Trust Policy and Procedure **Document ref. no: PP (23) 460**

Policy for role of the Anaesthesia Associate

For use in:	All appropriate areas within West Suffolk NHS Foundation Trust (WSFT)
For use by:	All Anaesthesia Associates (AAs), student AAs and those who work with AAs at WSFT
For use for:	Understanding the role and governance of AAs and student AAs at WSFT
Document owner:	WSFT Advancing Roles Oversight Group
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Policy summary

Recognising the need for all Anaesthesia Associates (AAs) to maintain good medical practice, the Trust has developed the following policy to define how AAs will be employed and developed within the West Suffolk Foundation Trust. It provides a framework of standards to which the Trust and AAs working within the WSFT should adhere to. This policy incorporates recommendations from the Royal College of Anaesthetists (RCoA), the Association of Anaesthesia Associates (AAA), NHSE Workforce, Training and Education (formerly Health Education England) and has been adapted from the WSFT Policy for the Role of the Physician Associate.

Contents

1. Introduction

1.1 Purpose

The purpose of this policy is to:

- Support the development and integration of AAs within the West Suffolk NHS Foundation Trust (hereafter referred to as the Trust or WSFT).
- Provide AAs and student AAs with a governance framework that supports safe, effective, and appropriate practice.
- Provide managers with a clear governance framework in relation to potential, new and existing roles for AAs.
- Ensure adherence to legal, ethical, professional, and clinical guidance to enable AAs to practice.
- For additional detailed professional guidance readers are advised to refer to the Royal College of Anaesthetists (RCoA) website or the General Medical Council (GMC) once statutory regulation is achieved, expected to be in late 2024.

1.2 Scope

The policy is intended for use by the following people:

- All AAs and student AAs at WSFT
- All AA educational, clinical and workplace supervisors
- Line managers of AAs
- Health care professionals who work alongside AAs
- Human resource (HR) department
- Clinical education team
- Higher Education Institutions and other education and training providers
- Patients and the public
- Professional and independent regulators.

2. Definitions

2.1 Medical Associate Professionals

Medical Associate Professionals (MAPs): This is an umbrella term that encompasses three healthcare professional disciplines: Physician Associates, Anaesthesia Associates and Surgical Care Practitioners.

2.2 Anaesthesia Associate

Anaesthesia Associate: Anaesthesia Associates are highly trained, skilled practitioners that work within an anaesthetic team under the direction and supervision of a Consultant Anaesthetist. All qualified AAs have successfully completed an Anaesthesia Associate Postgraduate Diploma (formerly Physicians' Assistant (Anaesthesia) Postgraduate Diploma) and are encouraged to maintain their presence on the voluntary register held by the RCoA.

2.3 Abbreviations

Term	Meaning
AA	Anaesthesia Associate
AAA	Association of Anaesthesia Associates
AARA	Anaesthesia Associate Registration Assessment
AAVR	Anaesthesia Associate Voluntary Register
AHP	Allied Health Professionals
AROG	Advancing Roles Oversight Group
AP	Advanced practitioner
CCGs	Clinical Commissioning Groups
CDs	Controlled drugs
CPD	Continuing professional development
DHSC	Department of Health and Social Care
DNACPR	Do not attempt cardiopulmonary resuscitation
EPARS	Escalation plan and resuscitation status
GMC	General Medical Council
HCP	Healthcare professional
HEE	Health Education England
HEI	Higher Education Institution
HR	Human Resources
IR(ME)R	Ionising Radiation (Medical Exposure) Regulations 2000
MAP	Medical Associate Professional
MHRA	Medicines & Healthcare Products Regulatory Agency
NHSE (WTE)	NHS England (Workforce, Training and Education)
PA	Physician Associate
PGD	Patient Group Directions
PSD	Patient Specific Directions
RCoA	Royal College of Anaesthetists
WSFT or 'The Trust'	West Suffolk NHS Foundation Trust

3. Responsibilities

3.1 General Medical Council

The General Medical Council (GMC) will become the statutory regulator for AAs (likely timescale being late 2024) and are currently developing policies and processes to cover registration, professional guidance, education and fitness to practice.

3.2 Royal College of Anaesthetists (RCoA)

- Reviews and sets the standards for the curriculum, education and training of AAs and works with the GMC regarding the AA national registration assessment (AARA).
- Oversees and administers the running of the Anaesthesia Associate Voluntary Register.
- Developing the Faculty of Anaesthesia Associates at the RCoA (FAARCA)

3.3 Association of Anaesthesia Associates (AAA)

- Provides professional support to AAs across the U.K and acts as the professional body to campaign for progression and change in the profession by offering advice to government and taking part in national debates.
- Provides support to both qualified and student AAs in their education, training, and professional development.

3.4 Chief Executive

The Chief Executive is legally accountable for the quality of care that patients receive and for assuring patient safety.

3.5 Medical Director

- The Medical Director has shared responsibility for strategic, governance, quality, productivity, and operational decisions.
- The Medical Director also holds executive responsibility for medical governance and revalidation. Within the WSFT these responsibilities extend to the governance and future GMC revalidation of AAs.

3.6 Executive Chief Nurse

- The Chief Nurse has shared responsibility for strategic, governance, quality, productivity, and operational decisions.
- The Chief Nurse also holds executive responsibility for WSFT Advancing Roles Oversight Group (AROG).

3.7 Director of Medical Education

The Director of Medical Education is responsible for the delivery of the educational programme for student AAs within the Trust, including overseeing supervision arrangements and organising the appointment of AA student facilitators.

3.8 Head of Clinical Education

- Act as 'point of contact' within the Clinical Education Team for all AA students.
- Provides advice regarding CPD courses, funding streams and application process to qualified AAs.
- Act as an external point of contact for an AA student who has any difficulties.
- Holds a register of all medical associate professionals

3.9 WSFT Advancing Roles Oversight Group (AROG)

The purpose of the AROG is to provide oversight and strategic vision for workforce development, training and governance of the advancing workforce roles in a consistent way to ensure patient and staff safety, quality of care and effectiveness. This includes multi-professional consultant, advanced and enhanced level practice practitioners, non-medical prescribers (NMPs) and the medical associate professions (MAPs) e.g. (physician associate (PA), anaesthesia associate (AA) and surgical care practitioner (SCP). Hereafter, this grouping is collectively considered the advancing roles.

3.9.1 Key responsibilities of the AROG relating to AAs are as follows:

- Develop and maintain a robust framework for recruitment, employment, career and professional development, clinical, educational and training governance for all advancing roles, including trainee roles.
- Develop and maintain Trust's policies, guidelines and supporting materials for all advancing roles.
- To support WSFT on workforce transformation across all advancing roles.
- Develop and maintain WSFT Register for multi-professional consultants and advanced level practitioners (identifying those practitioners that meet HEE Advanced Level Directory standards), trainee APs and student MAPs and NMPs.
- Advise on standards for CPD and pathways for expanding competence and capability, supervision and appraisal.
- Support trainees and trained NMP, AP & MAP supervisors.
- Undertake random audit of clinical portfolios for all advancing roles.
- Promote CPD, interdisciplinary learning and educational sharing opportunities for all advancing roles.
- Promote and support the WSFT advancing roles forum through working collaboratively with its members.

3.10 Higher Education Institutes (HEIs)

HEIs are responsible for working with WSFT to facilitate student AA placements, including occupational health clearance of students on placement, and for ensuring quality of student AA placement experiences and the delivery of the academic components of study. WSFT is currently linked to University College London for the student AA MSC programme.

3.11 Line Manager

- Ensure that individual job descriptions encompass clinical practice; leadership and management; education; and research.
- Support the post holder to work as an AA within the service.
- Participate as an appraiser for AAs.
- Support the training and development of AAs as identified within an individuals' Personal Development Plan and in accordance with service need to improve delivery of care and support national policy.

3.12 WSFT Lead AA

Pending appointment of a Lead AA for the Trust the responsibilities of the AA representative for the AROG are as follows:

- Work with other health care professionals and managers in health and social care to develop the roles and responsibilities of the AA.
- Champion, represent and develop the AA role within the Trust.
- Advise on student AA placements and AA employment opportunities.
- Take part in the recruitment and interview process for AAs.
- Advise and participate on AA induction.
- Advise and participate in the appraisal process for AAs working at the Trust.
- Assist with the facilitation of personal and professional development of AAs.
- Liaise with HEI leads to ensure structured and well governed placements.
- Advise on the governance of the role of the AA and workforce development.
- Support supervisors of AAs in terms of development and day to day working of the AA team.
- Advise on AA CPD programmes/ forums.

