breaks within the *Working Time Regulations*.[31]

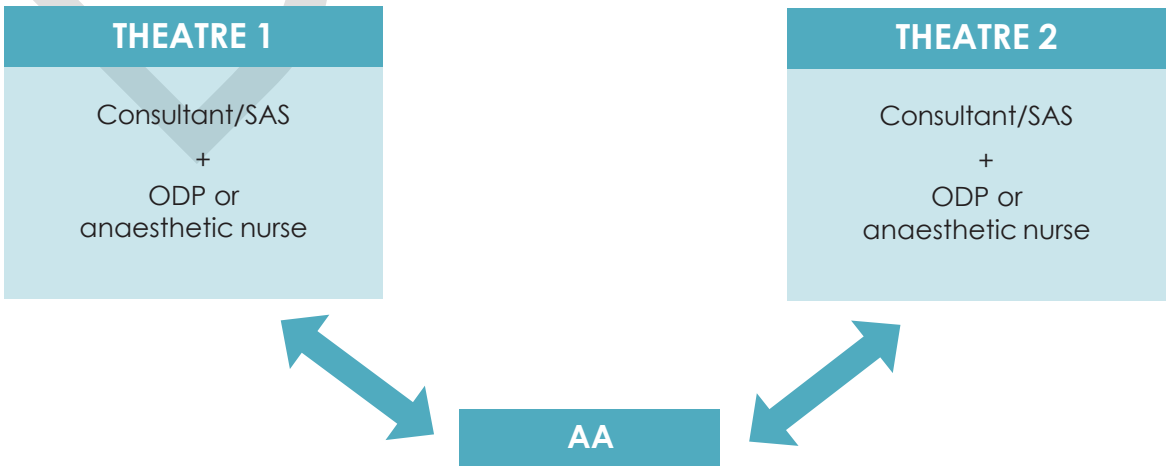
Model 4 One consultant to two theatres, working with AAs

Where adjacent theatres are available, the following models of care delivery could be used to allow a two-theatre working model.



Consultant supervision can be provided to two AAs. The model could also be run with an AA and an AiT, to ensure that the AiT receives the most appropriate training.

Model 5 Flexible AA support for two-theatre working



AAs can work in non-theatre roles under the supervision of a consultant in a team activity.

Changing the pattern of work in theatres will inevitably affect roles other than those of the AAs and there are complex issues in operating two systems in a single organisation. Each employer will need to define the roles of each member of the anaesthesia team to achieve the most effective and efficient system for their theatres.

Levels of supervision

Qualified AAs work under consultant supervision* at levels 1b and 2a when providing general anaesthesia. Student AAs must always be supervised at level 1a or 1b. These levels of supervision are specific to AAs and differ from the supervision levels in the 2021 anaesthetics curriculum, because the AA training and supervision requirements differ from those of an AiT.

1a	**Supervisor present in theatre throughout and required to assist case with proactive involvement**
1b	**Supervisor present in theatre throughout and available to assist reactively when needed**
2a	**Supervisor in theatre suite, available to guide aspects of activity through monitoring at regular intervals**

***Supervision of AAs may be undertaken by autonomously practising anaesthetists as defined in GPAS, such as a consultant or SAS doctor.*[28]

1.6 Business case

A robust and well-presented business case will be required, supported by key individuals at the right time. Therefore, before presenting the business case to any decision-making forum, hospitals and organisations should consider who needs to approve its development during the following stages:

Initial proposal
Developing case
Final case

Examples of a business case can be found here:

- NHSE[32]
- Association of AAs website[33]

When developing the business case, consider the following key points:

- how the AA role serves a specified local need, that is, whether it is patient and/or service driven
- its impact on improving service to patients in line with local priorities
- its relationship with national plans and targets such as the Delivery plan for tackling the COVID-19 backlog of elective care,[34] 18-week patient pathway from GP referral to treatment[35] and *Working Time Regulations*[31]
- the strength of local clinical support
- timeliness regarding availability of national financial support for student AAs and any approval process
- the cost-effectiveness of training AAs
- the cost benefits for the role such as reduced expenditure on theatre waiting list initiatives
- quality standards and expectations to which the role will adhere:
    - training standards
    - selection criteria
- the need to backfill vacancies created if experienced staff are appointed internally into an AA role.

Outlined below are some additional topics that should be discussed within the business case.

Options appraisal

Undertake an options appraisal of other workforce solutions as an alternative to introducing the AA role, followed by identification of the preferred option. Each option needs to be explored locally to assess its appropriateness, for example:

- increasing international recruitment
- extending the roles of current healthcare staff
- reconfiguration of both the elective and the out-of-hours services.

Sources of funding

Ongoing funding must be secured from the start of the project. The key driver when constructing a request for funding is a clear investment appraisal that identifies the cost–benefits of training AAs based on robust planning. Training AAs is a relatively long-term investment, typically taking three years from planning to delivery.

Consideration should be given to the long-term cost–benefits of introducing the AA role.

There are currently funding offers from NHSE and Health Education and Improvement Wales (HEIW). For more details on the funding available see section 2.1 and Appendix D.

Risk analysis

Within the business case, it is important to identify the risks and challenges associated with introducing the role and how each of the risks will be mitigated. Suggested areas to consider are shown in the table below:

Risk	Management of risk
Failure of AAs to provide high-quality anaesthetic care	National training programme agreed by the RCoA, HEIs and the GMC should be adhered to. When regulation commences, before registration AAs will need to pass the Anaesthesia Associate Registration Assessment (AARA).[36] Appropriate supervision and clinical governance systems should be implemented
Failure of front-line teams to accept the integration of the AA role within the anaesthesia team	Involvement of all key stakeholders within the local team should mitigate this risk. Clear, consistent and open two-way communication should be in place at all stages of the introduction of the AA role, and other medical associate roles, e.g. surgical care practitioners
Failure to manage the departments' training requirements and capacity, resulting in an impact on current training opportunities	A training capacity assessment should be undertaken alongside strategic planning, with local governance put in place to ensure that there is sufficient training capacity for AiTs if AAs are introduced
Failure to secure national professional registration and regulation, resulting in ambiguous career prospects and recruitment difficulties	The AA role is due to become regulated with the GMC in the second half of 2024. Until then local clinical governance arrangements will need to be addressed. Awareness of the Core Capabilities Framework for Medical Associate Professions[37] is advised
Variability of competence, due to employment of overseas, non-medically qualified practitioners with differing backgrounds, training and experience	Currently there are no processes available for overseas candidates, who should be referred to an HEI providing the course. Once the AARA is in place, the GMC will open a process for overseas practitioners in anaesthesia to apply to work as AAs. The process for registering overseas practitioners is in development, but it is expected that practitioners would need to provide evidence of an acceptable qualification and then pass the AARA
Withdrawal of funding	The role should be included as part of long-term staffing requirements for the department and incorporated within strategic workforce plans. Funding offers in England and Wales are provided to increase the number of AAs; further information can be found in section 2.1 and Appendix D
Unclear expectations of the role, resulting in role confusion and risks in delineating scope of practice	The remit of the role should be discussed and defined with all parties involved in the employment and training of AAs, including medical staff, non-medical staff, HR and finance
Failure to realise the benefits, due to poor organisational development and failure to reconfigure theatre work, and the role of medical and other staff	A clear organisational development strategy should be put in place for theatres that encompasses the role. Details will need to be locally agreed with all key stakeholders

KEY RECOMMENDATIONS

Consider who, or which committee, needs to approve the development of the business case during the initial proposal, developing case and final case.

