Planning the introduction and training for **Anaesthesia Associates**

Considerations for your Anaesthetic Department

The Association of Anaesthetists of Great Britain & Ireland

AfPP Progressing Safer Surgery

APAA Association of Physicians' Assistants Anaesthesia

College of Operating Department Practitioners

The Royal College of Anaesthetists

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FOREWORD

This guidance is a revision to the DH publication: *A toolkit to support the planning and introduction of training for Anaesthesia Practitioners*.

The RCoA and the AAGBI recognises the value that Anaesthesia Associates (AAs), previously called Physicians' Assistants in Anaesthesia (PA(A)s), offer to departments of anaesthesia.

Since their introduction over a decade ago data to show that AAs may enhance the working lives of all members of the perioperative team which they join, whilst improving efficiency and maintaining high standards of patient safety is steadily accumulating. This document aims to help individual departments of anaesthesia decide whether or not AAs might usefully augment their anaesthetic services by providing guidance that is structured around three stages:

- **PLANNING** – Determining the need for the role, obtaining support and securing the funding. How to ensure appropriate local stakeholder involvement.
- **PREPARATION** – How to commission a training programme from a Higher Education Institution (HEI). How to recruit AA students 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 AA student whilst ensuring safe practice.

Formal registration of AAs is vital, and we continue to work actively to establish this. Meanwhile, as with all employees within an NHS hospital, their clinical governance is the responsibility of the employing hospital which is vicariously liable for their practice.

Although the introduction of a new practitioner may seem complex, this document systematically leads the reader through each of the stages, providing the core information and guidance required. The Appendices provide examples of the experience gained from existing sites where AAs are employed and may help you to avoid or overcome some of the challenges faced during the introduction of this role.

Dr Andrew Beechey – Clinical Lead AA

Mr Paul Forsythe – Association of Anaesthesia Associates

Dr Kathleen Ferguson, **Dr Paul Barker,** and **Dr Paul Clyburn** – Association of Anaesthetists of Great Britain and Ireland (AAGBI)

Dr George Collee, **Dr Tom Clutton-Brock** and **Mr Charlie McLaughlan** – Anaesthesia Related Professionals Committee of The Royal College of Anaesthetists (RCoA)

Written in collaboration with **Ms Hannah Abbott** (College of Operating Department Practitioners) and **Mrs Ann Conquest** (The Association for Perioperative Practice)

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1. PLANNING

Determining the need for the role, obtaining support and securing the funding

Steps:

1.1 Critically consider key supporting information sources

1.2 Initial discussion within your anaesthetic department regarding possible benefits and scope for training of AAs

1.3 Gathering the 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 deriving from business cases

For introduction of AAs into your hospital to be successful, it is important for all those involved to be absolutely clear as to 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 department of anaesthesia to provide consistent high-class teaching over the entire duration of the course and beyond, into service delivery as post-graduate practitioners.

1.1 Key supporting information

Anaesthesia Associates Curriculum

The 2022 Anaesthesia Associate Curriculum is available on the **RCoA website.**

Currently the Higher Education Institutions (HEIs) offering the AA course, either a Postgraduate Diploma or MSc, are the University of Birmingham, University College London and Lancaster 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 course administrator.

Students eligible for entry into an AA programme derive from two sources:

- Biomedical or biological science graduates with no previous clinical exposure.
- Clinical NHS staff who have demonstrated their ability to work at degree level and will usually have had at least three years' experience as a registered healthcare professional.

Details of requirements for eligibility to the AA programmes are available on the HEIs websites:

University of Birmingham: https://www.birmingham.ac.uk/postgraduate/courses/taught/med/anaesthesia-associate.aspx

University College London: https://www.ucl.ac.uk/prospective-students/graduate/taught-degrees/anaesthesia-and-perioperative-science-msc

Lancaster Medical School: https://www.lancaster.ac.uk/study/postgraduate/postgraduate-courses/anaesthesia-and-perioperative-sciences-pgdip/

Prior to 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 to the course.

Key websites

Information and publications relating to the AA role can be found on the RCoA website: www.rcoa.ac.uk/training-careers/working-anaesthesia/anaesthesia-associates

Other useful websites are:

- Association of Anaesthesia Associates www.anaesthesiaassociates.org
- Association of Anaesthetists www.anaesthetists.org/
- The Association for Perioperative Practice www.afpp.org.uk
- British Anaesthetic & Recovery Nurses Association www.barna.co.uk
- Department of Health & Social Care www.gov.uk/government/organisations/department-of-health
- Association of Anaesthetists Trainee information www.anaesthetists.org/Home/Membership/Trainees
- Patient Voices at Royal College of Anaesthetists https://www.rcoa.ac.uk/patients/patient-public-involvement/patientsvoicesrcoa
- University of Birmingham www.birmingham.ac.uk
- University College London www.ucl.ac.uk/london
- Lancaster Medical School www.lancaster.ac.uk/lms/

1.1 Initial discussion

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

Possible topics for consideration during initial discussions are:

- 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?
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- What options are available to deliver the service in the future?

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

The following questions need to be asked:

- Can AAs be employed in the workplace?
- Is the case mix appropriate for the role?
- Will the theatre layout allow for the appropriate levels of supervision?
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- What are the benefits and risks of introducing this role?
- What changes are required in order to realise these benefits?
    - What workforce changes would be needed if AAs are not introduced into your department?

KEY RECOMMENDATION

Before proceeding, ensure there is a core group within the department of anaesthesia to provide training and utilise the skills and provide ongoing support for AAs.

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

1.2 Gathering evidence

Gather evidence to clarify the perceived benefits and potential risks of reconfiguring anaesthesia services using AAs.