3.13 Educational Supervisor

Oversee the education of the AA, act as their mentor, plan their training, monitor clinical and educational progress, and ensure the AA receives appropriate career guidance. Undertake a supervisory meeting at commencement and during their employment to:

- Establish a supportive relationship.
- Ensure an appropriate induction process (that covers Trust induction, specific speciality induction, and AA specific induction) is undertaken.
- Engage and liaise closely with the HEI delivering the student AA course.
- Ensure the WSFT process of developing competence and capability are understood. See Section 8.
- Discuss and agree personal development plan with clear objectives.
- Discuss WSFT preceptorship programme.
- Provide feedback to the AA through multi source feedback mechanisms. The mechanism of obtaining this information should be clear to the AA.
- Hold review meetings at 3 months, 6 months, and 12 months during their first year, and then annually to review work-based assessments, progress and

portfolio evidence and satisfactory progress against the AA's personal development plan (PDP) and RCoA recommendations. Update PDP as required.
- Encourage reflection and the collection of appropriate supporting information for portfolio and appraisal process. See section 10.
- Complete relevant documentation to support the development and career capability progression of the AA.
- Participate in the AA appraisal. If Educational Supervisor is unable to attend appraisal interview, they must submit a report to the other appraiser(s) prior to the appraisal.
- Offer pastoral care and support to AAs with differing needs or those in difficulty
- Discuss complaints and/or serious incidents ensuring that a reflective note is written in the portfolio.
- Liaising with the WSFT AROG, AA learning facilitator and Lead AA (when appointed).

3.14 Consultant Anaesthetic Supervisor (workplace supervisor for the clinical session)

AAs work under the supervision of a consultant anaesthetist at all times who has overall responsibility for the anaesthetic care of the patient. The supervising consultant anaesthetist is responsible for checking the preoperative patient assessment, suitability of the proposed anaesthetic techniques and patient consent.

For newly qualified AAs they 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.

If the supervising consultant anaesthetist has to leave the theatre suite for any reason, deputising arrangements must be made. A supervising consultant anaesthetist must not provide solo anaesthetic cover for another patient nor be supervising consultant 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 and the cases should be in adjacent theatres within the same theatre suite. Since AAs regulation by the GMC is not in place until 2024, AAs cannot currently prescribe medication. The supervising consultant anaesthetist must prescribe medication for each patient using the locally-developed patient specific tools on e-care that allow AAs to check and administer drugs within local guidance.

3.15 Learning Facilitator for student AAs

- Assist the HEI with any AA student placements.
- Being a named person of contact for student AAs and WSFT colleagues in respect to student AAs.
- Coordinate and deliver AA student teaching sessions as per HEI requirements.
- Participate in AA student examinations at the relevant HEI and RCoA.
- Work collaboratively with the Head of Clinical Education regarding any concerns about student AAs at WSFT.

3.16 Anaesthesia Associates

- Practise in compliance with current RCoA and future GMC guidance, being responsible and accountable for decisions, actions, and omissions at this level of practice.
- Practice within local policies when undertaking any advanced roles.
- Maintain own professional portfolio, continuing professional development (CPD) and recertification requirements as set out by the AAA and RCoA to remain on the AA voluntary register and in due course the GMC register.
- Participate in all aspects of departmental clinical governance activities, audits and quality improvement projects, and education and training events.
- Act as a mentor/buddy for student AAs and newly qualified AAs within WSFT.

3.17 Student AAs

- Always work clinically under direct supervision.
- Explore opportunities for education when on placement and discuss any educational needs with the clinical education team who may be able to arrange further training.
- Attend all training sessions required when on placement by their HEI.
- Report any absences from placement (e.g. due to sickness) to the clinical education team and their HEI promptly.
- Escalate any clinical concerns to their workplace supervisor.
- Escalate any concerns about their placement experience to the learning facilitator at WSH, Head of Clinical Education at WSFT and/or the HEI as appropriate.

4. Building Anaesthesia Associates into the workforce

4.1 General information about AAs

It is government policy to ensure that MAPs (alongside APs) are central to transforming healthcare service delivery; by providing enhanced capacity, capability, productivity, and efficiency within multi-professional teams. MAPs and APs will become a major component of the future workforce and will help to meet the needs of a healthcare service in the 21st century. Further information is outlined in the NHS Interim People Plan (NHS, 2019) and the expected Long Term Workforce Plan in 2023.

Currently, AAs are not subject to any form of statutory regulation. In July 2019, the Department of Health and Social Care (DHSC), with the support of the four UK governments, announced the GMC will become the regulator of AAs (General Medical Council, 2019). The GMC has indicated regulation is planned to be introduced in 2024. See GMC for further information. Regulation will help to increase the contribution AAs can make to UK healthcare, while keeping patients safe (General Medical Council, 2019).

AAs work as part of the anaesthetic team. They provide care for patients before, during and after their operation or procedure.

AAs are dependent practitioners working with an identifiable clinical supervisor but can work with delegated autonomy with appropriate support; see section 5.

AAs provide perioperative patient care in either a 1: 1 or 2:1 capacity depending on patient acuity. In a 2:1 model, one consultant anaesthetist supervises two AAs, or a senior trainee anaesthetist and an AA, providing anaesthetic care in two adjacent operating theatres. For patients with more complex needs, a 1:1 model may be employed where one AA works directly alongside a consultant anaesthetist to provide care for the patient. Increasingly alternative models are being employed across the UK e.g., a 1:2 model where one AA supports two consultant anaesthetists in two theatres.

AAs may be utilised to reduce operating theatre downtime, leading to increased throughput on operating lists and improved theatre utilisation. Depending on local needs, AAs may play a role in preoperative assessment, provision of sedation, cardiac arrest teams, and offer a range of other perioperative and non-perioperative support consistent with their scope of practice at qualification and subject to post qualification training and service needs. AAs may prove beneficial in supporting education for colleagues and students and are often engaged in local research and quality improvement projects.

4.2 Education and training

To enrol on a full-time AA programme, students must already hold an existing registration as a HCP with an undergraduate degree. Alternatively, they may hold an undergraduate degree in a biomedical or health/ life science field and have some prior health or social care experience.

The current HEIs offering the AA programme are the University of Birmingham (Pg Dip) University College London (MSc) and Lancaster University (Pg Dip). A typical week may consist of a tutorial, two to four days in the clinical practice and the rest involving clinical skills training and self-directed study. The standards of training are high and demanding on individuals to ensure a high calibre of competent AA graduates.

Successful graduation requires passing assessments requirement of the HEI that consists of written exams, Clinical skills Workbook completion, Record of In-Training Experience Diary, Tutor Assessments. Currently student AAs are awarded the status of Anaesthesia Associate on University graduation and are invited to become an Affiliate of the Royal College of Anaesthetists. Once the AARA is held by the GMC (probably first sitting in autumn 2025), entry onto the GMC register can only take place after successful completion of the Anaesthesia Associate Registration Assessment (AARA), when the AA will be registered to practice in the UK. The RCoA, alongside the Higher Education Institutes have a duty to ensure that the relevant standards are upheld to ensure highly skilled and safe to practice graduates.

4.3 Anaesthesia Associate Voluntary Register

- Successful completion of the approved training allows the AA to be entered on the AA voluntary register (AAVR). The RCoA currently holds the AAVR (which will transfer to the GMC with regulation), which allows employers to check whether an applicant or employee is a fully qualified and approved AA.
- The RCoA reviews applications to join the AAVR and establishes whether the AA applying is fit to practice in the UK.
- The Association of Anaesthesia Associates (AAA) has a Code of Conduct (AAA, (2016) to ensure good standards of practice and public protection and safety.
- The GMC in 2021 published Good medical practice: interim standards for physician associates and anaesthesia associates. It is expected that AAs and PAs will be included in the revised GMC GMP document in production.
- In lieu of statutory regulation, a voluntary register ensures that registrants meet agreed standards, adhere to the code of conduct, and meet set requirements to remain on the register.
- To maintain registration on the AAVR, AAs must maintain 50 CPD credits each year.

4.4 Recertification

There is no current requirement for AAs to sit any recertification process. With GMC statutory regulation these arrangements will be reviewed. It is highly likely that AAs will require an annual appraisal and revalidation system similar to doctors.

4.5 Recruitment and pre-employment criteria

- To be employed by WSFT, AAs must have successfully completed their HEI training from a UK based AA training course, and successfully passed the relevant examinations, hold affiliate membership with the RCoA and be entered on the AAVR.

- Evidence of being on the AAVR must be provided and checked prior to appointment and reviewed yearly during appraisal. Further information about the appraisal process for AAs is available in section 0.

4.6 Job description and job plans

Key recommendations are outlined below:

- A template job description/job plan and person specification for a Band 8a AA at WSFT is available from the WSFT AROG.
- The job description/job plan should be updated at least annually during the appraisal process, to accurately reflect all roles and responsibilities currently being performed.
- The job description/job plan must allow for ongoing professional development; see section 9.

