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Summary Report for the Leng Review

Evaluating the Supervision of Anaesthesia Associates

CMAPs College of Medical Associate Professionals

March 2025

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Abstract

Anaesthesia Associates (AAs) play a critical role in the delivery of anaesthetic services across the UK. This study presents a thematic analysis of survey data collected from Consultant Anaesthetists who supervise AAs, regarding key aspects of AA supervision, including training, governance, professional development, and contribution to the provision of anaesthetic service. Key findings show that while AA contributions are very valued, challenges remain concerning training, supervision, and professional recognition. The revised RCoA Interim Scope of Practice has altered role expectations and anaesthesia service provision, necessitating more explicit guidance and standardisation.

Introduction

Anaesthesia Associates (AAs) are healthcare professionals who work under the supervision of Consultant Anaesthetists, contributing to perioperative care. Since their introduction in the UK in 2004, AAs have played an increasing role in addressing workforce shortages and meeting the growing demand for anaesthetic services. A recent study has highlighted the scarcity of recent research into the efficacy and safety of AAs and used this to conclude erroneously that AAs are unsafe (1). A survey of anaesthetists in training found that opinion was polarised regarding the AA role, although those with direct experience were more positive, and the authors note that the context of general discontent and industrial action at that time may have influenced some of the negative responses (2).

Our survey explores Consultant Anaesthetists' perspectives on supervising AAs, examining their experiences, challenges, and views on professional training and regulation.

Recent regulatory developments, including revisions to the Royal College of Anaesthetists (RCoA) Scope of Practice (SOP) for AAs (3), have influenced how these practitioners are integrated and utilised in clinical environments. Those changes have resulted in variable levels of professional acceptance, differences in supervision and career progression across NHS Trusts. The findings of this survey aim to contribute to the Leng review discussion concerning the evolution of the AA role within the NHS.

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Methodology

A survey was disseminated through an online platform hosted by the College of Medical Associate Professionals (CMAPs), targeting Consultant Anaesthetists who supervise AAs across the UK. The survey examined key aspects of AA supervision, including training, governance, professional development, and contribution to the provision of anaesthetic service. The questionnaire incorporated multiple-choice and open-ended questions to capture supervisory experience, challenges, and the impact of the RCoA SOP changes (Appendix 1).

Survey distribution was facilitated via email lists and professional WhatsApp groups, with participation voluntary and without incentives. Respondents were required to provide identifiable details, such as a GMC number or work email address, to uphold data integrity and mitigate duplicate responses. Responses were anonymised where possible. The data portal was open to submissions from 19/01/25 to 28/02/25.

Data analysis involved descriptive statistics for categorical responses and thematic analysis for qualitative data, independently verified by two researchers.

Use of the NHS REC Tool and Ethical Considerations

In alignment with best practices for research governance, the NHS Research Ethics Committee (REC) decision tool was applied to assess whether this project required formal NHS ethics approval. Based on the tool's guidance, the activities undertaken in this project do not fall within the scope that mandates NHS REC oversight. Consequently, no formal submission to an NHS Research Ethics Committee was necessary.

Results

A total of 11 survey responses were obtained, pertaining to around forty qualified AAs and nine trainee AAs. Some respondents were retired and/or did not declare their number of supervisees, so the exact number cannot be calculated. This represents approximately 20% of the current UK AA workforce.

Professional Background and Motivation for AA Supervision

All participants had experience supervising AAs and overseeing Anaesthetists in Training (AiTs), and some were also involved in training Advanced Critical Care Practitioners (ACCPs). The number of AA trainees ranged from one to multiple per Consultant Anaesthetist.

Supervisory experience varied, with some respondents having between one and three years of experience, while others had been involved for over a decade since AAs were first introduced. The remaining participants had five to ten years of supervisory experience. The principal motivation for engaging AAs was to alleviate workforce shortages and enhance service efficiency. Many respondents highlighted that AAs contributed to improving theatre productivity and ensuring continuity of care. Their integration was regarded as a sustainable strategy for service delivery and workforce stability.