1.7 Outcome agreement of the business case

Local guidance will be available that will outline the due process of agreement and submission of business cases. The business case process should be in line with the business planning cycle of the organisation. It should normally be submitted no later than one financial year before the funding is needed, to allow it to be included in financial plans and forecasts.

KEY RECOMMENDATIONS

Generate an action plan for introducing the training for AAs within your hospital(s), with clearly agreed timescales and responsibilities.

2 PREPARATION

Identifying an education partner, recruiting the student AA and establishing clinical governance arrangements.

2.1 Cost breakdown for healthcare and educational organisations
2.2 Contact with a higher education institution
2.3 Recruitment
2.4 Generation of contracts
2.5 Clinical governance arrangements

2.1 Cost breakdown for healthcare and educational organisations

Funding

Currently, NHSE has a national funding offer in England, a 2-year funding plan established to enable delivery of the plan for tackling the Covid-19 backlog of elective care.[38] Funding is demand-led, informed through regional engagement, and currently capped at 120 students per year. The offer includes a contribution to salary cost for student AAs, and a contribution towards the cost of tuition fees and educational supervision in the workplace.[18]

Details about the funding model and how to access it can be found here:

- NHSE National funding model guidance[39]
- NHSE expressions of interest for funding guidance[40]

In 2022/23, 101 AA student places were funded across England.

HEIW is also providing a funding offer, which will include a contribution towards tuition fees of student AAs in Wales.

Further information, key contacts, guidance and resources about the AA funding and development in England, Wales and Scotland can be found in Appendix D.

Within a healthcare setting, anticipated costs for trusts training AAs include the following.

Breakdown of costs

Ongoing costs for organisations during training

- Salary for the student AA:
    - biomedical or life science graduates may expect to be retained on a bursary
- 0.25 programmed activities per week for consultant anaesthetists' time spent in teaching and administration
- It is essential to appoint a consultant clinical lead to oversee administration of training rotas and to ensure that teaching is delivered (1–2 hours per week)
- Teaching outside the operating theatres can be expected to take approximately two hours per week. Subject to local agreement, some of this time may come from existing supporting programmed activities
- Administrative support for the purposes of accounting for leave and sickness.

One-off costs

- Recruitment costs (initial)
- Training and education costs
- Course fees.

Costs for student/practitioner

- AA Registration Assessment
- Registration fee
- Travel costs and consumables.

Advice about contracting arrangements can be found at:

- Agenda for change - pay rates[41]
- NHS health careers – Anaesthesia associate[42]

2.2 Contact with a higher education institute

The University of Birmingham, University College London and Lancaster University Medical School provide an appropriate course for the training of AAs as a distance, blended learning programme. The educational fees of the courses are established and can be factored into a business case. They are also factored into NHSE's funding offer.

2.3 Recruitment

Student AA posts can be advertised as secondment opportunities for existing staff, external recruitment or a combination of both. The organisation will need to work within its current local recruitment policies.

There are two main routes of entry to the AA training programme, as follows (it is recommended to refer directly to the individual HEI for their specific entry requirements as they may vary).

New entrants to healthcare (graduates or graduate equivalent)

- A biomedical or life science background, preferably with a second-class honours degree or higher, or other evidence of recent and successful academic activity
- A demonstrable commitment to a career in healthcare.

Registered healthcare professionals (for example, nurses or ODPs)

- Three years' full-time, post-qualification work experience in a relevant area and evidence of recent (within three years) successful academic activity.

All applications will be individually assessed. The NHS hospital should be involved in the selection and interview process, and the selection panel should include both clinical and managerial staff. Potential student AAs must also be accepted by the HEI offering the appropriate course as being eligible to take the Postgraduate Diploma/MSc. The recruitment timeline will need to align with the requirements and course start dates of the individual HEI.

Where there are workforce shortages within certain geographical locations, a combined recruitment strategy covering both current healthcare professionals and new entrants to healthcare may need to be actively pursued.

Example job descriptions for newly qualified and student AAs, and the Knowledge and Skills Framework outline are available in Appendix C.

Additional information on the guidance relating to the employment of student AAs is contained within Annex 21 of the NHS Terms and Conditions Handbook[43] covering the application of arrangements for pay and banding of trainees.

KEY RECOMMENDATIONS

Identification of local HR policy in relation to recruitment will help highlight the most appropriate sources of recruitment.

2.4 Generation of contracts

Training clinicians is always a partnership and all sides will benefit from being clear about their responsibilities. There are several parties involved in the necessary agreements and/or contracts and each of these will need clear lines of responsibility and accountability in the following areas.

Student AA

- Employment during the training programme
- Implications of failure on the training programme
- Implications of unprofessional behaviour on the training programme
- Expectation at the end of the training programme.

NHS/service supervision and education

- Time/remuneration
- Standards
- Honorary agreements with HEI.

Higher education institution

- Educational delivery requirements
- Reporting data
- Quality assurance/standards
- Cost.

NHS hospital

- Clinical governance requirements
- Supervision
- Resources/clinical experience
- Reporting data to appropriate bodies.

These agreements are interdependent for success and should be seen as a whole. However, in practice, contracting between the HEI and the hospital will generally be handled by the hospital's own education and training department. The HEI will appoint a key trainer in the hospital to act on its behalf to ensure delivery of its educational content and will inspect the hospital on a regular basis to ensure that standards are maintained. (See section 1.1 for further information on the HEIs providing the AA training programme.)

2.5 Clinical governance arrangements

It is important that, when roles new to a hospital such as the AA are proposed, the organisation and the public have confidence that their introduction has been accompanied by a full consideration of clinical governance. Each organisation is expected to have robust systems in place to ensure sound clinical governance arrangements. These should cover both the qualified AA and the student AA and should clearly define their scope of practice.

Examples of clinical governance documents:

- Policy for role of the AA[44]
- Association of AAs website[33]

Qualified AAs should have a robust annual appraisal in place. It is anticipated that this will also be central to the AA revalidation process once GMC regulation is in place.