4.6.1 Job plans

Job planning is recognised as an important means of linking best use of resources with outcomes for patients and as a useful element of service redesign. By documenting professional activity in job plans WSFT will be able to understand the workforce capacity and match it to patient's needs, and meet the National Quality Boards expectations on safe, sustainable and productive staffing (National Quality Board, 2016).

In line with the NHS Long Term Plan commitment, it is expected that all the clinical workforce will have an e-job plan, except staff who work exclusively in one clinical area (e.g., purely ward-based staff) and doctors in training (since e-rostering, generic work schedules and training curricula are considered sufficient for these workforce groups) (NHS England and NHS Improvement 2020).

Job plans are considered best practice when employing an AA or trainee AA (NHS England and NHS Improvement 2020). Where possible a proposed job plan should be available in the application pack during recruitment.

A job plan is a prospective, professional agreement describing an AA or developing trainee AA duties, responsibilities, accountabilities and objectives. It sets out how a practitioner's working time is spent on:

- specified direct clinical care (DCC)
- specified supporting professional activities (SPA) for example activities such as: education, teaching and training (including time for participating in supervision), continuing professional development, clinical governance activities, including attendance at departmental governance meetings, appraisal and revalidation
- other activities, such as additional NHS responsibilities and external duties.

A comprehensive job plan will show the timetabling of scheduled activities and define the number of flexibly timetabled, annualised activities. This enables monitoring of an individual practitioner's annual outputs, particularly when combined with e-rostering. In addition, a job plan should outline an AA or trainee AA's professional objectives for the coming year, including any support the WSFT will provide to enable the

practitioner to achieve their objectives. This may include a list of supporting resources or a plan to overcome any relevant barriers to meeting their objectives.

The process of job planning should be collaborative and co-operative and the job plan must be agreed, and not imposed. It should focus on enhancing outcomes for patients while maintaining service efficiency. Job planning is an ongoing process. AAs do not need to wait for an annual review to address concerns with their job plan. A request for an interim review can be made if:

- duties or needs have changed
- there are concerns surrounding whether objectives can be met.

For further guidance please refer to NHS England and NHS Improvement (2020) (2020) e-job planning the clinical workforce available at: https://www.england.nhs.uk/wp-content/uploads/2020/09/e-job-planning-guidance.pdf or An overview of job planning published by the BMA (2020).

4.7 Interviewing

It is highly recommended that the interview panel for prospective AAs should include the line manager, a consultant anaesthetist, an existing AA from WSFT, and an HR representative.

4.8 Induction

All AAs new to WSFT should attend Trust Induction; this includes student AAs.

All AAs and student AAs should have a departmental induction; this should include:

- Meeting key colleagues, both clinical and non-clinical within their area of practice.
- A tour of all areas of the building and grounds, including fire safety arrangements.
- A clear understanding of the requirements and expectations of the AA role.
- How to gain support from senior colleagues.
- Training on clinical software and systems.
- Discussion of relevant clinical guidelines, policies, and procedures
- How to access clinical and learning resources.

Each qualified AA should be allocated an educational supervisor; the specific requirements of this relationship is set out in section 0 of this policy. A WSFT specific AA induction should also be coordinated by the Lead AA (when appointed) when new AAs join the WSFT.

4.9 Career framework and salary

AAs in the NHS fall under the Agenda for Change pay scale. Guide bandings for recruitment are suggested but not limited to:

- Band 7 – for student AA's and AAs going into a substantive service delivery post.
- Band 8a - for AAs with leadership and management responsibilities, and/or additional clinical responsibilities.

NHS WTE (formerly HEE) is working collaboratively with key stakeholders including the RCoA and the AAA to develop a nationally agreed career development

framework to link to HEE & Skills for Health's (2022) Core Capability Framework for Medical Associate Professions to inform career progression.

Since the introduction of AAs in the UK workforce, the AA career structure and development has been organic and deliberately non-prescriptive to allow for workforce innovation and the ability for individuals to be responsive to local healthcare needs. AAs who have expanded their clinical and/or non-clinical scope of practice to meet service needs may require a job evaluation exercise to be performed.

4.10 Professional identification

AAs have a distinct role and remit within the wider multidisciplinary team. It is important that AAs identify themselves to patients and colleagues. There is no national or professional requirement for AAs to wear a specific uniform. AAs should always be dressed appropriately for the environment they work in. Further information can be found in the *Dress Code Policy* PP(19)215.

4.11 Indemnity

Currently, AAs practising in secondary care are indemnified under NHS Resolution (previously known as NHS Litigation). To be covered under this, AAs and student AAs must adhere to all local policies and guidelines, and AAs must be operating within their job description/job plan and contract of employment.

Where an AA (listed on the AAVR) is practicing within their agreed scope of practice, job description/ job plan, contract of employment, and following all appropriate local policies and guidelines, WSFT will accept vicarious liability for their actions, covering costs and damages arising from clinical negligence. This relates to acts and omissions of healthcare staff whilst working under a contract of employment and where the negligence occurs in the course of that employment.

Key issues for this vicarious liability and indemnity are that the job descriptions / job plans are kept up to date.

The AAA encourage AAs to take out personal indemnity insurance for their practice (to provide additional private coverage and medicolegal advice); although, it is not required under NHS Resolution indemnification. Further advice on indemnity is available through NHS Employers.

4.12 Return to practice

Where an AA is returning from a break in practice, they must notify their line manager and educational supervisor to discuss whether a return to practice programme is required. In some circumstances, AAs may require a period of direct supervised practice.

4.13 Fitness to practice

Concerns about the performance or behaviour of an AA should be discussed with the individual in the first instance and their immediate clinical supervisor. Further

discussions may involve the educational supervisor, and as appropriate, the service lead consultant and line manager.

Discussions about fitness to practice should always remain factual and avoid subjective opinions and bias.

If the AAs performance is not reaching the required standard the clinical supervisor should discuss this with the AA as soon as identified and ensure:

- A written record of the meeting is kept.
- Corrective measures are put in place as soon as possible with clearly defined written objectives.
- That the AA is given an opportunity to correct any learning needs identified within an agreed supportive plan that may include support from the clinical education department.
- The appropriate line manager and lead consultant should be informed of any significant problem.

5. Supervision and accountability of AAs

5.1 Regulation and delegation

Currently the AA profession is unregulated; however, the Department for Health and Social Care on behalf of the UK Governments, has announced the General Medical Council (GMC) will be the statutory regulator for AAs (General Medical Council, 2019). This is expected to be in late 2024.

Once statutory regulation is in effect, the title 'Anaesthesia Associate' will become protected, and only those on the statutory register will legally be allowed to practise as an AA.

In lieu of statutory regulation, AAs can currently practice in the UK because of a clause within the British General Medical Council's (2013 a,b) guidance on Good Medical Practice Delegation Clause, paragraph 45 [1].

'*45. When you do not provide your patients' care yourself, for example when you are off duty, or you delegate the care of a patient to a colleague, you must be satisfied that the person providing care has the appropriate qualifications, skills and experience to provide safe care for the patient.'*

When a doctor delegates an aspect of a patient's care or treatment to an AA, the AA must practice in compliance with their code of conduct, act within their agreed scope of practice, and is responsible and accountable for their decisions, actions and omissions. The consultant retains overall responsibility for the care of the patient.

5.2 Types of supervision

The following four types of supervision are involved in the supervision of AAs:

5.2.1 Line management supervision

The terms managerial supervision and line management maybe used interchangeably. The line manager will have responsibility for rostering shifts, approving annual leave and study leave requests, managing absenteeism and other workplace issues. Line managers will assist in the appraisal process of AAs within a tripartite arrangement (with the educational supervisor, and the WSFT lead AA, or a MAP peer colleague in the lead AA's absence) and may set priorities/objectives in line with the organisation's objectives and service needs.

The following have been adapted from Health Education England's document on the supervision of postgraduate doctor training (NHS Health Education England).

5.2.2 Educational supervision

Each AA should have an educational supervisor assigned to them; this should be a consultant from their speciality who has ideally undergone educational supervisor training. A list of appropriate individuals is held with the Director of Medical Education.

AAs will require a variable amount of supervision in their career; this will vary from individual to individual and lessen over time. As AAs learn new skills and take on new responsibilities, supervision arrangements will need to be appropriate. On this premise, the scope of practice and supervisory requirements for the AA must be regularly reviewed in line with section 0.

If the relationship between the AA and the educational supervisor is not mutually beneficial, the AA should discuss this with their educational supervisor and/or managerial supervisor. In some cases a new educational supervisor may need to be identified.