Flexibility – making medical anaesthetists more available

With a significant number of AAs in a department, anaesthetists will be able to work using mixed teams of consultants, staff and associate specialists doctors, trainee doctors and AAs. Working in teams, it may be possible for medical staff to be released to do other activities such as attend the high dependency unit, outreach and pain services whilst still maintaining the required level of supervision of the AAs (availability to attend within 2 minutes); this is developed further in Section 2.4. By reconfiguring the number of anaesthetists required to provide the same service, more senior anaesthetists may be able to participate routinely in out-of-theatre activities that are at present usually attended by junior doctors. This development has the potential to improve both the staff experience and patient care.

Examples of possible improvements could include:

- Less waiting for a medical anaesthetic opinion in pre-admission clinics.
- Faster resolution of problems in patients' post-operative pain.
- More immediate response by senior medical staff for attendance to 'outreach' patients.
- Less waiting for out-of-theatre procedures such as vascular access and sedation for minor procedures.
- Two to one working can release more senior anaesthetic staff for service provision.
- Development of new services, e.g. regional anaesthesia, sedation and vascular access.
- Greater opportunities to provide tuition to anaesthetic trainees while maintaining patient safety.
- Reduction in the service component of trainee anaesthetists' workload.

AAs can increase capacity in teams

Consultant anaesthetists can supervise two AAs during the maintenance phases of anaesthesia. This allows one consultant to supervise 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 is 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

By freeing trainees from service elements of their work, and thereby facilitating their attachment to theatre lists which optimise appropriate teaching opportunities the employment of AAs may enhance trainee teaching. Consultants can also be freed to teach.

AA supervision and limitation of scope of practice

The Royal College of Anaesthetists and the Association of Anaesthetists of Great Britain and Ireland have agreed a Scope of Practice for AAs on qualification based upon the competencies they have achieved during their training. This is included as Appendix E . AAs must work within an established anaesthetic team with a named supervising consultant anaesthetist at all times. Integrating a new practitioner into such a team takes time.

While it is understood that in some centres AAs with further experience and training have extended practices beyond this basic level the RCoA and AAGBI have not yet reached agreement regarding formal approval of such 'extended' practices, therefore it is especially important that the clinical governance of such arrangements must be carefully addressed at a local level.

AAs 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. Activities within anaesthetic assessment clinics often incorporate additional administrative preparatory work, with which AAs will may not be familiar. AAs can administer medicines but are not able to act as independent or supplementary prescribers.

KEY RECOMMENDATION

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

1.3 Wider discussion of the proposal with key stakeholders

Following 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, the AA should be consulted where appropriate. Discussions should also commence at this stage with patient representatives.

Detailed discussions should be held with key stakeholders within theatres and with 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 consultant anaesthetist clinical lead – the local expert in anaesthesia education
- the clinical/medical director – for clinical leadership
- College tutor and trainee representative
- the theatre manager – for understanding of theatre staffing and rostering
- the director of nursing – for nursing leadership as part of a multi-disciplinary team
- the director of finance – to consider financial backing and future investment planning
- the director of human resources – for understanding of 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.

A small working party should be set up to consider the issues around establishing training for the AA role. An important consideration is the effect that training AAs may have on existing medical trainees. This will require some administrative/ project management support

KEY RECOMMENDATION

Establish monthly meetings and terms of reference for key stakeholders in order to move the training forward.

Links should also be made with local healthcare organisations that may have experience in training AAs (see Appendix B for a list of hospitals employing AAs).

1.4 Organisational development planning for operating theatres

Traditionally, anaesthesia staffing in theatres follows the model below, but it is acknowledged that there are added complexities such as the training of junior doctors *and having two anaesthetists for complex cases.*

THEATRE 1	THEATRE 2	THEATRE 3
Consultant + ODP or Anaesthetic Nurse	Consultant + ODP or Anaesthetic Nurse	Consultant + ODP or Anaesthetic Nurse

When assessing the need for AAs, consideration should be given to how they will function in the team once they are qualified. With the introduction of AAs, greater flexibility can be introduced as to how staff can be employed within theatres. The models below show some of the ways the role can be employed within theatres.

Model 1 – Using the AA to improve theatre throughput

THEATRE 1
Consultant **AA** + ODP/Anaesthetic Nurse

The AA may support the consultant in setting up complex anaesthesia or support same day and staggered admissions. Theatre through-put can be increased by consultants and AAs working in a turn and turnabout manner minimising theatre down-time between cases . The AA may provide additional skilled supervision in the recovery room for specific patients.

Model 2 – Employing the AA to improve theatre teaching

THEATRE 1
Consultant + Trainee **AA** + ODP or Anaesthetic Nurse

Employing the AA will allow the consultant time to undertake competency-based teaching of, for example, blocks and epidurals.