The GMC has published an updated version of *Good medical practice,* effective from January 2024. This applies to all doctors, and will apply to physician associates and AAs when they become regulated, providing a framework for decision-making and describing the professional values and behaviours expected:

- for qualified AAs: *Good medical practice 2024*[45]
- for student AAs: *Achieving good medical practice: interim standards for physician associate and anaesthesia associate students*[46]

The proposal for the training role and the qualified role should be taken through local clinical governance procedures. Local mechanisms, such as regular meetings between AAs and their clinical leads, must be established whereby the following aspects of the AAs clinical work are regularly reviewed:

- the scope of the role and its boundaries
- interaction with other roles
- compliance with the organisation's policies and procedures
- patient and public understanding and expectations of the role
- monitoring and evaluation of the role while it is being introduced
- the training programme, its standards and its external validation
- the preparation and induction of student AAs before they have contact with patients
- supervision of student AAs during training
- prescribing, supply and administration of medicines.

Patient consent

The protocols for obtaining patient consent for treatment by AAs are no different to those for any other healthcare professional. AAs must make their role clear to patients and be prepared to answer questions pertaining to their training, experience and supervision.

KEY RECOMMENDATIONS

AAs should be managed and governed by the anaesthetic department. Early discussions should be held with the organisation's chair of the clinical governance committee or equivalent to seek advice on local expectations.

Ensure availability of patient information leaflets.

3 IMPLEMENTATION

Delivering the programme, supporting the student AA and ensuring safe practice.

3.1 Induction
3.2 Delivering education and training
3.3 Summative assessments
3.4 Post-qualification clinical practice
3.5 Regulation
3.6 Prescribing and administration

3.1 Induction

Student AAs need to be orientated to their changing role and their training programme. Broadly, the orientation is in three areas.

1. The organisation

All student AAs need to be fully conversant with the organisation's policies and procedures and have the relevant statutory or other mandatory training, for example:

- health and safety
- manual handling
- cardiac pulmonary resuscitation (CPR)
- corporate induction
- full HR procedures, including verification of all documentation.

They should be fully inducted into the expectations of the organisation regarding their behaviour, the reporting of incidents, their personal health and safety, and what they can expect the organisation to provide for them, for example, occupational health and support.

2. The training programme and the HEI

All student AAs should have the opportunity to understand and discuss their training programme, including their placements/clinical experience, the supervision they can expect, the academic component, the competences and capabilities, and the standards expected for successful completion.

Student AAs will be registered students of a university and should have a formal university induction which will outline all aspects of university work and expectations regarding their course and the requirements of academic submissions.

3. The work to be undertaken by the student AA

As well as the organisational induction, the student AA should be inducted specifically into the anaesthesia department and the operating department. This should include all the operating procedures/protocols for each and any specific expectations in terms of reporting untoward incidents.

The boundaries and limitations of the role should be clearly covered and reference should be made to the AA curriculum.[6]

Particular attention should be paid to expectations regarding working as part of a team and under supervision and in what circumstances student AAs should request additional support.

The induction package should be tailored to the needs of the individual and should reflect the individual's prior experience.

The first week of the education and learning programme should involve introduction to HEI staff and the clinical team, and a one-to-one meeting with their identified clinical mentor. Information about, and access to, all educational and academic facilities should also be provided.

3.2 Delivering education and training

After the preparation of the course in line with the AA Curriculum,[6] the delivery of the education programme for the first cohort provides a vital learning experience for the programme tutors, supervisors, mentors and student AAs.

The programme is predetermined, but this should not be seen as a block to improvements and can be shown to increase its effectiveness and those delivering the programme should take every opportunity to record its effectiveness and refine it as appropriate.

During the initial stages of the programme, close attention should be paid to the core standards, for example, supervision and attendance, because inappropriate standards or behaviour in either student AAs or others can become increasingly difficult to correct as the programme progresses.

Student AAs and staff support

During the initial stages of the programme, an open-door policy should operate for students, with access to both an identified clinical mentor and university staff. These students will be training to form part of a new workforce within your organisation and will be introducing significant change to working practice within theatres. Managing the clinical and academic environment and offering high levels of support will mitigate some of the initial difficulties that may be faced.

Equally, it is important to recognise the support needs of the staff supervising the student AAs. It is anticipated that many of the staff delivering the education and training will be highly experienced in their specialty, but they may need guidance in dealing with the level of training for AAs and the style of the course. It is useful to hold regular meetings of supervisors and mentors to discuss problems within the programme and, if necessary, with individual student AAs.

Formative assessment

Formative assessment of student AAs' progress should be built into the end of each module and cover:

- feedback on practical competence acquisition
- review of progress, ensuring that hours and experience, and variety of clinical cases, meet the course-specified standards
- promotion of student self-assessment and reflective practice.

Monitoring progress

The introduction of the AA role will require clear systems of monitoring to consider the impact of the new member of staff both during training and after qualification. Key areas for monitoring should be around:

- patient safety
- professional conduct
- patient and staff feedback
- impact on theatre flow.

It is anticipated that this will be achieved within the normal audit processes of the anaesthetic department. Where there is variation in data when compared against baseline information, clear mechanisms for analysis, review and management of the situation should be available.

Evaluation and review of training

Organisations should have a robust system for obtaining feedback from student AAs and a continuing evaluation of progress from supervising staff, theatre staff, HEIs and other stakeholders. The review of feedback should include both the healthcare organisation and the HEI. Engagement from clinical staff is required, and active feedback and engagement will provide a smoother path for the second part of the course. A written brief of progress should be provided for local hospital stakeholders at key points in the programme; this will also continue to highlight the role within the hospital and ensure continued

alignment and value to the anaesthetic team. These briefings should then be fed into management team meetings.

KEY RECOMMENDATIONS

Setting up robust arrangements for obtaining feedback during the first year of the training programme will identify any problems and rectify them. It is recommended that a formal review of the training of AAs and the wider impact on the department be conducted after 12 months, this should include feedback from AiTs.

3.3 Summative assessments

Regular assessment is a necessary part of training and education. It provides evidence and assurance of a level of competence achieved and enables progression through a training programme. Assessment has varied purposes and the combination of formative (section 3.2) and summative processes ensures that all aspects of student AA development are addressed. Guidance will be available from the HEI partner concerning expectations of the student AAs and the responsibilities of the tutor. The programme will have systematic plans to support student AAs who are in difficulty and the resources of the validating HEI will be available. However, it is important that assessment schedules remain intact.

Examples of summative assessments within the AA training programme include:

- review of competencies (knowledge and understanding, skill and application) leading to block and module sign-off (across all blocks and modules to date)
- professional behaviour and attitudes – assessment by multisource feedback recommended
- multiple choice question paper
- maintaining progress in a logbook
- Objective Structured Clinical Examination (OSCE).

Satisfactory completion of the programme and the assessment process will lead to the award of a Postgraduate Diploma or MSc at the discretion of the awarding HEI.

The structure of the AA training programme may vary depending on the course provider; refer to the individual HEIs (see section 1.1) for their course timings and structures.