5.2.3 Workplace supervision

Every AA needs some degree of supervision in the workplace. The less experienced the AA, the more direct supervision they will require. As part of a multidisciplinary team, the AA is initially accountable to their immediate consultant supervisor.

AAs must work under the supervision of a consultant anaesthetist who has full registration with the General Medical Council and appears on the speciality register. Every AA should always know the name of this supervisor during the clinical session, and how to contact them. The consultant must be available to advise and assist the AA as appropriate; sometimes this will require the consultant's urgent presence but, on many occasions, less direct involvement will be needed. Further information on the role of the supervisory consultant anaesthetist is outlined in section 3 and within the Executive Summary: Scope of Practice for a PA(A) at qualification publication (RCoA 2016). Post qualification the process for developing the AAs capabilities and scope of practice is covered in section 8.

However, with certain tasks or skills a separate workplace supervisor can supervise the AA. Workplace supervisors have delegated authority from the Clinical Lead Supervisor with overall patient responsibility. This will usually be the Consultant responsible for the operating list.

As part of their workplace supervision, healthcare professionals should routinely inform the workplace supervisor, clinical supervisor, and AA's educational supervisor about the performance of the AA in the workplace.

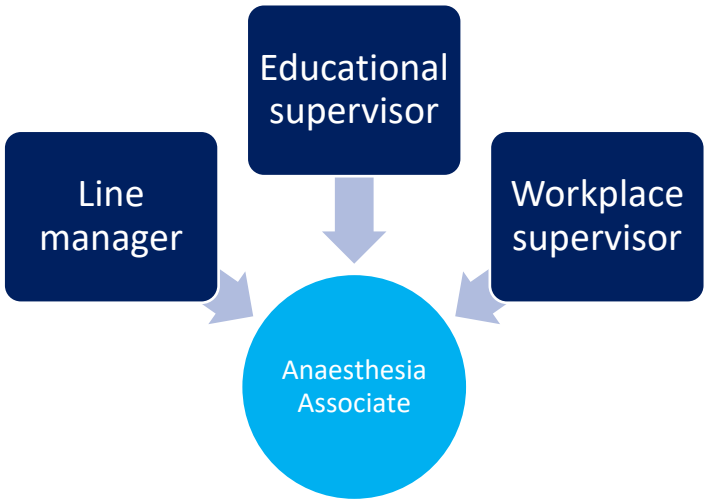

Figure 1 - Supervision of AAs

5.3 Accountability

All AAs must be listed on the RCoA anaesthesia associate voluntary register.

AAs are professionally accountable for their own actions, decisions, and omissions. AAs are accountable to their immediate workplace clinical supervisor, their educational supervisor, lead consultant for their speciality, and ultimately, the medical director.

Appendix 3 provides an organisational chart for the responsibility for the Trust wide development / leadership of AAs.

5.4 Considerations for new AAs

It is recognised that a new AA graduate will require more intensive supervision compared to an experienced AA. For new graduates, or for AAs who move into a new clinical role, it is recommended that the first year is a period to consolidate their core knowledge and skills and develop their competence in clinical practice.

During this period, the AA should be supervised more closely, have experiential leaning in the clinical area, and should maintain their portfolio which is regularly reviewed with their educational supervisor.

The level of support and supervision an AA requires should lessen as the AA develops knowledge, skills, and confidence.

5.5 Preceptorship programme

It is highly recommended that all new qualified AAs are enrolled onto the WSFT multi-professional preceptorship programme. This is a structured programme with mandatory study days, which cover elements of generic professional capability.

Further information about the preceptorship programme can be obtained via the clinical education team.

6. Clinical practice

6.1 Introduction

AAs manage patients according to legal, ethical, and professional guidance, corporate and clinical policies, local/ national guidelines, acting within an agreed scope of practice and predetermined level of supervision. Practitioners are responsible and accountable for decisions, actions and omissions at this level of practice. Supervision of AAs is discussed in section 0. Core skills listed below are not exhaustive and may change with the introduction of the new AA curriculum. This will include peripheral nerve blocks and spinal anaesthesia.

6.2 Core skills

- Perform initial patient assessment and examination, request and interpret investigations, formulate an appropriate anaesthetic plan, and discuss with patient and supervising anaesthetic consultant.
- Implementation of anaesthetic care plan subject to agreed scope of practice and local governance arrangements.
- Perform diagnostic/therapeutic procedures (core*and extended skills**) subject to agreed scope of practice and local governance arrangements.
- On qualification induction and reversal of anaesthesia should be supervised directly. In time this can be indirect under prior departmental agreement and sign-off and ensuring that there are no specific patient concerns and confirming rapid consultant support if requested.
- Initiate, evaluate and modify a range of interventions which may include administration of fluids, blood products and medications during anaesthesia.
- Initiate and communicate a comprehensive plan of care for recovery staff to follow.
- To be available for any postoperative concerns that may occur. To hand over any concerns to the on-call person at the end of the session.
- Facilitate productive team working by communicating effectively within the multidisciplinary team and internal and external stakeholders to facilitate productive team working.
- Produce accurate, contemporaneous, and complete records of patient consultation, and electronic anaesthesia records consistent with legislation, policies, and procedures.
- To understand when a patient's care is beyond own clinical limitation and to liaise with senior members of the team, or other professionals for advice
- Work in partnership with individuals, families, and carers to promote person-centered approaches in health and care.
- Demonstrate effective communication skills to promote shared decision making to enable patients to make informed choices with planning care and consenting to treatment.
- Effectively communicate with and support patients and families receiving complex information or bad news.

- Anticipate barriers to communication recognising the need for alternative methods to overcome different levels of understanding, cultural background, and preferred ways of communicating.
- Act as an advocate for patients and carers.
- Ensure awareness of sources of support and guidance (e.g. PALS) and provide information in an acceptable format to patients and carers recognising any difficulties and referring where appropriate.
- Empower patients in meeting their own health and wellbeing needs by providing health promotion and disease prevention advice, information, and support.
- Participate and lead quality improvement activities, including clinical audit.
- Deliver education and training events.
- Participate in departmental research and quality improvement initiatives.

6.3 Extended clinical skills

The pathway for extending clinical skills (otherwise known as expanding scope of practice) is outlined in section 0.

Extended clinical skills may include regional anaesthesia, neuraxial anaesthesia, advanced venous access or more complex cases. Other procedures are subject to agreed scope of practice and local governance arrangements.

6.4 Consent

AAs must be aware of the WSFT policy on consent for examination or treatment document PP (16) 113 and the GMC guidance on Decision Making and Consent (General Medical Council, 2020). AAs can obtain verbal and written consent for skills that they are familiar with, providing that the verbal consent is documented.

6.5 Ordering investigations

- AAs can request standard blood tests autonomously.
- AAs can request specialist blood tests under instruction by a workplace or clinical supervisor.
- AAs cannot request any investigations that involve ionising radiation (see section 0).
- AAs can discuss all imaging requests with the duty radiologist.
- All imaging requests must be sanctioned by the clinical supervisor or workplace supervisor, who takes overall responsibility for reviewing and acting upon the results of that investigation. The rationale for the request must be clear to both the requesting and reporting clinicians.

6.6 Ionising radiation

The use of ionising radiation has been subject to specific legislation since 1988. Guidance on the Ionising Radiation (Medical Exposure) Regulations 2000 and amendments made in 2017, known as IR(ME)R, state that only registered healthcare professionals are able to order ionising radiation. Further information is available within Guidance to the Ionising Radiation (Medical Exposure) Regulations 2017

(Department of Health and Social Care 2017). Therefore, as AAs currently lack statutory regulation, they are currently unable to make requests for ionising radiation. This will be reviewed once GMC registration is in place.

AAs may discuss requests for an ionising radiation investigation with radiologists, on behalf of a registered clinician who orders the test as appropriate.

6.7 Blood transfusions

All AAs must be aware of the following WSFT policies and clinical guidelines:

- CG10010 Blood policy administration
- CG10126 Transfusion reactions
- CG10146 Transfusion training
- CG10079 Pathology sample requests, identification, and acceptance
- CG10089 Major Haemorrhage
- CG10298-2 Non-medical authorisation of blood

AAs can request ‘group & screen’ samples, but not crossmatch samples. AAs can administer blood products as required during anaesthesia subject to the correct training and with agreement from the supervising consultant. This includes the administration of autologous blood collected via a cell saver unit in line with correct procedure.

6.8 Clinics

AAs can assist in pre-operative assessment clinics under supervision of the consultant anaesthetist. A consultant anaesthetist must be available for the AA to seek clinical advice.