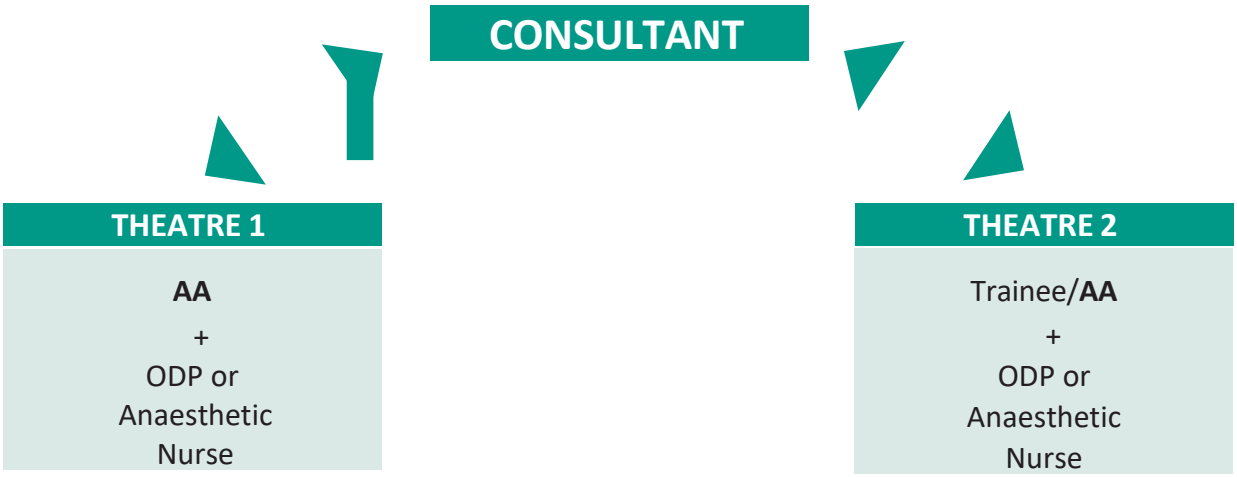
Model 3 – Using the AA to support long and complex surgical cases

THEATRE 1
Consultant **AA** + ODP or Anaesthetic Nurse

AAs can provide the support that would be typically given by a second anaesthetist and, where appropriate, allow for rest breaks for other staff members.[1] This is in line with Improving Working Lives[2] and compulsory rest breaks within the Working Time Directive.[3]

Model 4 – One Consultant to two theatres, working with AAs

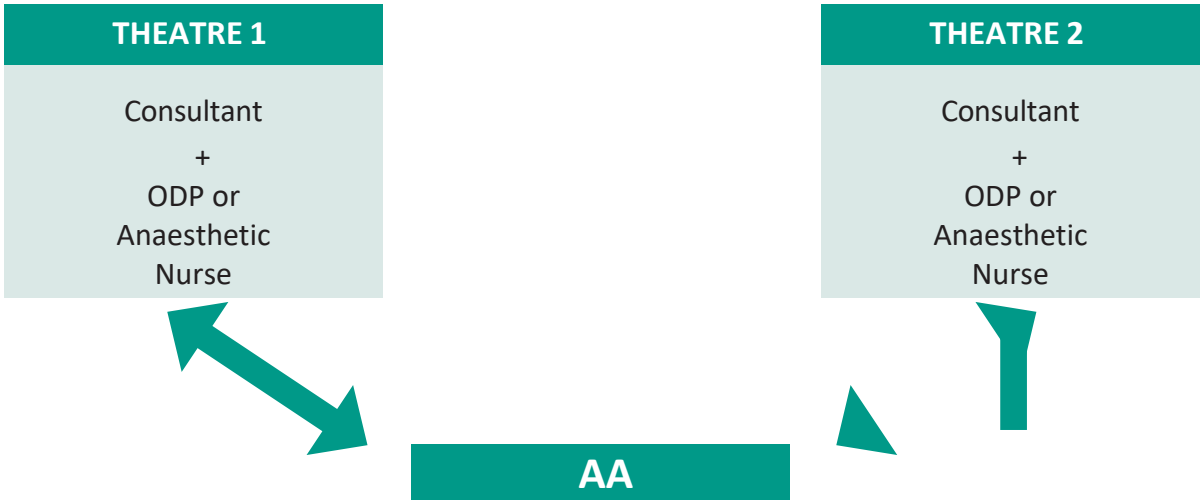
Where adjacent theatre suites are available, the following models of care delivery could be used to allow a two-theatre working model.



Consultant supervision can be provided, as required, to both the AA and the junior doctor, to ensure that the junior doctor receives the most appropriate training. This model could also be run with two AAs, particularly in non-teaching hospitals.

1 Willoughby L, Morgan R. Neuroanaesthetists' workload issues. Anaesthesia 2005; 60:151–4
2 www.nhsemployers.org/~/media/Employers/Publications/Improving%20Working%20Lives.pdf
3 http://ec.europa.eu/social/main.jsp?catId=706&langId=en&intPageId=205

Model 5 – Flexible AA support for two theatre working



The AA can be employed to free up consultants to work outside theatres, so they can provide additional support, as required, throughout complex procedures or in emergency situations.

AAs are also able to 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 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 in order to achieve the most effective and efficient system for their theatres. An evaluation of the impact of AAs on anaesthesia and theatre practice was undertaken by the Association of Anaesthetists of Great Britain and Ireland and is available at

1.5 Business Case

Achieving success will require a robust and well-presented business case, but it also depends on that case being seen and supported by key individuals at the right time. Therefore, prior to presenting the business case to any decision-making forum, you should consider who needs to approve the development of the business case during the following stages:

Initial proposal

Developing case

Final case

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

- How the AA role serves a specified local need, i.e. whether it is patient and/or service driven
- Its impact on improving service to patients in line with local priorities
- Its relationship with national targets such as the 18 week patient pathway from GP referral to treatment, Working Time Directive 2009, Modernising Medical Careers, the productive time agenda, etc.
- The strength of local clinical support
- Timeliness regarding availability of funds and any approval process
- The cost effectiveness of training AAs
- The cost benefits for the role
  - Reduced requirement for locum medical anaesthetists
  - 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 should experienced staff be appointed

internally Outlined below are some additional topics that should be discussed within the

business case.

Options appraisal

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

- Employing additional doctors
- Increasing international recruitment
- Extending the roles of current healthcare staff
- Reconfiguration of both the elective and out of hours services.