3.4 Post-qualification and clinical practice

The AA curriculum[6] prepares the student AAs to meet the levels of practice in clinical anaesthesia and professional practice that will be required of them on qualification. These levels are clearly defined in the curriculum. Once GMC regulation is in place, qualified AAs will need to apply to the GMC for registration and complete the AA Registration Assessment (AARA)[36] before being included on the register.

Qualified AAs and their supervisors are directed to *Good medical practice*,[45] which will apply to AAs when regulation commences.

Currently, more experienced AAs undertake practice beyond the level attained at qualification. The governance, liability and accountability of this rests with the employing trust and is determined by local practices. Once regulated (expected in the second half of 2024), AAs will be subject to a system of revalidation and annual appraisal similar to doctors. This will be defined by the GMC and will likely include multisource feedback.[47]

We recommend qualified AAs achieve a minimum of 50 hours of accredited continuing professional development (CPD) per year. This should be reviewed within an appraisal process and should include lessons learned and further developments required to develop a personal development plan. This appraisal process should also include feedback from colleagues, supervising anaesthetists, other members of the multi-professional team and, importantly, patients.

Guidance to the development of AAs post-qualification is available in the *Core Capabilities Framework for Medical Associate Professions* published by NHSE and Skills for Health in 2022.[37]

Within different hospitals, there will be an overlap of activities undertaken with other healthcare practitioners such as nurses, physician associates and ODPs. However, the delivery of anaesthesia to patients should be administered only by those who have undertaken a formal anaesthetic training programme, such as AiTs, SAS doctors, consultant anaesthetists and AAs. Where delivered by an AA they will require the supervision of a consultant or other autonomously practising anaesthetist.

3.5 Regulation

Although it is not a requirement that everyone working in healthcare is regulated, it is normal practice that, where a body of specific knowledge and skill defines a new professional group, then that group works towards regulation. AAs currently have no statutory regulatory body; however, the Department of Health and Social Care (DHSC) and the GMC have announced that statutory regulation by the GMC for AAs is expected to commence in the second half of 2024. AAs may hold NMC (Nursing and Midwifery Council) or HCPC (Health and Care Professions Council) registration (for example, as a nurse or ODP), although this may not cover the totality of their practice as an AA. Every individual is accountable for their own practice and the limitations of their registration with their statutory regulatory body.

In the absence of statutory regulation, the RCoA holds a voluntary register. Further information about the voluntary register can be found in Appendix B. It is recommended that all student AAs and qualified AAs register their details with the RCoA and that hospitals should not employ AAs who are not registered with the RCoA. When statutory regulation of AAs commences, the register will sit with the GMC. It will become compulsory for all qualified AAs to register with the GMC in order to practise.[48] Before registration, all newly qualified AAs will need to pass the Anaesthesia Associate Registration Assessment (AARA),[36] which will comprise of a knowledge test and a formal assessment of clinical skills using workplace-based assessments (WPBA), that require sign off from the supervisor. The AARA is applicable to student AAs beginning on a training programme from September 2023 onwards. Further information will be available on the GMC's website.[48]

The RCoA will develop and publish a comprehensive and clearly defined scope of practice beyond qualification for AAs. Until then, local clinical governance mechanisms should be informed of the role's scope of practice and status, and appropriate steps should be taken within the organisation to establish the validity of the qualifications and competences of these practitioners. For more information see section 2.5.

When the role is established within an organisation, it is possible that overseas practitioners in anaesthesia may apply to work as AAs. Once the AARA is in place, the GMC will open a process for overseas practitioners in anaesthesia to apply to work as AAs. The process for registering overseas practitioners is currently in development; however, it is expected that practitioners would need to provide evidence of an acceptable qualification and then pass the AARA. Pending the implementation of formal arrangements, organisations should refer to the RCoA or HEIs providing the course for advice on overseas practitioners.

3.6 Prescribing and administration

Within the operating theatre, any administration of drugs by AAs is regarded as being on the order of the supervising anaesthetist.* AAs can administer medicines but are not able to act as independent or supplementary prescribers. A robust mechanism for regulating this arrangement should be devised locally. Many hospitals have adopted a route of generating patient-specific directions as evidence of prescription by the supervising anaesthetist. A good explanation of this can be found in the Department of Health publication *Good Practice in Clinical Perfusion Science*.[49]

The following is an example of an authorisation document for administration of intraoperative medication by AAs:

- Authorisation of intraoperative medication for administration by AAs to adults[50]

It has been possible to have an effective and safe AA working practice without the need for prescribing rights. Non-medical prescribing (NMP) cannot be established until statutory regulation has been completed because it is subject to separate legislation that can pertain only to professions that are statutorily regulated. The ability to remotely countersign prescriptions should be considered when introducing electronic prescribing. There is a current application to move the profession towards NMP post-statutory regulation with the GMC.

Please note that the supervising anaesthetist remains responsible and accountable for all medicines administered by the AAs.

**Supervising anaesthetist applies to autonomously practising anaesthetists as defined in GPAS, including consultant or SAS doctor.*[28]

Appendix A: Frequently asked questions

What is an anaesthesia associate?

AAs are members of the anaesthetic team, trained in both the underlying scientific and medical knowledge pertinent to anaesthesia, and in the skills of administering anaesthesia. They work within the anaesthetic team under a named, supervising anaesthetist.* The AA role has been evaluated through the *Agenda for Change*[41] and has been placed at an average of Band 7 for newly qualified AAs. This may increase to a higher band with increased experience and advanced capabilities.

What is the potential of this role?

The RCoA's *Medical Workforce Census 2020*[5] revealed a shortfall of 1,400 anaesthetists which is estimated to prevent one million operations and procedures from taking place per year. This gap is expected to grow to 11,000 by 2040.

Although there is also a need to increase the numbers of consultant and SAS anaesthetists, AAs can help to fill some of this gap by adding to the workforce, not replacing doctors. The AA role has the potential to increase the flexibility of medical anaesthetists and support them to deliver services, complementing the work of the anaesthetic team and helping to deliver the work necessary to reduce the backlog.

What will AAs do?

The emphasis will be on working as part of a team in partnership with colleagues and under the supervision of a physician, autonomously practising anaesthetist. On qualification, AAs perform duties entrusted to them by their anaesthetist supervisor. These include pre- and postoperative patient assessment and care, conducting the induction of and emergence from anaesthesia, and maintenance of anaesthesia under appropriate supervision, deputising for anaesthetists in a variety of situations where their airway and venous cannulation skills are required and assisting in patient care as determined by their supervising anaesthetist.

The qualified AA will be an additional member of the anaesthesia team. They may undertake the induction of general anaesthesia under the direct supervision of a consultant* and will make clinical decisions themselves under indirect supervision while established anaesthesia is maintained. This level of supervision is based on their position as a member of a clinical anaesthetic team which at all times is led by a medically qualified anaesthetist at the recommended levels of supervision for AAs (see section 1.5 for further information). This role, with its continual 'consultative' relationship, is a different way of working for consultant anaesthetists. The medically qualified, supervising anaesthetist is responsible for entrusting responsibility to the AA; however, the AA is ultimately responsible for their own actions.