6.9 Escalation plan and resuscitation status (EPARS) decisions

- AAs are not authorised to make independent decisions regarding resuscitation status.
- AAs may be involved in discussions with patients and relatives around end-of-life care and resuscitation if this is likely to have an impact on their anaesthetic care. The AA is responsible for clearly documenting the discussion.
- Further information is available in policy PP (17) 305 Escalation Plan for Resus Status (EPARS) including DNACPR.

7. Medicines management

7.1 Initial registration

AAs listed on the AAVR are expected to have a good understanding of the appropriate medications and doses to be given for a range of conditions across a range of specialties that could potentially affect the delivery of anaesthesia.

7.2 Prescribing rights

AAs are currently an unregulated profession in the UK and therefore are currently not able to prescribe medication. Prescribing rights for AAs may change once GMC statutory regulation is introduced. AAs who hold independent or supplementary prescribing qualifications from being registered with a regulated healthcare profession should not prescribe whilst working as an AA within the WSFT.

7.3 Responsibility and accountability

- By working under medical delegation clauses, AAs can determine and propose appropriate therapeutic interventions from the full range of available prescription medications used in the clinical setting. All therapeutic agents must be prescribed by a registered prescriber.
- Although legal responsibility for prescribing lies with the prescriber who signs the prescription, AAs who advise on medicines are professionally accountable for their actions and omissions and cannot delegate this accountability to any other person and must be prepared to explain and justify their decision-making.
- A pre agreed list of accepted anaesthetic drugs must be included in the patients records electronically on e-care between the AA and the supervising consultant. This will be initiated on the PSD for Anaesthesia Associates tab in the Anaesthetic (Adult) order set in eCare by the supervising Consultant Anaesthetist (see section 7.6)
- AAs must have a working knowledge of and adhere to all WSFT medicines management policies, protocols, and procedures.
- AAs must be aware of national and local guidance relevant to their field of practice.
- AAs must work within their own level of professional competence and expertise. They must always adhere to current legislation and the AA professional code of conduct and professional prescribing standards.
- AAs must ensure they familiarise themselves with Royal Pharmaceutical Society publication *A Competency Framework for All Prescribers* (Royal Pharmaceutical Society, 2021), the British National Formulary, National Institute for Health and Care Excellence, the Medicines and Healthcare products Regulatory Agency (MHRA) and its drug safety updates, and the Yellow Card Scheme for reporting adverse incidents with medicines in the UK.
- Adverse drug reactions, medication related incidents and near misses should be reported via Datix.

7.4 Advising on medicines

- The provision of medication advice by AAs should always be based on clinical suitability, research evidence, cost effectiveness and adherence to current legislation, organisational/ local CCG medicines policies/ formularies.
- AAs will only provide medication advice following guidance outlined by A Competency Framework for All Prescribers (Royal Pharmaceutical Society, 2021).
- AAs are responsible for communicating their role as a non-prescriber to both patients and the prescriber verbally and where appropriate in writing.
- Medication advice should only be given following comprehensive clinical assessment of the patient; informal medication advice should not be given by AAs who are unfamiliar with the specifics of the case.
- If further information or confirmation of information is required before advising on medicines, AAs will need to ask for the patient's consent prior to contacting their GP or other clinical service.
- AAs may advise on controlled drugs (CDs) where they are aware of current legislation, national/ local policies and guidance around prescribing and the safe use and management of controlled drugs. All appropriate WSFT guidance on restrictions and strategies to reduce risks with the prescribing of controlled drugs must be adhered to (WSFT policy for the use of medicines PP (19)200).
- AAs may advise on medicines for use outside of their licence indication/ UK marketing authorisation ("off-licence" or "off-label" use) if considered clinically appropriate. In order to advise off-label, the AA must:
  - Be satisfied that it would better serve the patient's needs than a licensed alternative.
  - Be satisfied that there is a sufficient evidence base to demonstrate its safety and efficacy.
  - Explain to the patient in broad terms why the medicines are not licensed
  - Make clear, accurate and legible records for all medicines prescribed and the reason for prescribing off label.
- AAs cannot advise on any unlicensed medicines i.e., products without a UK marketing authorisation/ product not licensed for human use for any indication or age group.
- AAs providing medication advice must have access to regular continuing professional development as appropriate to maintain their competencies/ capabilities for providing medication advice.
- AAs have a responsibility to ensure that they are aware of the legal requirement around prescribing for a person who may drive whilst taking medicines and the advice and guidance they have to give around the effects of the medicines. For further information, all AAs should access the Driver and Vehicle Licensing Agency website: http://www.dft.gov.uk/dvla/medical/aag.aspx

7.5 Patient Group Directions

Patient Group Directions (PGDs) are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment (Royal College of Nursing, 2021). PGDs

can only be used by those health care professionals listed in legislation. AAs are currently not included and therefore cannot operate under a PGD.

7.6 Patient Specific Directions

A Patient Specific Direction (PSD) is a written instruction, signed by a prescriber for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis (Royal College of Nursing 2021). AAs can administer medicines under a PSD.

The PSD for each anaesthetic episode will be initiated on the *PSD for Anaesthesia Associates tab in the Anaesthetic (Adult) order set* in eCare by the supervising Consultant Anaesthetist prior to the case commencing. Any medication considered inappropriate for that case will be deleted and documented in the comments section. Should the patient need to return to theatre, even on the same day, a new PSD must be initiated by the Consultant as the clinical situation has changed.

The PSD details the anaesthetic related medications that the AA may need to use during an anaesthetic. The listed medications will be available to use if clinically indicated but the majority will frequently not need to be used. Once the anaesthetic episode is finalised a copy of the medications used during the anaesthetic will automatically appear in the patient record as administered but will not form an active prescription. Post-operative medications are prescribed separately from the PSD by the supervising consultant.

The AA will have been trained and assessed in the theoretical knowledge, clinical application and practical use of all the medications listed in the PSD during their University course.

7.7 Administering medicines

WSFT policy for the use of medicines PP (19) 200 provides guidance on safe and effective prescribing, dispensing and administration of medicines and specific considerations in the administration of drugs (such as intravenous drugs and controlled drugs).

The administration of medications is a high-risk procedure. It is recommended that the educational supervisor ensures that the AA has undertaken, where necessary, recognised WSFT training and has been assessed as competent; see section 0 and 0. Prior to delegating the administration of medicines, the clinical or workplace supervisor must be satisfied that the AA is competent. The safe administration of anaesthesia is the central component within the AA Pg Dip and MSc curriculum.

7.8 Summary of administration of medications

Further details about administration of medicines is listed in Table 1below

Table 1

Summary of administration of medications

Criteria	Administration allowed?
Patient specific direction (PSD) Administer medication under a PSD	Yes
Patient group direction (PGD) Administer medication under a PGD	No
Transfer delegated tasks to another healthcare professional or individual to administer medications on their behalf	No
Non-parenteral medications e.g. oral, nasogastric, rectal, and nebulised	Yes
Subcutaneous / intramuscular e.g. injections	Yes
Intravenous Prior to administering intravenous drugs AAs must complete training and assessment of competence according to WSFT local arrangements	Yes
Normal saline flushes e.g. in intravenous cannulation	Yes
Oxygen In the event of an emergency, oxygen may be administered by an AA without a prior prescription, however this should be documented after the emergency.	Yes
Entonox by self-demand Prior to administering Entonox by self-demand AAs must complete training and assessment of competence according to WSFT local arrangements	Yes
I**ntrathecal** For the purpose of administering regional anaesthesia only	Yes
Blood products and components (packed red blood cells, platelets, fresh frozen plasma, cryoprecipitate, or granulocytes)	Yes
Systemic anticancer therapies Chemotherapy and/or immunotherapy for use in anticancer treatment.	No
Emergency situations AAs who hold a valid Adult Advanced Life Support certificate from the Resuscitation Council UK may administer without a prescription the following: Adrenaline 1:10,000 up to 1.0mg via the intravenous route and amiodarone 300mg iv as per UK Resuscitation guidelines 2021 (Resuscitation Council UK, 2021). All AAs may administer medications listed in Schedule 19 of the Human Medicines Regulation 2012 (Legislation.gov.uk, 2012) for the purpose of saving a life in emergency.	Yes
Controlled drugs Schedules 2-5 can be administered by an AA under a patient specific directive. Local guidance for the administration of controlled drugs as outline in WSFT Policy for the use of Medicines PP (19) 200 must be followed.	Yes

7.9 Transcribing medications and documenting medicines histories

Transcribing medications is the act of making an exact copy of previously prescribed medicines to enable their administration (Royal College of Nursing, 2020). AAs must not transcribe medications.

Initiation of new medication or changes to prescriptions can only be made by a qualified and registered prescriber.

AAs can document medications histories on eCare (from a recent inpatient drug chart or primary care list or patient's medications source). It is essential that the AA ensures a registered prescriber reconciles these into a prescription, as appropriate.