Sources of funding

Ongoing funding must be secured from the beginning of the project.

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

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

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 managed. 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 should be adhered to. There should be effective supervision by the consultant anaesthetist 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, but clear, consistent and open communication should be provided at all stages of the introduction of the role.
Variation in implementation of the AA curriculum at departmental and regional level, resulting in variable output of competence.	Strategies for development of local and regional expertise, clear expectation and contracts between all parties involved, and adherence to the training curriculum.
Failure to secure national professional registration and regulation, resulting in ambiguous career prospects and recruitment difficulties.	This issue is being addressed local clinical governance arrangements will need to be addressed.
Variability of competence, due to employment of overseas non-medically qualified practitioners with differing backgrounds training and experience.	Currently there are no equivalence procedures available and potential candidates should be referred to a HEI providing the course, however when GMC regulation of AAs commences, it is expected there will be an equivalence process with a registration assessment.
Withdrawal of funding before a critical mass of AAs are trained.	The role should be included as part of long-term staffing requirements for the department and incorporated within strategic workforce plans.
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 is in place for theatres which encompasses the role. Details will need to be locally agreed will all key stakeholders.

1.6 Outcome agreement of business case within NHS Hospitals

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

KEY RECOMMENDATION

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

Workforce skill mix

While some areas still have staff shortages, others may be looking at reducing total staff numbers.

The AA role may provide career development for the existing workforce to meet future service need and form an additional clinical career pathway.

Where there are workforce shortages, the AA role may provide science graduates from outside the NHS with an opportunity to have a clinical career.

2. PREPARATION

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

2.1 Cost breakdown for healthcare organisations

2.2 Contact and contracting with a HEI

2.3 Recruitment

2.4 Generation of contracts

2.5 Clinical governance arrangements

2.1 Costs breakdown for healthcare and educational organisations

Within a hospital, anticipated costs for training AAs include the following:

Pay:
Salaries for AA student.

Biomedical science graduates may expect to be retained on a bursary.

0.75 – 1 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 teaching is delivered (1-2 hrs per week).

Teaching outside the operating theatres can be expected to take approximately 2 hrs 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 will be required.

Non pay:

- Recruitment costs
- Training and education costs
- Course fees
- E-learning access
- Final OSCE examination at the RCoA
- Travel costs and consumables.

Funding for training of Advanced Practitioners may well be held by the appropriate national health educational funding bodies. It is advised that early contact is made with these organisations, so that bids may be considered and entered into their planned budgets.

Successful bids to these bodies can result in substantial financial support for a training programme, commonly up to 60% of pay with on costs at Band 6 and educational fees.

Advice regarding contracting arrangements can be found at:

www.healthcareers.nhs.uk/about/careers-nhs/nhs-pay-and-benefits/agenda-change-pay-rates

www.healthcareers.nhs.uk/explore-roles/physician-associateassistant/physicians-assistant-anaesthesia

2.2 Contact and Contracting with a HEI

The University of Birmingham (UoB), University College London (UCL) and Lancaster Medical School (LMS) provide an appropriate course for the training of AAs, as a distance learning programme, although it is expected there will be additional HEIs offering the AA programme in 2023. The educational fees of UCL and the UoB courses are established and can easily be factored into a business case.

2.3 Recruitment

AA student 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:

Registered healthcare professionals (for example nurses or ODPs)
with at least one of the following:

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

New entrants to healthcare (graduates or graduate equivalent)

- with a biomedical science or biological science background
- preferably 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.

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 AA students must also be accepted by the University of Birmingham or other HEI offering an appropriate course as being eligible to take the PG Diploma.

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.

A job description for the newly qualified AA and the Knowledge and Skills Framework outline is available in Appendix C.

Additional information on the guidance relating to the treatment of AA students is contained within Annex U of the *NHS Terms and Conditions Handbook* covering the application of Agenda for Change to trainees.

KEY RECOMMENDATION

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

2.4 Generation of contracts

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

AA student

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

NHS/service supervision and education

- Time/remuneration
- Standards
- Honorary agreements with HEI

HEI

- 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/University of Birmingham 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.

2.5 Clinical governance arrangements

It is important that, when new roles such as the AA are proposed, the organisation and the public have confidence that their introduction has been accompanied by a full consideration of the clinical governance issues. Each organisation will have robust systems in place to ensure sound clinical governance arrangements. These should cover both the trained AA and the AA in training and should clearly define the scope of practice of the AAs. An example of a clinical governance document can be found at: https://anaesthesiaassociates.org/

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

- 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 AA students before they have contact with patients
- supervision of AA students during training
- prescribing, supply and administration of medicines.

The RCoA Lay Committee has developed an information leaflet for patients, which is available at: AnaesAssociate-patientinfo2019web.pdf (rcoa.ac.uk)

Patient consent

The rules 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 RECOMMENDATION

Early discussions should be held with the organisation's chair of the clinical governance committee or their equivalent to seek advice on the expectations for your particular organisation.

Ensure availability of patient information leaflets.

3. IMPLEMENTATION

Delivering the programme, supporting the AA students and ensuring safe practice

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

3.1 Induction

AA students need to be orientated to their changing role and to the training programme generally. Broadly, the orientation is in three areas:

The organisation

All AA students 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.

The training programme and the university

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

AA students will be registered students of a university, with all the privileges and rights that go with that, and they should have a formal university induction which will outline all aspects of university work and expectations regarding their course, e.g. rules on plagiarism, etc. and the requirements of academic submissions.

The work they will undertake

As well as the organisational induction, the AA student 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 *Anaesthesia Practitioner Curriculum Framework*.