Although it is acknowledged that there is an inevitable overlap of skills and competences with both medical and non-medical roles, the delivery of anaesthesia to patients should be administered only by those who have undertaken a formal anaesthetic training programme; this includes consultant anaesthetists, AiTs, SAS doctors, locally employed doctors and AAs.

Given the variability inherent in the clinical management of different types of patient and types of surgery, AAs cannot work only from protocols. Their work requires them to make considered, independent clinical decisions and actions with a limited degree of discretion. An example is monitoring, interpreting and acting on physiological changes (for example, breathing and blood pressure) and taking the necessary anaesthetic care to manage these during a surgical intervention.

**Supervising anaesthetist applies to autonomously practising anaesthetists as defined in the GPAS, including consultant or SAS doctor.*[28]

Will the AA remain as a part of the consultant team or be able to work independently?

The AA will remain as part of the anaesthesia team working under the supervision of a named, physician anaesthetist. AAs are advanced practitioners with a recognised role on qualification and range of competencies. The supervising physician anaesthetist is responsible for entrusting responsibility to the AA and devising and agreeing an anaesthetic plan with the AA. However, deviation from an anaesthetic plan that has been agreed, failure to carry out tasks for which they have been trained in a competent manner and attempting tasks at which they are not competent are the responsibility of the AA.

Who is liable for the AA's actions?

NHS organisations are vicariously liable for the acts, omissions and negligence of their employees and those working under their direction. Therefore, the trust is liable and responsible for the actions of the AA, provided that team members have responded and undertaken duties that are required of them. For example, if the AA has called for assistance when needed and not unreasonably deviated from an agreed plan or undertaken any duties for which they are not trained or competent without communication with their supervising anaesthetist. The supervising anaesthetist should be available and responsive should the AA require assistance.

Can an anaesthetist refuse to work with an AA?

During initial discussions and early planning phases, departments should ascertain that they have identified a sufficient number of consultant/autonomously practising anaesthetists who will be available and in agreement to supervise AAs (supervision and responsibility for AAs would not be within the remit of the AiTs). It is important that any concerns from team members are raised and considered in advance, in order to help departments plan sufficiently and highlight any potential issues.

Further information and resources can be found in the GMC's *Advice for doctors who supervise physician associates and anaesthesia associates*.[51]

Is the AA role a replacement for anaesthetists?

No. AAs are additional to, not instead of, other members of the anaesthesia team. As healthcare changes, and new drugs and technology offer new ways to treat patients, the roles of all NHS staff are changing and the UK is now seeing the development of new roles that complement various clinical professions. The AA role is designed to meet current patient needs and better employ consultant skills. Aligned with this, we will also require an increasing consultant workforce to ensure the best training and development of AiTs, SAS doctors and AAs. The aim is to increase capacity, flexibility and continuity while ensuring that patients are given the appropriate treatment by the most appropriate practitioner within the healthcare team. It can improve the working lives of consultants and enable them to provide high- quality input where needed. It will expand the availability of skills that currently only anaesthetists have. It will also allow staff to have rewarding jobs that allow them to develop an alternative career within the clinical environment.

What criteria are being used to evaluate formally the benefit to both patients and staff?

Experience in provider sites, the Association of Anaesthetists' survey[21] and evidence such as the YHASHN AA Impact Case Studies[24] and other reports[22] have not shown that patient safety has been compromised by the introduction of AAs. The research shows that patient safety and satisfaction may also be improved by the AAs enabling increasing continuity of patient care. However, the evidence base needs to be expanded and a survey of RCoA members as well as an independent literature review will be undertaken.

What is the background/training/experience of an AA?

Two prime sources of recruitment have been identified.

New entrants (graduates or equivalent)

- With a biomedical science or life science background, with a second-class honours degree

or better, or other evidence of recent and successful academic activity

- With a demonstrable commitment to a career in healthcare at application.

Registered healthcare practitioners

- At least three years full-time, post-qualification work experience in a relevant area and evidence of recent (within three years) successful academic activity.

Patient/public safety, together with rigorous adherence to clinical governance requirements, is central in developing this role, with treatment and care being delivered by competent practitioners who have been trained and educated to the agreed national standards for this practice.

What is the training of an AA?

Depending on their level of skill, previous education and experience, current student AAs will take part in an enabling programme of clinically focused education that will last for 24–27 months, depending on the HEI. Regulators will be guided by experts within the RCoA and other key stakeholders, including HEIs, to set out the exact requirements for fitness for practice, fitness for purpose and fitness for award of the course qualification.

Workplace teaching and competency assessment are combined with distance learning and small-group teaching in the theory elements of anaesthetic practice. There are academic assessments and work-based assessments throughout the course which will lead to the simultaneous award of a Postgraduate Diploma/MSc. Student AAs who are enrolled on a Postgraduate Diploma programme and wish to achieve a Masters' degree will be able to continue part-time academic work while working as a trained AA.

How is training organised?

Academic support will be provided by the appointed HEI offering the course. There will be a programme of workplace instruction and regular tutorials and small-group sessions. Successful student AAs will be awarded the Postgraduate Diploma or MSc by their HEI.

Who sets the standard for the level of training/knowledge/experience required to practise as an AA?

The RCoA worked in close collaboration with the GMC and others to develop the draft AA curriculum,[6] which was published in autumn 2022. The draft curriculum is aligned with the GMC's *PA and AA generic & shared learning outcomes*[52] and the professional standards in *Good medical practice*.[45]

Which universities or education bodies are providing the education and training for AA roles?

The University of Birmingham, University College London and Lancaster University Medical School are the current HEIs providing AA training programmes (see section 1.1).

What is the interaction with nurses and other non-medical professionals in advanced roles undertaking anaesthesia work?

These members of the anaesthetic team are skilled and trained to work alongside the anaesthetists, providing support in the preparation and management of the environment and patient care. Some hospitals have elected to train their practitioners to take on a number of advanced roles; however, the delivery of anaesthesia to patients should be administered only by those who have undertaken a formal anaesthetic training programme, such as consultant anaesthetists, AiTs, SAS doctors and AAs.

Can a patient refuse to be treated by an AA?

Any patient can refuse care from any healthcare professional.

Are patients involved in the development of the AA role?

Patients are key stakeholders whose views should be considered at a local level when considering whether to introduce the AA role. Patient representatives were involved in the initial development of the role and there is patient representation on the AA Founding Board of the RCoA.

How are patients reassured that their care with an AA will be to the same high standard as provided by other anaesthesia colleagues?

Patient safety is paramount. AAs work under the supervision of a consultant and accept only delegated duties that they are confident and competent to perform. Patients must be informed as to who is providing

their care. AAs must make their role clear to patients and be prepared to answer questions pertaining to their training, experience and supervision.