The AA is responsible for ensuring that time-critical medications or treatments are not delayed because of the patient seeing an AA.

8. Development and assessment of competence and capabilities

8.1 Introduction to expanding scope of practice

It is essential that AAs are both competent and capable within their role, specialist area of practice and setting, and that competency and capability develop as their career both changes and/or progresses across clinical practice, leadership and management, education and research. Career changes and progression may require the AA to further develop and demonstrate their competence and capability (NHS Health Education England, 2019).

'Ensuring and advancing high quality and safe patient care depends on an infrastructure for ongoing learning, assessment and feedback' that supports lifelong learning (Cate and Carraccio, 2019). Assessment provides assurance to the AA, their supervisor, employer, and the public that a satisfactory level of competence and capability has been achieved. Assessment also delivers important feedback to the AA to help them identify potential areas where further training and development may be needed (NHS Health Education England, 2019).

AAs must be able to recognise what level of competence is required within any given situation and apply this, successfully recognising the limits of their competence. Capability may also require the AA to have the ability to extend these limits when required and flexibly adapt to unfamiliar professional environments (NHS Health Education England, 2019).

AAs must practice in compliance with legal, ethical and professional guidance, corporate and clinical policies, local/national guidelines, acting within an agreed scope of practice and predetermined level of supervision, being responsible and accountable for decisions, actions and omissions at this level of practice.

8.2 Expanding scope of practice within specified practice setting and role to support role development and career progression

As part of lifelong learning, the Trust expects AAs to develop competence and capabilities in a manner that upholds a high standard of care, and to safeguard the patient, practitioner, and the Trust. Appendix 2 is a flow chart that summarises the key steps as outlined below.

Step 1. Scope of practice

Agreement must be reached to expand the AAs scope of practice (clinical practice, leadership and management, education, or research) according to service demands. The agreement should be between the AA, the educational supervisor, the lead consultant, the line manager and service manager as appropriate.

Step 2. Competencies and capabilities

Agreement must be reached on expected competencies and capabilities pertaining to expansion of scope of practice, recognising that scope of practice varies according to which professional regulatory/registration bodies a healthcare professional is registered with. Within the WSFT if an AA holds dual registrations (e.g. with the RCoA AAVR and Nursing & Midwifery Council (NMC) or Health and Care Professions Council HCPC), any agreement on expansion of role must fall within the agreed scope of practice of the AAVR and not the NMC/HCPC.

Before new competencies and capabilities are introduced, the required educational and assessment framework or entrustable professional activity (EPA) must be agreed between the Lead Clinician, Clinical Director and the WSFT Advancing Roles Oversight Group.

Wherever possible the practice of each competence and capabilities associated with a high-risk procedure must be supported by an organisational policy, procedure, protocol, or guideline.

Step 3. Learning plan

To augment existing competencies and capabilities of the AA, a learning needs analysis must be undertaken to generate an individual learning plan within a tripartite agreement between the AA, educational supervisor, and line manager. The format that training and supervision takes will vary according to the expected competencies, capabilities and agreed learning plan. Training may include a variety of learning modalities e.g. direct observation, e-learning, self-directed study, simulation, and recognised courses.

Agreement should be reached upon the range of evidence to demonstrate expected competencies and capabilities and the approved sign-off / summative assessor.

All learning should be recorded into the AA portfolio.

Step 4. Education and workplace supervision

Established AAs who have organisational agreement to expand their scope of practice should be matched with workplace supervisors who can best support identified training needs in knowledge and skills development. A workplace supervisor will not necessarily hold the same professional registration as the AA. Given the need to ensure that the workplace supervisor is qualified and competent to train at the required level of practice, all AAs must seek guidance from their educational supervisor, lead consultant or line manager.

See Section 0 for further information regarding AA supervision.

Whenever possible the named sign-off / summative assessor and workplace supervisor roles should be undertaken by different people, although it is recognised that at times the same individual may provide both roles; in such a circumstance, it should be clear if the supervisor is working in a summative or formative capacity.

The educational supervisor and work-based supervisors for AAs should meet the requirements for these roles in line with HEE requirements (Health Education England). All supervisors are required to be appropriately supported and trained in supervision practice and given adequate time in their job plans to fulfil the role (COPMed, 2020).

Doctors who are educational or clinical supervisors are required to be recognised and/or approved in line with GMC Recognition and Approval of Trainers requirements or meet the requirements of any future standards for supervisors practice published by HEE.

Step 5. Collection of supporting evidence for portfolio

Work based assessments (WBAs) are increasingly grouped into formative supervised learning events as assessments for learning, and summative assessments of performance and learning (COPMed, 2020).

Learning to augment the existing clinical competence and capabilities of an AA must involve the use of formative SLEs/ discussions that capture low stakes episodes of feedback and learning utilising several different work-based assessment tools where appropriate. WBAs provide a method of obtaining a series of snapshots of aspects of practice which are used to guide learning, evaluate progress, provide high-quality narrative feedback on performance, and assess competence and capability in each situation.

WBAs must be utilised to assess the development of competency and capability that may support career development and changes to the AA role. WBAs are also integral to the assessment of on-going competence and capability for the AA as part of the appraisal process.

In addition to WBAs, AAs are required to collect range of supporting evidence to demonstrate competences and capabilities for example: logbook of operative/ procedural activities including complications, continuing professional development, reflections, patient/ carer feedback, significant event analysis, evaluation of teaching, learning and assessment activities, research/audit/quality improvement activities.

Sources of evidence must be documented within the AA portfolio. The number of formative assessments undertaken prior to a summative assessment is not stipulated.

WBA templates/portfolio tools are accessible via the RCoA website. HEE have provided a brief summary of the following commonly used assessment tools: Acute Care Assessment Tool (ACAT), Case Based Discussion (CbD), Direct Observation of Procedural Skills (DOPS), mini Clinical Evaluation Exercise (miniCEX), Multi Clinician Report (MCR), Multi-Source Feedback (MSF) (NHS Health Education England, 2019).

Step 6. Review of supporting evidence for portfolio

The AA must submit all supporting evidence to demonstrate they meet expected agreed competencies to previously identified 'sign off' assessor/s. Where possible each piece of submitted evidence should state why a capability is demonstrated. Adequate time must be agreed between submission and a sign off/ entrustment decision to enable a comprehensive review of supporting evidence to occur.

Step 7. Sign off/ and entrustment decisions (summative assessment)

Approved 'sign off' assessor/s must be suitably authorised, registered professionals who have the competences and capabilities in the required area of practice relevant to the role of the AA, and are aware of the benchmark level of competence/ capability at the required level of practice. This will generally be a consultant anaesthetist but in certain situations an experienced MAP or AP, or a member of the multi professional team (NHS Health Education England, 2019). They must be appropriately trained to assess work-based learning at the required level, be familiar with the chosen WBAs, the review process of supporting evidence and trained to facilitate reflective feedback (NHS Health Education England, 2019).

Each capability must have sufficient evidence to demonstrate achievement. Reliability of this process is increased where the evidence is triangulated. Triangulation consist of applying evidence that reflects capability through writing, observation, and conversation.

Since an entrustment decision implies the acceptance of risk, as it can never be fully predicted what the AA will encounter, the AA wherever possible should not choose either the 'sign off' assessor/s or cases for summative assessments. Whenever possible, the sign off process (summative assessment) should be undertaken by different professional/s to those involved supervised learning events (Health Education England, 2019). To avoid subjective bias, entrustment decisions should include an agreement between multiple observers that the entrustment is justified.

The entrustment and supervision scale is in line with the AA student curriculum, RCoA guidance for AAs due for publication in the first half of 2023 and that being used by the GMC in developing the AARA. Readers are directed to the RCoA Anaesthesia

Associate webpages for contemporaneous documents at Anaesthesia associates | The Royal College of Anaesthetists (rcoa.ac.uk)

Table 2 – Supervision and entrustment scale

Supervision Scale	
Levels	**Definitions**
Level 1a	Supervisor present in theatre throughout and required to assist case with proactive involvement
Level 1b	Supervisor present in theatre throughout and available to assist reactively when needed.
Level 2a	Supervisor in theatre suite, available to guide aspects of activity through monitoring at regular intervals.
Level 2b	Supervisor within hospital for queries, able to provide prompt direction/assistance.
Level 3	Supervisor on call from home for queries able to provide directions via phone or non-immediate attendance
Level 4	Should be able to manage independently with no supervisor involvement (although should inform consultant supervisor as appropriate to local protocols).