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

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

Week one of the education and learning programme should involve introduction to HEI staff and the clinical team, and identification of a clinical mentor as well as a one-to-one meeting with them. Information about, and access to, all educational and academic facilities should also be provided.

3.2 Delivering education and training

Following the preparation of the course in line with the Curriculum Framework, the delivery of the education programme for the first cohort provides a vital learning experience for the programme tutors, supervisors, mentors and AA students. The staff delivering the programme should take every opportunity to record the effectiveness of the programme and refine it.
Although the programme is predetermined, this should not be seen as a block to improvements where these can be shown to increase its effectiveness. 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 AA students or others become increasingly difficult to correct as the programme progresses.

AA student and staff support

During the initial stages of the programme, an open-door policy should operate for students, with access to both an identified consultant anaesthetist mentor and university staff. These students will be undertaking a new type of training within your organisation and also will be introducing significant change to working practice within theatres. Therefore managing the clinical and academic environment and offering high levels of support will often help offset some of the initial difficulties that may be faced.

In addition, it is important to recognise the support needs of the staff supervising the AA student. It is anticipated that many of the staff delivering the education and training will be highly experienced in their speciality, 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 AA students.

Formative assessment

Formative assessment of AA students' progress should be built into the end of each module, and cover:

- feedback on practical competence acquisition
- review of progress within the Record of In-service Training Experience (RITE) Diary, ensuring 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 take into account the impact of the new member of staff both during training and after qualification. Key areas for monitoring should be around:

- patient safety
- patient and staff feedback
- operational issues such as delays and cancelled operations

It is anticipated that this would 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 of feedback from AA students and a continuing evaluation of progress from supervising staff, theatre staff, university and other stakeholders. The review should include both the healthcare organisation and university.

KEY RECOMMENDATION

Setting up robust arrangements for obtaining feedback during the first year of the training programme will ensure any major problems are avoided in the future.

Major involvement from clinical staff is required, and active feedback and engagement will provide a smoother path for the second part of the course. Consideration should be given to providing a written brief of progress for local hospital stakeholders at key points in the programme and will allow the continued highlighting of the role within the hospital. These briefings should then be fed into management team meetings.

3.3 Summative assessments

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

Month 8

This is the first of the compulsory summative assessment points within the programme. The assessment is led by the designated tutor and comprises 4 elements all of which must be completed satisfactorily to allow progress:

- 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 is recommended
- Review of the RITE Diary
- Multiple choice question paper.

The examination is coordinated across all HEIs and has a pass/fail assessment scheme. Failure in individual elements will require the AA student to resit this element only. Only one re-sit attempt is allowed.

There is a one-month 'resit' period. Failure to pass at this stage will invoke individual HEI progression regulatory processes. AA students will leave the training programme at this stage.

Month 24

This is the final assessment point within the programme, and as at 8 months the breadth of competencies are assessed using several methods.

The assessment elements are:

- Multiple-choice question paper
- Practical assessment of competence within the workplace
- Review of the RITE Diary
- Objective Structured Clinical Examination (OSCE) undertaken by RCoA with university staff.

These are equally weighted and compulsory. Failure in any element will be afforded a single resit under the same HEI regulations as before.

Satisfactory completion of the programme (which includes a probationary 3 months of clinical practice) and the assessment process will lead to the award of the post-graduate diploma Anaesthesia Associate at the discretion of the awarding HEI .

3.4 Pre-qualification clinical practice

Prior to successful sign-off of clinical competence, all AA students are required to undertake three months of work-based experience working under supervision as identified within the Curriculum Framework. During this period of time the AA students' work will be observed and any areas of development addressed.

This three-month period will also provide AA students who were not successful initially at the 24-month examinations with an opportunity to retake their qualification examinations and to consolidate any knowledge and skills required. The University of Birmingham allows candidates a single opportunity to retake any examination they have not passed on the first attempt.

Upon successful completion of the three-month period of clinical practice and the award of the diploma, the AA student will be classed as qualified and competent to work within the scope of practice of a newly qualified AA.

AAs will be expected to maintain their skills by undertaking appropriate continuing professional development in their areas of practice.

KEY RECOMMENDATION

Continuing professional development requirements will need to be promoted from initial qualification as the responsibility of the practitioner.

3.5 Post qualification and clinical practice

Currently the AAs require a minimum of 25 hours of accredited CPD per year. This should be reviewed within appraisal (see below) and should include lessons learned and further developments required to develop a Personal Development Plan.

Annual appraisals – CPD will be monitored through the appraisals process. This should also include feedback from colleagues, supervising Consultants, other theatre staff and most importantly patients.

3.6 Regulation

Although it is not a requirement that everyone working in healthcare is part of a regulated profession, it is normal practice that, where a body of specific knowledge and skill defines a new professional group, then that group works towards regulation. Vigorous attempts continue to address this situation. AAs currently have no statutory regulatory body . AAs may hold NMC or HCPC registration (as a nurse or operating department practitioner etc.) However this may not cover the totality of their practice as an AA. The implications of working out with the recognised scope of practice of any group with whom they remain registered must be given careful consideration. 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, a managed voluntary register was established by the Association of Anaesthesia Associates, AAA. As part of the drive for statutory registration and regulation a new by the Royal College of Anaesthetists. recommended that all AA students and qualified AAs should register their details with the RCoA **and that hospitals should not employ AAs who are not registered with the RCoA.**

Prior to formal regulation of AAs, 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. There is currently no system for establishing equivalence. This is currently under review. Pending the implementation of formal equivalence arrangements, organisations should refer to the RCoA or HEIs providing the course for advice on overseas practitioners.