Before employing AAs, many hospitals faced recruitment difficulties, including shortages of Consultant Anaesthetists and challenges filling AiT posts. Some hospitals relied on locum staff, exacerbating pressures on anaesthetic departments. The introduction of AAs was perceived as a necessary response to these challenges, supporting the maintenance of high standards of patient care.

Supervision and Governance

Supervisors' initial understanding of the AA role varied; some had limited awareness of their full scope of practice, while others had prior exposure through training initiatives or supervision experience. Many reported that their understanding evolved through direct supervisory experience, leading to a greater appreciation of AA contributions to theatre efficiency and patient care. However, some noted that regulatory adjustments linked to the revised RCoA Scope of Practice required ongoing adaptation within governance structures.

Most respondents (82%) allocated designated time for AA supervision, though frequencies differed. Weekly sessions were reported by 64%, while 27% conducted supervision fortnightly, and 9% integrated it into routine practice without a fixed schedule. Supervision activities typically encompassed clinical case discussions, procedural skill development, and professional mentoring.

Supervision models also varied; 55% employed a 1:1 structure ensuring direct oversight, 36% adopted a 2:1 model in which a single consultant supervised two AAs, and 9% used rotational or mixed approaches. Mentoring activities similarly differed across NHS Trusts, with 73% documenting supervision, including competency assessments and case discussions. Conversely, 27% did not formally record supervision, mentioning administrative burden as a limitation.

Governance frameworks were formally established in 64% of hospitals, typically comprising competency assessments, local governance policies, and prescribing guidelines. However, 18% of respondents indicated an absence of formal governance, relying instead on departmental consensus or agreed protocols of AA practice.

Experience and Perceptions of the AA Role

Many participants recognised the positive contributions of AAs to patient care, service efficiency, and

workforce sustainability. Nevertheless, challenges were identified in maintaining the balance between ensuring AAs remained within their defined scope while allowing sufficient autonomy for professional development. Some consultant anaesthetists experienced difficulties in balancing AA supervision with other clinical responsibilities, particularly in settings with limited consultant capacity. Others underscored the necessity of national guidelines to standardise expectations and supervision levels across all NHS trusts.

The integration of AAs into hospitals was generally reported as smooth, although some respondents initially encountered resistance from colleagues unfamiliar with the role. A few supervisors noted concerns among anaesthetic trainees regarding potential impacts on training opportunities. However, over time, a structured collaboration between AAs and trainees was perceived to benefit the clinical environment.

Patient responses were largely positive, with supervisors reporting that transparency about the AA role and clear communication fostered acceptance. AAs were particularly valued for their role in ensuring continuity of care, which was seen as enhancing both patient experience and workflow efficiency.

Views on training varied. Some respondents considered an MS university degree to provide a solid foundation, albeit requiring adaptation within anaesthetic departments. Others emphasised the need for standardised training pathways and continued professional development to uphold clinical standards.

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Regulatory and Policy Adjustments

The introduction of the RCoA Interim Scope of Practice (3) had a marked impact on the AA role. A significant proportion of respondents (36%) reported a reduction in clinical tasks previously undertaken by AAs, requiring role adjustments. Many expressed concern that such restrictions impeded service efficiency by limiting procedures AAs could perform.

Additionally, 27% reported challenges in implementing the updated SOP, noting consultant shortages and disruptions to AA training. Some respondents (18%) reported uncertainty about the new changes, citing discrepancies in hospital interpretations of the new RCoA SOP. A further 18% observed changes in AA supervision levels, including more strict supervision measures.

Challenges and Future Outlook

Nearly half (45%) of respondents expressed no concerns regarding AAs, reflecting confidence in their integration. However, 27% emphasised the necessity of structured mentorship for newly qualified AAs to facilitate transition into practice. Additionally, 18% raised concerns regarding the unjust treatment of AAs within multidisciplinary teams due to the influence of social media. A further 9% expressed uncertainty about the long-term professional recognition and development of AA as a profession.

Workforce retention was identified as a key issue, with 55% noting concerns about job satisfaction due to uncertainties surrounding role progression and supervision levels proposed by RCoA. Most respondents (73%) acknowledged that external scrutiny had adversely impacted professional confidence and AA job security, reinforcing the need for sustained consultant support.