Supervision Level 2b equates to remote clinical supervision. This enables the AA to work with more delegated autonomy for a specific activity agreed during the 'sign off' process. It is essential that if an AA is remotely supervised a consultant anaesthetist must be readily contactable, if not immediately available in person. This would include the supervisor and AA working in different locations within the theatre complex at WSFT. There must be regular supervision meetings which must include a review of a sample of medical records from patients managed by the AA. Different levels of supervision may be required for different tasks.

Step 8. Record Keeping

Summative assessment (sign off) and evidence of assessment must be recorded within the AAs portfolio. Follow local guidance for record keeping.

Step 9. Job descriptions or plans

Line manager in conjunction with AA should consider the need for amendments to job descriptions or job plans.

Step 10. Appraisal

Evaluating and assessing the competence and capability of each AA through reviewing evidence within a logbook and portfolio is an essential part of the appraisal process. See appraisal section 10 within this policy.

8.3 Assessment of portfolio evidence/ role of the Advancing Role Oversight Group (AROG)

Random audit of advanced practice portfolios by a panel will be undertaken for AAs and coordinated by the WSFT AROG. On request all AAs must be prepared to submit their portfolio.

9. Continuing Professional Development

9.1 Introduction

Following graduation as an AA, CPD is the process by which an AA builds on and develops their knowledge, skills, behaviours and attitudes and keeps up to date. A lifelong commitment to CPD is vital to assure fitness to practise as a condition of regulation. The focus of CPD must be on the outcome (Health Education England 2019).

An AA is required to maintain their breadth of competence and broad clinical knowledge base throughout their professional career. While some AAs may work in specialist areas, the additional expertise that they may acquire fields through experience or further training, is in addition to this general competence and not a substitute for it.

As the career of an AA progresses, they may change specialist areas of practice, take on teaching, management, or leadership roles, or move into academia. CPD is important to plan for and support personal and professional development (NHS Health Education England, 2019). CPD should be tailored to the scope of practice of the AA. It is the responsibility of each AA to undertake sufficient CPD to remain up to date and fit to practise.

9.2 Planning CPD

AAs are personally responsible for identifying their ongoing CPD activities, and for planning how these needs should be addressed and undertaken to support their professional development. Current statutory and voluntary regulators of MAPs have developed CPD guidance to support MAPs in maintaining and developing their professional standards.

On appointment, the CPD requirements of the AA, linked to their PDP, should be agreed by the AA, and their educational supervisor. This should be reviewed regularly in the first year in post. Thereafter the CPD should be linked to the assessment programme, appraisal process and PDP, with flexibility should the role of the AA change between appraisals (NHS Health Education England, 2019).

An individual also has the flexibility to undertake additional CPD activities that may not have been recognised during annual appraisal such as opportunistic learning events that can arise at any time or development needs that may change during a 12-month period (NHS Health Education England, 2019).

CPD activities should be in line with the requirements of their employers and aim to maintain and improve the care that AAs provide. Activities should be shaped by assessment of the needs of the AA and their multi-professional teams and the needs of the service users. CPD should focus on outcomes or outputs and what has been learnt and understood from the activity, its potential impact on practice, patients, carers, and service delivery.

It is important that attendance at CPD and other attainments can be evidenced, documented, and reviewed, ensuring that an AA can demonstrate sufficient learning to support their practice. It is entirely appropriate that this can be by a process of reflection (NHS Health Education England, 2019).

AAs working full time and less than full time have an equal obligation to provide high quality patient care and must meet the same requirements for CPD.

All registered AAs will be required to provide documentation that they are participating in CPD.

More detailed information is available in HEE *'Establishing Common Standards For Continuing Professional Development, Assessment and Appraisal for Medical Associate Professionals' (NHS Health Education England, 2019)*

9.3 Study leave and study budget

To support the attainment of CPD and AAVR registration, WSFT offers each employed AA 30 study days over a 3-year period. There is a study leave budget to support this; the medical education team can provide further details, in addition to the WSFT study leave policy. Attendance at mandatory training will be in addition to these 30 days but will be at the discretion of their educational supervisor and line manager.

All study leave must be approved via the educational supervisor and agreed by the line manager; further information is available in Study leave policy PP (19) 067.

More detailed information is available in HEE's *'Establishing Common Standards for Continuing Professional Development, Assessment and Appraisal for Medical Associate Professionals'.*

10. Appraisal

10.1 Introduction and key principles

Specific considerations for an AA in their first 12 months of a new job are set out in section 5.0. After the initial 12 months, all AAs should have an annual appraisal.

AAs are expected to participate in the WSFT Individual Performance review / appraisal process according to WSFT PP (17) 184. In addition to the WSFT individual performance review (IPR)/ appraisal process, AAs are required to demonstrate they are continuing to meet the principles and values set out in the GMC Good Medical Practice: interim standards for physician associates and anaesthesia associates (General Medical Council 2021).

It is essential that the appraisal process should also adhere to the principles of the GMC appraisal processes and cover the following four domains of GMC Good Medical Practice (General Medical Council 2013b).

- Domain 1 Knowledge, skills, and performance
- Domain 2 Safety and quality
- Domain 3 Communication, partnership, and teamwork
- Domain 4 Maintaining trust

The appraisee must provide evidence of their inclusion on the AAVR at their annual appraisal.

An essential component of the AA appraisal interview is a focused self-review supported by information related to the full scope of practice. It is a protected time to focus on:

- Critically reflecting on achievements, challenges and lessons learnt, including reviewing the previous year's personal development plan objectives.
- Reviewing information about both clinical duties and how the quality of work is maintained and, where appropriate, extended and improved.
- Evaluating and assessing the competence and capability of each AA through reviewing evidence within a logbook and portfolio.
- Establishing aspirations, identifying learning needs and recording new personal development plan objectives.

10.2 Appraisers

It is recommended that there are three appraisers to adequately represent all aspects of the AA role: the line-manager, the educational supervisor, and the lead AA (or a peer MAP colleague in their absence). This tripartite arrangement may alter based on the role of the AA. If the educational supervisor is not present at the appraisal interview, a supervisor report must be submitted. The educational supervisor should arrange for multi-source feedback of the AA to be provided at the appraisal. It is recommended to have the lead AA or another senior AA or MAP colleague present at the appraisal discussion to guide profession specific discussion.

10.3 Responsibilities of the appraisee

Ensure an annual appraisal is undertaken, using a mechanism that adheres to the requirements of the WSFT IPR/ appraisal process and the AA policy plus the requirements from the GMC following regulation.

Collecting information to enable the appraiser(s) to review the quality of the AA work activity, facilitate discussion to identify where changes can be made, and to reflect on whether changes which have been made have improved their practice.

10.4 Supporting Documentation

Each AA must maintain a portfolio which includes a logbook, this should be submitted to the educational supervisor in adequate time before the appraisal meeting. AAs will have access to the WSFT medical appraisal software to record their evidence.

Supporting evidence may include the following:

Career details:

- Employment history, details of duties and responsibilities
- Qualifications
- Job plan, job description and agreed scope of practice
- Publications e.g., journal publications, blogs
- Presentations e.g., conference presentations and posters
- Achievements e.g., leading a practice development group in the work setting, contributing to an ICS, regional or national project
- Continuing professional development e.g., certificates of attendance /learning
- Appraisals
- Membership of professional bodies, special interest groups, committee memberships
- Other learning.

Clinical

- Reflective accounts
- Reflective case studies
- Work based assessments (formative and summative) to demonstrate assessment of competences and capabilities - Anaesthetic Clinical Exercise (A-CEX, Case Based Discussion (CbD), Direct Observation of Procedural Skills (DOPS), Multi Clinician Report (MCR), Multi-Source Feedback (MSF)
- Educational supervisor or other supervisor reports
- Patient/ carer feedback
- Teaching observation
- Logbook of operative/procedural activities including complications
- Significant events e.g., adverse events, near misses or never events
- Patient survey

- Courses – ALS, stimulation courses etc
- Quality improvement project.

Leadership and management, education and research

- Evidence of leadership: reflective accounts, CPD, 360 feedback, self-report/reflections, peer reviews, observation, clinical supervision, leadership PDP
- Evidence of delivering education/ training either formally or informally, reflective accounts, evaluation of teaching, learning and assessment activities
- Evidence of applying research in practice e.g., in relation to national standards or local policies, identifying gaps in evidence, developing a culture of research, journal club evidence, evidence significant involvement in or contribution to quality/service improvement activities, primary research and reflective accounts.

11. AA students

11.1 National provision of training

AA training courses are provided by The University of Birmingham, University of Lancaster and University College London (UCL) with the AA training being with placements within NHS Trusts. Places are advertised directly from the Trusts on NHS Jobs website. Successful applicants must fulfil the University criteria and from September 2025 it is envisaged that student AAs will need to pass the GMC Anaesthetic Associate Registration Assessment before being registered to practice. Student AAs employed within the WSFT are likely to be attached to UCL.