3.7 Prescribing and administration

Within the operating theatre administration of drugs by AAs is regarded as being on the order of the supervising consultant. A robust mechanism for regulating this arrangement should be devised locally. Many hospitals have gone down the route of generating Patient Specific Directions as evidence of prescription by the supervising consultant anaesthetist. A good explanation of this can be found in the Department of Health publication 'Good practice in Clinical Perfusion Science'.[41] The AAA is developing a set of generic directions that can be tailored to local use.

It has been possible to have effective and safe working practice of AAs without the need for prescribing rights. The ability to remotely countersign prescriptions should be considered when introducing electronic prescribing. **Please note that the supervising consultant remains responsible and accountable for all medicines administered by the AAs.**

1 www.scps.org.uk/pdfs/GuidetoGoodPractice.pdf

4. APPENDICES

Appendix A: Frequently asked questions

What is an Anaesthesia Associate?

An Anaesthesia Associate (AA) is a member of the anaesthetic team. AAs are trained both in the underlying scientific and medical knowledge pertinent to anaesthesia, and in the skills of administering anaesthesia. They work in a team with anaesthetists under consultant supervision. The AA role has been evaluated through Agenda for Change and has been placed at Band 7 for newly qualified AAs. This may increase to a higher band with increased experience and advanced competencies.

Why are we highlighting the potential of this role this role?

Rapidly changing demographics, changes in technology and patients emphasise the need for a modernised NHS workforce with access to a more flexible career pathway. This will be achieved by basing job design on the skills and competences required, leading to the development of roles that lie outside traditional boundaries; it may extend to the creation of completely new roles within the Career Framework for the NHS.

All workers within health and social care organisations are being encouraged to consider new ways of working to improve the patient's experience. It is not about staff working harder or cost cutting, or simply to address staff shortages; it is ensuring that the service user receives the most appropriate care, at the most appropriate time from the most appropriate person.

What will AAs do?

The emphasis is on working as part of a team in partnership with colleagues under the supervision of a physician. On qualification they perform duties delegated to them by their consultant 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. AAs will also deputise for anaesthetists in a variety of situations where their airway and venous cannulation skills are required and will assist in patient care as determined by their supervising consultant.

An AA is an additional member of the anaesthesia team; as part of that team they fulfil a role that has traditionally been provided in the UK only by medically qualified staff. On qualification the AA may undertake the induction of and emergence from general anaesthesia under the direct supervision of a consultant or senior anaesthetist, and will make clinical decisions themselves under indirect supervision while established anaesthesia is maintained. This partial autonomy is based on their position as a member of a clinical anaesthetic team that is at all times led by a medically qualified consultant anaesthetist, with supervision that must not exceed 2:1 in accordance with national guidelines. This role, with its continual 'consultative' relationship, is a different way of working for consultant anaesthetists. When delegating responsibility to AAs the medically qualified anaesthetist remains responsible for the AA's actions.

The AA role has a defined scope and does not require the knowledge and skills specific to other groups of healthcare professionals (e.g. the wider theatre skills of Operating Department Practitioners and perioperative nurses); however, it is acknowledged that there is an inevitable overlap of skills and competences with both medical and non-medical roles.

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 (e.g. breathing and blood pressure) and taking the necessary anaesthetic care to manage these during a surgical intervention.

How does this new role fit in with the current anaesthesia team?

The role will complement existing roles already developed in acute care.

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

The practitioner will remain as part of the anaesthesia team working under the direction of a consultant. AAs are advanced practitioners with a recognised scope of practice and range of competencies. Deviation from an anaesthetic plan as formulated by the consultant, failure to carry out tasks for which they have been trained in a competent manner or attempting tasks at which they are not competent are the responsibility of the practitioner.

Is this new role just a cheap substitute for anaesthetists?

As healthcare changes, and new drugs and technology offer new ways to treat patients, the roles of all NHS staff are changing and we are now seeing the development of new roles that cut across various clinical professions. 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 and the AAGBI survey has shown that patient safety has not been compromised by the introduction of AAs. Patient safety may be improved by increasing continuity of patient care and patient satisfaction maintained.

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

Two prime sources of recruitment have been identified.

Registered healthcare practitioners

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

New entrants (graduates or equivalent)

- with a biomedical science, or biological science background
- preferably 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.

Patient/public safety, together with rigorous adherence to clinical governance requirements, will be central in developing this new 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 a AA?

Depending on their level of skill, previous education and experience, current AA student will take part in an enabling programme of clinically focused education that will last for 27 months. Regulators will be guided by experts within the relevant Royal Colleges and other key stakeholders, including higher education institutions, to set out the exact requirements for fitness for practice, fitness for purpose and fitness for awards.

Generally, AA students will undertake a 27-month service-based course. Workplace teaching and competency assessment will be combined with distance learning and small-group teaching in the theory elements of anaesthetic practice. There will be academic assessment and work- based assessment throughout the course that will lead to the simultaneous award of a Postgraduate Diploma in Anaesthetic Practice and Affiliate of the Royal College of Anaesthetists.

AA students who wish to do so will be able to continue part-time academic work whilst working as a trained AA, in order to achieve a Master's degree.

How will the training be organised?

Academic support will be provided by the appointed HEI that has been recruited to support the hospital in offering the course developed by the RCoA, and the University of Birmingham. There will be a programme of workplace instruction and regular tutorials and small-group sessions. Successful AA students will be awarded the Postgraduate Diploma in Anaesthetic Practice by the local university that has supported their cluster.