All staff performing new duties are undergoing, or have undergone, training and will collect a portfolio of evidence to demonstrate competence which will be assessed by the local supervising consultant and HEI course directors. Local monitoring of performance through audit, incident reporting and mortality and morbidity meetings is an integral part of anaesthetic departmental practice. Individual clinical practice will be reviewed through appraisal.

Further details on the role of the AA on qualification can be found in Appendix E.

What is the experience of teams overseas?

The role of the AA overseas, notably in the USA, is different to the role of the AA in the UK. The scope of practice is different, as is the supervision ratio of medical anaesthetists to AAs. Therefore, comparisons with the US system are not always meaningful given the very different healthcare contexts, where there are both certified registered nurse anaesthetist (CRNAs), who can practise independently and are not comparable to AAs, and certified anesthesiologist assistants (CAAs) who work under the supervision of an anesthesiologist.

Although it is difficult, therefore, to draw comparisons, we do see comparable outcomes in terms of patient care and, in those countries that currently use mixed doctor/non-doctor teams, there is no evidence of poorer outcomes.

Appendix B: Anaesthesia associate register

The AA managed voluntary register is held by the RCoA. It allows employers to verify whether an employee is a fully qualified AA and view the sites currently employing AAs. All qualified AAs who have successfully completed an AA training programme are encouraged to maintain their presence on the register:

- Anaesthesia Associate Managed Voluntary Register[53]

When regulation commences, the AA register will sit with the GMC and qualified AAs will be required to register with the GMC to practise. To register, existing AAs who are already practising will be required to demonstrate their fitness to practice by providing evidence of successful completion of an approved AA training programme and a form of fitness to practice statement from their employer. In addition, the GMC is working with the RCoA, AA course providers and others to develop an AA Registration Assessment (AARA),[36] which will become a mandatory requirement for GMC registration at some point in the future. Further details on the assessment will be available on the GMC's website.[48]

Appendix C: AA job description template including the NHS Knowledge and Skills Framework outline

The NHS Knowledge and Skills Framework – *A Short Guide to KSF Dimensions*.[54]

Hospitals may choose to use and adapt as appropriate the generic job description below. Other examples of job descriptions are available here:

- NHSE student AA job description[55]
- Association of AAs website[33]

NAME OF NHS HOSPITAL

JOB DESCRIPTION

Job title: Anaesthesia associate

Responsible to: Consultant anaesthetist

Accountable to:

Core purpose

To provide anaesthetic services to patients requiring anaesthesia, respiratory care, cardiopulmonary resuscitation and/or other emergency, life-sustaining services within the anaesthesia and wider theatre and critical care environments.

Responsibilities

To work competently, under appropriate supervision, in the role of an anaesthesia associate, within the GMC's *Good medical practice,*[45] being aware of the boundaries of the role and referring patients appropriately to other healthcare professionals as appropriate.

Dimension 5, level 2

To work as a member of the anaesthetic team.

Dimension 5, level 3

To perform/participate in the preoperative interviewing and physiological and psychological assessment under supervision of the consultant anaesthetist.

Dimension Health and Wellbeing (HWB) 6, level 3

To evaluate and/or collect patient information from the patient's history, physical examination, and laboratory, radiographic and other diagnostic data, and identify relevant problems.

HWB 6, level 3

To implement the anaesthesia care plan under the supervision of the consultant anaesthetist.

HWB 6, level 3

To administer and/or participate in the planned administration of a general anaesthetic for a variety of surgical and medically related procedures.

HWB 7, level 3

To use a broad variety of techniques, anaesthesia agents, drugs and equipment in providing anaesthesia care.

HWB 7, level 3

To administer drugs as prescribed and use prescribing mechanisms as permitted by medicines legislation for your primary registered qualification. (This is subject to change once the anaesthesia associate role has been regulated.)

HWB 7, level 3

To interpret and utilise data obtained from the effective use of current invasive and non-invasive monitoring equipment.

HWB 7, level 3

To initiate and manage fluid and blood therapy within the plan of care.

HWB 7, level 3

To recognise and take appropriate actions with reference to complications occurring during anaesthesia management.

HWB 7, level 3

To position or supervise positioning of patients to assure optimal physiological function and patient safety.

HWB 7, level 3

To identify and take appropriate actions related to problems with anaesthesia equipment that might lead to patient problems.

HWB 7, level 3

To identify and take appropriate action in the immediate postoperative period in relation to common postoperative problems.

HWB 7, level 3

To assess patient responses for readiness to move to the next level of care in relation to common postoperative problems.

HWB 7, level 3

To serve as a resource person in cardiopulmonary resuscitation and respiratory care, and for other acute needs.

Dimension 3, level 2

To participate in the education of patients and their careers.

Dimension 2, level 3

To participate in the critical review of audit, complaints, compliments and clinical/ non-clinical incidents, with a view to improving patient care as part of the wider anaesthetic team.

Dimension 4, level 2

To assist with the implementation of risk management and health and safety recommendations as part of the wider anaesthetic team.

Dimension 3, level 2

To monitor and maintain a safe, clean and therapeutic environment for patients, staff and visitors, initiating appropriate action to achieve this.

Dimension 3, level 2

To adhere to quality objectives, hospital policies, governance and codes of practice.

Dimension 5, level 2

To be responsible for timely, accurate and complete records, both manually and electronically, ensuring safety and confidentiality of information and that any hospital and statutory requirements are met.

HWB 6, level 3

To use resources appropriately to ensure a high-quality and cost-effective service.

Dimension 5, level 2

To actively participate in all relevant meetings.

To promote and contribute to the development of new ways of working in anaesthesia, within the hospital and other organisations, by taking part in presentations and conferences.

Dimension 1, level 3

To assist the local management team in the research and evaluation of the role, including the collection

and analysis of data required.

Dimension 4, level 2

To establish working relationships with the rest of the hospital and act as an ambassador for the role.

Dimension 1, level 3

To assist in the development and review of protocols and patient group directives within the anaesthetic team.

Dimension 4, level 2

To take part in the teaching, supervision and assessment of other team members.

Dimension 2, level 3

To take part in personal development planning. To maintain a professional portfolio and logbook.

Dimension 2, level 3

To ensure that own actions support equality, diversity and rights.

Dimension 6, level 2

32. To ensure that the required details are submitted to the Managed Voluntary Register (MVR) for anaesthesia associates, currently held by the RCoA but expected to be moved to the GMC when statutory regulation is implemented, and that registration is maintained at all times.

    Staff working within the anaesthetic department are required always to exercise and maintain confidentiality. Any breach of confidentiality will become a disciplinary matter.

    This job description is intended only as a guide and it can be subject to change as the anaesthesia associate role develops. All changes will be undertaken in consultation with the post holder.