11.2 Induction

All student AAs should attend WSFT induction at the earliest opportunity during their first placement.

11.3 Supervision

Trainees are expected to place the well-being and safety of patients above all other considerations.

Whilst on placement, AA students will be supervised by the WSFT appointed learning facilitator, for weekly review of their progress and educational needs.

AA students will also be supervised by consultant workplace supervisors within the speciality placement.

Student AAs should always work under supervision and work within their own competence; student AAs should not make independent clinical decisions.

The workplace and clinical supervisors retain responsibility for patient care whilst training AA students.

11.4 Placement standards

HEIs are responsible for the quality assurance of their student AA placements.

Concerns about the quality of the educational experience or specific placement concerns should be raised to the learning facilitator in the first instance, or the WSFT clinical education team, and the HEIs.

11.5 Work based learning

Students must follow their HEI guidance for work-based learning and assessment.

Prior to taking blood samples independently, student AAs must be assessed as competent via the blood and transfusion nurse specialists.

11.6 Student indemnity

- WSFT has a service level agreement with HEI that covers all students on official placements at WSFT. The trust is deemed to be the employer of students undertaking practice learning opportunities; therefore, trust indemnity covers students.

11.7 Raising concerns and student well-being

- The WSFT Clinical Education Department acts as 'point of contact' for all AA students.
- Concerns about the progress of an AA student should be with the individual in the first instance and may be raised with the WSFT learning facilitator and clinical education team and, as appropriate, involve the HEI.

12. Document information and monitoring

12.1 Implementation and monitoring

This policy will be reviewed at a minimum annually by the AROG and will also need to be updated following GMC regulation of AAs. Earlier review may be required in response to exceptional circumstances, organisational change, relevant changes in legislation or guidance.

To demonstrate compliance with this policy, the following elements will be monitored.

Table 3 - Monitoring implementation of the WSFT AA policy

Aspect of compliance being monitored	**Monitoring method**	**Individual responsible**	**Frequency of monitoring activity**	**Committee which receives monitoring report**
AA portfolios	Random selection of AAs	AROG – portfolio review body	Annual	AROG

12.2 Equality and diversity assessment tool

Does the document affect one group less or more favourably than another on the basis of:		
Race	No	This document demonstrates commitment to create a positive culture of respect for all individuals, including staff, students, patients, their families, and carers as well as those from other institutions and community partners. The intention is, as require by the Equality Act 2010, to identify, remove or minimise discriminatory practice in the nine named protected characteristics; it is also intended to sue the Human Rights Act 1998 to promote positive practice and value the diversity of all individuals and communities. This document can be made available in different languages and formats upon request to the WSFT equality and diversity lead.
Gender	No	
Sexual orientation	No	
Age	No	
Disability	No	
Marriage and Civil Partnership	No	
Pregnancy and Maternity	No	
Culture	No	
Does this document affect an individual's human rights?	No	

12.3 Document control and archiving

Full History		**Draft**	
Version	Date	Author	Reason
Final v1.0	30.12.21	Dr N.W. Penfold, E. Davies and C. Waters	New policy written
V2	02.02.22	Dr NW Penfold and E Davies	PSD update
V3	24.03.23	Dr NW Penfold & E. Davies	Update re GMC and HEE changes

12.4 Document configuration and information

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Approvals and endorsements:	Advancing Roles Oversight Group
Consultation:	Feedback on this document were sought from: Advancing Roles Oversight Group, Chief Executive, Medical Director, Deputy Medical Director, Chief Nurse, Director of Medical Education, Head of Clinical Education, All consultant anaesthetists at WSFT, Chief Pharmacist, Governance Manager, Physician Associates at WSFT.
File name:	WSFT Policy for the Role of Anaesthesia Associate
Supersedes:	PP (22) 460
Equality Assessed	Yes
Implementation	This document will be widely circulated within WSFT and added to intranet site. A copy will also be sent to all consultants and AAs. Further advice can be obtained via the AA representative of the Trust's AROG.
Monitoring: (give brief details how this will be done)	This policy will be reviewed at a minimum annually by the AROG and will also need to be updated following GMC regulation of AAs. Earlier review may be required in response to exceptional circumstances, organisational change, relevant changes in legislation or guidance.
Other relevant documents/documents & references:	
Additional Information:	

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Appendix 1 – Key information, local policies, and clinical guidelines

Key information

Association of Anaesthesia Associates

A toolkit to support the planning and introduction of training for Anaesthesia Practitioners (nationalarchives.gov.uk)

Anaesthesia Associates | The Royal College of Anaesthetists (rcoa.ac.uk)

England Five-Year Forward View (NHS 2014)

England Next Steps on the NHS Five-Year Forward View (NHS 2017)

Establishing Common Standards for Continuing Professional Development, Assessment and Appraisal Guidelines for Medical Associate Professions (HEE 2019)

GMC: Anaesthesia associate and physician associate regulation and guidance.

Interim NHS People Plan (NHS 2019)

Long Term Plan (NHS 2019)

MAP regulation - GMC (gmc-uk.org)

Planning-introduction-training-PAA-2016.pdf (rcoa.ac.uk)

Royal College of Anaesthetists: Anaesthesia Associates

We are the NHS: People Plan for 2020/2021 – action for us all (NHS 2020)

What will regulation look like - GMC (gmc-uk.org)

Who are physician associates and anaesthesia associates - GMC (gmc-uk.org)

We are the NHS: People Plan 2020/21 - action for all (NHS England 2020)

Key WSFT policies and guidelines

- Blood policy administration CG 10010
- Consent to examination or treatment PP (16) 113
- Dress Code Policy PP(19)215
- Escalation plan for resus status (EPARS) including DNACPR PP (17) 305
- Individual performance review (IPR/appraisal) PP (17) 184
- Intravenous fluid therapy in adults in hospital CG 10310-3
- Major Haemorrhage CG 10089
- Non-medical authorisation of blood CG10298-2
- Oxygen prescription adult administration guideline CG 10131-6
- Pathology sample requests, identification, and acceptance CG 10079
- Policy for the use of medicines PP (19) 200
- Study leave policy PP (19) 067
- Transfusion reactions CG 10126
- Transfusion training CG 10146

- Verification of expected death CG 10217-4

Appendix 2 – Pathway for expanding scope of practice for Anaesthesia Associates.

Steps	Key steps for expanding scope of practice within specified practice setting & role See policy guidance for detailed information
1.	**Scope of practice** Identify and agree expansion to scope of practice (clinical practice, leadership and management, education, and research) according service demands
2.	**Competencies and capabilities** Identify and agree expected competencies and capabilities keeping within the agreed scope for an AA registered with the RCoA AAVR
3.	**Learning plan** Identify learning requirements and learning plan/PDP required within a tripartite agreement between the AA, named educational supervisor and line manager. Agree upon the range of evidence to demonstrate expected competencies and capabilities and the approved 'sign off' /summative assessor
4.	**Education and workplace clinical supervision** AA to undertake agreed individual learning plan/PDP matched with workplace supervisors who can best support identified learning outcomes Workplace supervisor/s may not hold the same professional registration as the AA
5.	**Collection of supporting evidence for portfolio** Range of supporting evidence for portfolio required e.g.: logbook of procedural activities, reflections, CPD, work-based assessments, patient feedback, significant event analysis, evaluation of teaching, learning and assessment activities, research/audit/quality improvement activities (examples are not exclusive) Where possible each piece of submitted evidence should explain why competence and capability is demonstrated WBA templates/ portfolio tools available via Royal Colleges website
6.	**Review of supporting evidence within portfolio** Previously identified approved 'sign off' summative assessor/s to review submitted evidence within portfolio to demonstrate agreed expected competencies and capabilities
7.	**Sign off /entrustment decision (summative assessment)** Approved 'sign off' summative assessor/s to make overall judgement on the final 'sign off' decision and if appropriate agreement upon an entrustment decision according to a supervision scale To avoid subjective bias, entrustment decisions should include an agreement between multiple supervisors that the entrustment is justified
8.	**Record keeping** Document 'sign off' and record evidence of assessment within AA portfolio Follow local guidance for record keeping
9.	**Job descriptions and job plans** Consider need for amendments to job descriptions or job plans
10.	**Appraisals** Evaluating and assessing the competence and capability of each AA through reviewing evidence within a portfolio and a logbook is an essential part of the appraisal process. See policy for requirements.
Audit of portfolios held by AAs is undertaken by the WSFT Advancing Roles Oversight Group	

Further Information
WSFT Anaesthesia Associate Practice Policy and Royal College of Anaesthetist websites

Appendix 3 Organisational chart for the responsibility for the Trust wide development / leadership of Anaesthesia Associates