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

The RCoA has worked with the AAGBI, The Association for Perioperative Practice, the British Anaesthetic and Recovery Nurses Association, the College of Operating Department Practitioners, patient representatives and higher education institutions to develop the competences and Curriculum Framework for this role.

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

A Curriculum Framework has been developed and is being used in the University of Birmingham to ensure that educational programmes produce practitioners who are 'fit for purpose'.

Don't we already have nurses and other non-medical professionals in advanced roles undertaking this work?

These members of the anaesthetic team are educated and trained to work alongside the anaesthetists providing support in the preparation and management of the environment and patient care; this does not include the devolved responsibilities for any of the clinical care of the anaesthetised patient. Some hospitals have elected to train some practitioners to take on some advanced roles, but AAs are the only professional group who are able to offer the breadth of skills which cover the whole of the anaesthetic process.

Can a patient refuse to be treated by a AA?

A patient is entitled to refuse care from any health care professional.

Are patients involved in the development of the AA role?

Patients are clearly key stakeholders whose views should be considered at a local level when considering whether the introduction of the AA role is of benefit to an individual Department of Anaesthesia. Patient representatives were involved in the initial development of the role and there is patient representation on the Anaesthesia Related Professionals Committee of the RCoA.

What is being done to reassure patients that the new or redesigned roles are not providing an inferior service?

Patient safety is paramount. AAs work under the supervision of a consultant and only accept delegated duties that they are confident and competent to perform, this is defined in Appendix E for AAs on qualification

All staff performing new duties are undergoing or have undergone training and will collect a portfolio of evidence to demonstrate competence that will be assessed by the local supervising consultant and training centre staff. 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.

Will clinical standards deteriorate?

In those countries that currently use mixed doctor/non-doctor teams, there is no evidence of poorer outcomes. The UK operates a service with a much larger contribution from trainee anaesthetists than in most countries, and in particular more junior trainees are permitted greater autonomy. The safety of this arrangement rests with the supervising consultants and this will also be the case with the introduction of AAs.

Overseas, non-medical anaesthetists work in operating theatres that have been designed for teamwork, using theatre management practices that give special consideration to anaesthetic difficulty during the allocation of surgery to theatres and teams. The UK does not have this experience and the AA programme continues to collect information about changes in practice that are needed as the current AAs are added to the teams. Importantly, the introduction of AAs to a department requires that the clinical director and consultants have the flexibility to consider major changes in their working practices. A team approach should evolve and cooperation between all members of the team is vital.

Appendix B: Sites currently training and/or employing AAs

Examples of departments with PA/As in UK (2014/5)

Clinical lead for AA e-mail address : PAA@rcoa.ac.uk

Trust	AAs (AA students)	Clinical areas	Contact number
Aintree University Hospitals NHSFT	1 (2)	Main Theatres and DSU	0151 525 5980 (Switchboard)
Barnsley Hospital	1	Main Theatres and DSU	01226 730000 (Switchboard)
Blackpool Victoria Hospital	2	All theatres except Maternity	01253 300000 (Switchboard)
Bristol Royal Infirmary	1	Theatres and wards	0117 923 0000 (Switchboard)
Diana, Princess of Wales Hospital, Grimsby	2	Theatres	01472 874111 ((Switchboard)
Gartnavel General Hospital, Glasgow	2	Main Theatres/DSU/Interventional Radiology/Dental	0141 211 3000 (Switchboard)
Hairmyres Hospital Lanarkshire Scotland	3	Main Theatres	01355 585 000 (Switchboard)
Heart of England NHS Foundation Trust	6	Main Theatres and DSU	0121 424 2000 (Switchboard)
Hull and East Yorkshire NHS Trust	3	Anaesthetics, Main Theatres, DSU, Eyes	01482 875875 (Switchboard)
Lancashire Teaching Hospital NHS Trust (Preston/Chorley)	2	Anaesthetics-main theatres/DCU/ gynae/CPEX	01772 716565 (Switchboard)
Lincoln County Hospital	4	Theatres	(01522) 512512 (Switchboard)
North Bristol NHS Trust	1	Main Theatres	0177 9505050 (Switchboard)
Northumbria Healthcare Foundation Trust	6 (2)	Theatres	0344 811 8111 (Switchboard)
Nottingham University Hospitals	4	Main Theatres	0115 9691169 ext 55637
NWLH Trust Northwick Park Hospital	2	Main Theatres	020 8864 3232 (Switchboard)
Queen Elizabeth Hospital Birmingham	9	Main Theatres, Ambulatory Theatres, Hand centre	0121 627 2000 (Switchboard)
Royal Devon and Exeter	4	Main Theatres	01392 411 611 (Switchboard)
Royal Infirmary of Edinburgh	3	Main Theatres, DSU, Pre-assessment	0131 537 1000
Royal Liverpool Hospital	2	Main Theatres	0151 706 2000 (Switchboard)
Royal Victoria Hospital Belfast	4	Main Theatres/ ENT	(028) 9024 0503 (Switchboard)

Continued on next page

Trust	AAs (AA students)	Clinical areas	Contact number
Russell's Hall Hospital Dudley West Mids.	2 (2)	Theatres, DCU and pre-op	01384 456111 (Switchboard)
Salford Royal Hospital	4 (4)	All departments	0161 789 7373 (Switchboard)
Sheffield Teaching Hospital	6 (6)	Cardiothoracic anaesthesia, pre assessment	0114 226 9696
St John's Hospital Livingston	1	Main Theatres	01506 523000 (Switchboard)
The Royal Orthopaedic Hospital Birmingham NHS FT	4	Theatres	0121 685 4000 (Switchboard)
University College Hospital London	3	Main Theatres and Interventional Radiology	020 3456 7890 (Switchboard)
University Hospitals of Leicester	5		0300 303 1573 (Switchboard)
West Wales General Carmarthen	5	All departments	01267 235151
Western General Hospital, Edinburgh	1	Main Theatres, DCN, EBU, OPD	0131 537 1000 (Switchboard)
	93 (16)		

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.