Appendix D: Key contacts

NHS England (previously Health Education England)

- For information about the NHSE funding offer, AA ambassadors and regional contacts, please refer to the NHSE website[18]
- NHSE Medical Associate Professionals (MAPs) enquiries: MAPS@hee.nhs.uk

NHS Education for Scotland (NES)

- NES MAPs enquiries: nes.maps@nhs.scot

Health Education and Improvement Wales (HEIW)

- Enquiries: heiw@wales.nhs.uk

Appendix E: Role of the AA on qualification

This is a revision of a joint Royal College of Anaesthetists and Association of Anaesthetists 2016 document *Scope of Practice for a PA(A) on qualification*. It remains the responsibility of those leading departments of anaesthesia, together with their constituent consultants, to always ensure that anaesthesia associates (AAs) work under the supervision of a consultant anaesthetist.* It is expected the AA's role and career pathway will progress beyond the role on qualification.[37] For example, many AAs work across the whole perioperative pathway, support complex trauma lists and routinely undertake regional blocks, and some hospitals have trained AAs in conscious sedation and advanced vascular access.[24] Further information can be found in section 3.4.

1. The AA must always work within an anaesthesia team led by a consultant anaesthetist whose name must be recorded in the individual patient's medical notes. Overall responsibility for the anaesthesia care of the patient always rests with the named consultant.
2. The consultant anaesthetist leading the anaesthesia team must undertake the duty of the supervising anaesthetist or may delegate responsibility for this duty to another consultant anaesthetist. Supervision must be delegated only to a consultant anaesthetist who is competent to provide anaesthetic care for the patient concerned and who is aware of the duties required of a supervising anaesthetist.
3. The supervising consultant anaesthetist must check and take overall responsibility for preoperative patient assessment, suitability of the proposed anaesthetic techniques and patient consent.
4. The supervising consultant anaesthetist must ensure that the Cappuccini test is applied: https://rcoa.ac.uk/safety-standards-quality/patient-safety/cappuccini-test
5. For every case, the supervising consultant anaesthetist must:
   (a) be present in the theatre suite, be easily contactable and be available to attend within two minutes of being requested to attend by the AA
   (b) be present in the anaesthetic room/operating theatre directly supervising induction of anaesthesia
   (c) regularly review the intraoperative anaesthetic management
   (d) remain in the theatre suite until control of airway reflexes has returned and artificial airway devices have been removed, or the on-going care of the patient has been handed on to other appropriately qualified staff.

   (See section 1.5.)
6. If the supervising consultant anaesthetist leaves the theatre suite for any reason, deputising arrangements must be made. A formal handover of the case to the new supervising consultant anaesthetist must take place.
7. A supervising consultant anaesthetist must not provide solo anaesthetic cover for another patient.
8. The supervising consultant anaesthetist must not be responsible for more than two anaesthetised patients simultaneously, when one involves supervision of an AA. In such instances it is essential that the clinical complexity of the anaesthetic management be appropriate.
9. There must be a dedicated trained assistant, that is, an ODP or equivalent, in every theatre in which anaesthesia care is being delivered, whether this is by an anaesthetist or an AA.
10. The AA must always ensure that their role has been made clear to patients and be prepared to answer questions pertaining to their training, experience and supervision.
11. AAs cannot prescribe medication until GMC regulation is in place, followed by further legislation being passed by Parliament. Until then, the supervising consultant anaesthetists must prescribe medication for each patient using suitable, locally developed, patient-specific tools that allow AAs to check and administer drugs within appropriate limits (see section 3.6 for further details).
12. The nationally agreed curriculum[6] leads to limits on the scope of practice of AAs on qualification.

On completion of training they are:

(a) **not** qualified to undertake obstetric anaesthesia or analgesia

(b) **not** qualified to undertake paediatric anaesthetic practice

(c) **not** qualified to undertake initial airway assessment and management of acutely ill or injured patient (except when the AA is part of a multidisciplinary hospital resuscitation team called to attend a patient and is first to arrive).

13. A statutory regulation arrangement for AAs is expected in the second half of 2024. Until then, the RCoA has established a voluntary register to facilitate future progress towards national regulation. We advise Fellows and Members to supervise only those AAs who have registered with the RCoA. When statutory regulation of AAs commences, it will become compulsory for all AAs to register with the GMC to practise.

14. We acknowledge that development of AA-enhanced roles has occurred. Until further guidance is produced by the RCoA and AA Founding Board together with the regulator, this must remain under local anaesthetic department governance.

15. The potential impact on AiT training opportunities continues to remain under close scrutiny by the RCoA and local departments as the AA contribution to patient care expands.

16. Clinical governance is the responsibility of individual institutions and should follow the same principles as apply to medically qualified anaesthetists, reporting through the clinical director for anaesthesia, and ensuring:

(a) training that is appropriately focused and resourced

(b) supervision and support in keeping with practitioners' needs and practice responsibilities

(c) annual appraisal processes.

April 2023

*****_Supervision of AAs may be undertaken by autonomously practising anaesthetists as defined in_ the Guidelines for the Provision of Anaesthetic Services (GPAS)_, such as a consultant anaesthetist or SAS doctor._[28]

Appendix F: Principals of a training capacity assessment

Introduction

As detailed in section 1.2 of this guidance, a process of assessing the training capacity within a department is recommended before committing to introducing student anaesthesia associates (student AAs).

This training capacity assessment (TCA) document is co-authored by the anaesthetists in training (AiT) representatives on the RCoA Council and members of the Training, Curriculum and Assessments Committee, with input from the Association of AAs and members of the AA Founding Board. It is designed to guide departments through the process of undertaking a TCA and ensure they have the capacity required to provide high quality training for student AAs, whilst maintaining the appropriate levels of training and supervision for AiTs.

While it is not possible to develop a standardised formula or tool that can be utilised in all departments, this document outlines the principles that should be applied, and factors to consider when undertaking a TCA. Although this has been written to assist departments in evaluating whether they have capacity to introduce and train student AAs, many of these principals are applicable when introducing all new learners into an anaesthetic department.

Where the term consultant is used when describing who can undertake the role of a supervisor, this also includes other autonomously practising physician anaesthetists (i.e. SAS doctor) as defined in *Guidelines for the Provision of Anaesthesia Services (GPAS)*.[28]

Step 1: Factors to consider when beginning a training capacity assessment

- A review of the current state of training within the department should be undertaken at the start of the TCA process. If a department is not able to deliver the training needs of its existing AiTs, then it should inform the school of anaesthesia and should not be considering introducing student AAs, or any other new learners.
- Number of consultants in the department available to supervise each day.
- Number of consultants who are recognised by the GMC as an educational or clinical supervisor.
- Number of daily educational opportunities available across all sites (should include other training opportunities in the department such as pre-assessment/peri-operative medicine (POM) clinics, CPEX clinics, pain procedures/clinics, maternity etc.).
- Number of current learners requiring training time each day (this will be affected by factors such as gaps in rotas, rest days pre- and post-call and annual leave etc.).
- Training and experiential needs of the current cohort of AiTs at all stages and the ability of a department to provide appropriate supervision.
- Training needs of other learners already within the department which includes locally employed doctors (LED), medical training initiative (MTI), and specialty and specialist (SAS) doctors.
- Level of supervision and learning outcomes required to support student AAs within the department.
- In a consultant/SAS-led service, all patients will have a nominated consultant or autonomously working SAS anaesthetist (ACSA standard).
- Other factors to consider include the availability of teaching opportunities and who can deliver in and out of theatre teaching for the student AAs (i.e. resuscitation training officers or senior AAs within the department).