Discussion

This data provides a snapshot of AA supervision, challenges and aspirations derived from the direct experience of 11 clinicians supervising around 40 qualified AAs. This constitutes a valuable addition to the existing limited research into the safety and efficacy of AAs.

Findings indicate that AAs significantly contribute to anaesthetic services, improving service efficiency and workforce sustainability. However, governance inconsistencies, scope of practice, and professional recognition require further improvement. The introduction of the revised RCoA Scope of Practice (3) resulted in restrictions on AA practice in some hospitals, reducing the effectiveness of service delivery. While some supervisors viewed these changes as required for role clarity, others considered them to hinder the optimal utilisation of AAs.

Conclusion

AAs are integral to the UK anaesthetic workforce, enhancing efficiency and supporting Consultant Anaesthetists. This data shows that while their contributions are very valued, challenges remain concerning training, supervision, and professional recognition. The revised RCoA Scope of Practice has altered role expectations and anaesthesia service provision, necessitating more explicit guidance and standardisation.

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Declaration of Interest

All authors are MAPs with the exception of Maria Herdt.

References

1. Greenhalgh T and McKee M 2025. Physician associates and anaesthetic associates in UK: rapid systematic review of recent UK based research. BMJ 2025;388:e084613
2. Evans B, Turkoglu LM, Brooks J, Subramaniam J, Edwardson S, Freeman N, McCrossan R and Wong DJN 2024. Experiences and perceptions of working with Anaesthesia Associates: a survey of UK anaesthetists in training. British Journal of Anaesthesia, 132 (5): 964e966 (2024).
3. Anaesthesia Associate Interim Scope of Practice 2024. Royal College of Anaesthetists December 2024.

Appendix 1: Survey questions

- Name (first, last)
- Email
- Method of validation (GMC number, MVR number, work email)
- Name of supervisor (if willing to provide) (first, last)
- Are you currently, or have previously been, a Consultant Anaesthetist trainer? What roles do you supervise within your practice?
- How many Anaesthesia Associates (AAs) do you currently supervise?
- How long have you been supervising your AA(s)?
- What motivated you to employ or supervise an Anaesthesia Associate?
- Prior to hiring a AAs, did your hospital face challenges in recruitment?
- How would you describe your initial understanding of the Anaesthesia Associate role when you began supervising? How has this understanding evolved over time?
- Do you allocate dedicated supervision time?
- How frequently do these sessions occur, and how long do they typically last?
- What levels of supervision model do you use for your AA's, 1 to 1, 2 to 1, or other?
- What topics are covered in supervision sessions (e.g., clinical cases, professional development?)
- Do you audit or maintain records of supervision activities?
- Do you have a written governance or best practice documentation for supervising AAs?
- How would you describe your overall experience of supervising Anaesthesia Associates?
- What challenges or limitations have you encountered in supervising your AA(s)?
- How did you approach integrating the AA role into your hospital? Were there any challenges during this process?
- Have your colleagues or other employees expressed any concerns regarding the role of AAs?
- How have patients responded to consultations with an AA in your hospital?
- What value does an AA add to your workplace as a colleague or employee?
- As a supervisor, what is your opinion of the training Anaesthesia Associates receive at University?
- Do you feel that your AA(s) consistently work within their competencies?
- How have you utilised your AA(s) in a clinical setting?
- Can you provide examples of how AAs have positively contributed to your hospital?
- Do you have any examples of where AAs have benefitted the practice?
- How has the addition of AAs affected patient accessibility to care?
- Have you made any adjustments to your hospital based on the revised RCoA scope of practice guidance?
- Do you have any concerns about the AA(s) in your hospital?
- How do you view the role of AAs in compared to other secondary care roles?
- What do you believe the future holds like for Anaesthesia Associates within secondary care?
- What are your aspirations for the role of AAs in terms of their practice and development?
- Do you feel that the current AA landscape has had an impact on the AAs in your department? If so, what specific challenges or opportunities have arisen, and how have you supported your AA(s) in navigating these?
- Do you have any additional comments or observations you would like to share?

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