Hospitals may choose to use and adapt as appropriate the generic job description below. Other examples of job descriptions are available on the Association of AAs website.

NAME OF NHS HOSPITAL

JOB DESCRIPTION

Job role: 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 Anaesthesia Practitioner, within their code of professional practice, being aware of 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 patients history, physical examination, laboratory, radiographic and other diagnostic data and identify relevant problems.
HWB 6, level 3

To implement the anaesthesia care plan under supervision of the consultant anaesthetist.
HWB 6, level 3

To administer and/or participate in the planned administration of 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 AA role is 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
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 physiologic function and patient safety.
HWB 7, level 3

To identify and take appropriate actions related to anaesthesia equipment problems 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, respiratory care and for other acute needs.
Dimension 3, level 2

To participate in the education of patients and their carers.
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 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 any hospital and statutory requirements are met.
HWB 7, level 3
HWB 6, level 3

To use resources appropriately in order 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 the 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 rest of 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 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 of Physicians Assistants and that registration is maintained at all times.

    Staff working within the anaesthetic department are required to exercise and maintain confidentiality at all times. 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 Practitioner role develops. All changes will be undertaken in consultation with the post holder.

Appendix D: Summary of key recommendations

Planning

Before proceeding, ensure there is a sufficient body of support from the anaesthesia department to explore AAs as a potential workforce solution to service demand.

Independent sector organisations should partner with NHS organisations in their initial proposals and implementation of training.

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

Establish monthly meetings and terms of reference for key stakeholders in order to move the training forward.

Consider consulting your local organisational development specialist, or equivalent, for help in supporting any change, and use the national resources and experience available for introducing new roles.

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

Generate an action plan for introducing the training for AAs within the cluster of hospitals, with clearly agreed timescales and responsibilities.

Discussions regarding training capacity should take place with the RCoA regional representative and local workforce deanery.

Preparation

Clinical leads should have 2.5 programmed activities per week to provide teaching and administration support across the cluster of hospitals.

The tender specification must be based on the Curriculum Framework and Statement of Requirements for the national programme. Any serious variation puts at risk the national transferability of the qualification.

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

Early discussions should be held with the organisation's chair of the clinical governance committee or their equivalent to seek advice on the expectations for your particular organisation.

Ensure availability of patient information leaflets.

Implementation

Setting up robust arrangements for obtaining feedback during the first year of the training programme will ensure any major problems are avoided in the future.

Appendix E: AAGBI and RCoA Executive Summary: Scope of Practice for an AA on qualification

It remains the responsibility of those leading departments of anaesthesia, together with their constituent consultants, to ensure that Anaesthesia Associates (AAs) – work under the supervision of a consultant anaesthetist at all times.

1 The AA must work at all times 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 rests with the named consultant at all times.

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 only be delegated 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 For every case the supervising consultant anaesthetist must:

- be present in the theatre suite, must be easily contactable and must be available to attend within two minutes of being requested to attend by the AA
- be present in the anaesthetic room/operating theatre directly supervising induction of anaesthesia
- regularly review the intra-operative anaesthetic management
- directly supervise emergence from anaesthesia until the patient has been handed over safely to the recovery staff
- 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.

5 If the supervising consultant anaesthetist has to leave 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.

6 A supervising consultant anaesthetist must not provide solo anaesthetic cover for another patient.

7 The supervising consultant anaesthetist must not be responsible for more than two anaesthetised patients simultaneously, where one involves supervision of an AA. In such instances it is essential that the clinical complexity of the anaesthetic management is appropriate, i.e. ASA I – II cases undergoing minor to intermediate surgery only, and the cases should be in adjacent theatres within the same theatre suite.

8 There must be a dedicated trained assistant, i.e. an ODP or equivalent, in every theatre in which anaesthesia care is being delivered, whether this is by an anaesthetist or AA.

9 AAs cannot prescribe medication. 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.

10 The nationally agreed curriculum leads to limits on the scope of practice of AAs on qualification. On completion of training they are not qualified to undertake:

- Regional anaesthesia/regional blocks.
- Obstetric anaesthesia or analgesia.
- Paediatric anaesthetic practice.
- 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).

11 There is currently no statutory regulation arrangement for AAs. The RCoA established a voluntary register to facilitate future progress towards national regulation. Our advice will be for Fellows and Members to only to supervise those AAs who have registered with the RCoA .

12 The AAGBI and RCoA acknowledge that development of AA enhanced roles is taking place and that this remains a controversial issue. The AAGBI and RCoA would only support role enhancement when statutory regulation is in place. Responsibility where such role enhancement exists currently remains a local governance issue.

13 The potential impact on medical training opportunities continues to raise concern and must remain under close scrutiny by the RCoA and local departments.

14 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

- training that is appropriately focused and resourced
- supervision and support in keeping with practitioners' needs and practice responsibilities
- practice-centred audit and review processes

15 With reference to the range of enhanced roles currently being undertaken, standards of monitoring and supervision are as described in points 1-10 above.

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THE ROYAL COLLEGE OF ANAESTHETISTS
Churchill House 35 Red Lion Square London WC1R 4SG
020 7092 1500 info@rcoa.ac.uk www.rcoa.ac.uk
Registered Charity No: 1013887 VAT Registration No: GB 927 2364 18 Registered Charity in Scotland No: SCO37737