Step 2: Evaluating your current workforce

The *2021 Curriculum for CCT in Anaesthetics*[56] describes three stages of training which encompass the knowledge, attributes, and skills that AiTs are required to demonstrate over an indicative period of seven years (full time equivalent). These training outcomes are evidenced in a variety of settings including (but not limited to) operating theatres, intensive care units, non-theatre environments, theatre recovery rooms, "block rooms", inpatient wards, radiology departments and emergency departments as well as pre-assessment and CPEX/POM clinics.

AiTs are a heterogenous cohort of doctors, comprising learners at different stages of experience and training. As they progress through the curriculum and their career, their requirements for supervision will

change and evolve. The ability of a department to supervise their AiTs and ensure that they can deliver the needs of the curriculum must be factored into the TCA.

In addition to supporting AiTs, a department should also make an assessment of their ability to support the other learners within their staffing groups e.g., LED, MTI, and not yet autonomously working SAS anaesthetists. Once a department has established that it can meet the needs of these groups, they can then consider if they have the capacity to take on student AAs.

Clinical Supervision Requirements:

1) **Anaesthetists in training:**

   Stage 1 Training:

   New starter CT1 AiTs require 1:1 supervision until they achieve their Initial Assessment of Competence (IAC), whereupon they are entrusted to perform *Anaesthetic Pre-operative Assessment* and *Anaesthesia for ASA I/II Patients Having Uncomplicated Surgery*. The indicative time for obtaining this is 3-6 months.

   Post IAC requirements for CT1-3; for the majority of Stage 1 training they will be with a consultant anaesthetist reducing their level of supervision depending on the caseload but still requiring a nominated autonomously practising anaesthetist to be responsible for them at all times.

   Stage 2 & 3 Training:

   AiT years ST4 to ST7 will still work under the supervision of a consultant anaesthetist. During this stage of training, they require a minimum of three supervised lists a week. The level of supervision required is outlined in the curriculum with graded outcomes leading to the end of ST7 where trainees should be undertaking work independently.[57]

2) **LED, MTI & SAS Anaesthetists:**
   LED, MTI, and not yet autonomously practising SAS anaesthetists are employed by the trust/health-board, and all will have an individual training requirements. Although they work under different terms and conditions, it is recommended that these doctors should be provided with the required learning opportunities and clinical/educational supervision, in line with AiTs working at an equivalent level.

3) **Student anaesthesia associates:**
   Student AAs require 1:1 supervision (1a/1b level) by a consultant anaesthetist throughout the two years of their training programme. In addition, a department will need to appoint a clinical lead for AAs. Departments should be confident that they have appropriate consultant capacity to provide these training requirements. The higher education institute providing the AA training programme will also undertake a quality assurance assessment of departments' ability to deliver training of student AAs.

4) **Qualified anaesthesia associates:**
   At the point of qualification, AAs work under consultant supervision at levels 1b and 2a, as stated in the AA curriculum[6] and this guidance.

Step 3: Consideration of training safeguards:

Departments should identify the importance of training and education for anaesthetists and other learners, and any workforce plans should ensure that these opportunities are not compromised.[58] Departments wishing to undertake the training of student AAs should ensure that:

- Provisions are put in place to prevent AiTs from having excessive last-minute redeployments to "solo" lists should there be insufficient consultant numbers on any given day. (This is applicable to all departments, not only those who are training student AAs).
- Where AAs are employed, a department will need to ensure that there is always a consultant allocated to supervise trained AAs and student AAs within the appropriate supervision models. If this is not possible on the day (i.e., sickness), departments should ensure that additional cover can be found or that activity is reduced to allow appropriate supervision to be provided, in order to meet local governance requirements.

- AiTs should not be expected to provide training or supervision of student AAs without their prior agreement. Training student AAs is the remit of consultant or autonomously practising SAS anaesthetists, though this can be extended to stage 3 AiTs should they express interest in doing so under a consultant's supervision.
- There should be safeguards to prevent "tripled up" lists where a consultant is directly supervising and training both an AiT and a student AA, unless there is a clear benefit identified by the AiT and supervising anaesthetist. AiTs have different training needs to student AAs and a department should ensure they have sufficient training capacity to prevent the need to double up AiTs and student AAs training.

Step 4: Actions for Clinical Directors and College Tutors

- Ensure that there are the correct number of available consultant lists per week per student AA (currently 6-7 sessions in theatre teaching for most HEIs), that are appropriate in terms of both surgical specialty and patient selection to support the clinical requirements of the AA curriculum.
- Ensure there is a nominated AA lead consultant with sufficient job planned time allocated for that role.
- Ensure there are sufficient educational supervisors with dedicated time in their job plans to provide the supervision for student AAs. Equity for educational supervisors of student AAs should be at the same level as medical AiTs.
- Ensure all of the above is in addition to the training capacity already agreed to deliver the curriculum, experience and supervision of AiTs and other learners already within the department.
- Undertake an annual internal review of departmental training capacity including feedback from AiTs, and other learners and trainers.

Step 5: Final principles

High quality training in individual departments requires the ongoing support of clinical and educational supervisors and college tutors. We recognise that the capacity of these individuals to deliver training is finite. It is this capacity that has historically governed the number of training places awarded within schools of anaesthesia over the years, and it needs to be upheld. To this end, it is vital that any decision by a department to begin training AAs includes confirmation from the college tutor(s) and clinical director(s) that the ability of AiTs to access all aspects of the curriculum available in their department is assured. If college tutors have any concerns about their department's ongoing capacity to train AiTs, they should contact their head of school and/or regional adviser anaesthesia for support. This will ensure that the school of anaesthesia is aware of any difficulties and can share details of these with the College if further support is needed. In addition, if AiTs have concerns in relation to their ability to access supervised lists or clinical experience appropriate to their level of training, they should escalate these concerns to their educational supervisor, college tutor and training programme director. This is also applicable to other learners, including MTI, LED, and SAS doctors, as well as student AAs (for which the HEIs will have a responsibility to ensure that the departments in which their students have been appointed are able to deliver the requirements of the AA curriculum). AiTs should be directly involved in the annual review of a department's training capacity and ability to deliver high quality training to its learners.

Step 6: Signoff

In line with the requirements outlined above we confirm that we have assessed the training capacity within our department and can confirm that we have the capacity to train (....) students AAs.

Signed: (College Tutor)

Date:

Signed: (Clinical Director)

Date:

This assessment should be signed and a copy submitted to the Head of School & Regional Adviser Anaesthesia

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