

# Guidelines

## The Anaesthesia Team 2018



Association  
of Anaesthetists

July 2018

# The Anaesthesia Team

---

## Membership of the working party

Prof Richard Griffiths, Consultant Anaesthetist, Peterborough; Association of Anaesthetists (Chair)

Mrs Hannah Abbott, President, College of Operating Department Practitioners

Dr Paul Barker, Consultant Anaesthetist, Norwich; Hon Treasurer, Association of Anaesthetists

Dr William Harrop-Griffiths, Consultant Anaesthetist, London; Council Member, Royal College of Anaesthetists

Dr Gerry Keenan, Consultant Anaesthetist, Edinburgh; Council Member, Association of Anaesthetists

Mr Bill Kilvington, Patient Safety Lead and Immediate Past President, College of Operating Department Practitioners

Ms Marina Quantick, Association of Physicians' Assistants Anaesthesia

This guideline has been seen and approved by the Board of the Association of Anaesthetists. It is endorsed by the College of Operating Department Practitioners and the Royal College of Anaesthetists

Separate guidance is available for Ireland.

Published by the Association of Anaesthetists  
21 Portland Place, London, W1B 1PY  
Tel: +44 (0)20 7631 1650  
Email: [info@aagbi.org](mailto:info@aagbi.org)  
[www.aagbi.org](http://www.aagbi.org)

Association of Anaesthetists is the brand name used to refer to both the Association of Anaesthetists of Great Britain & Ireland and its related charity, AAGBI Foundation (England & Wales no. 293575 and in Scotland no. SC040697).

## Contents

1. Recommendations	4
2. Introduction	4
3. Organisation and management	5
4. Pre-operative assessment	6
5. The operating department	7
6. The role of 'anaesthetic assistant'	8
7. Recovery in the post-anaesthetic care unit (PACU)	10
8. Postoperative pain management	10
9. References	11

To be reviewed by 2023

This work is licensed under a Creative Commons Attribution-NonCommercial-No Derivs 4.0 International License CC BY-NC-ND

## 1. Recommendations

- Anaesthetic care within the peri-operative pathway can only be provided by an anaesthesia team led by consultant anaesthetists. All members of the team should be trained to nationally agreed standards.
- Effective pre-operative assessment of patients for anaesthesia and surgery is vital. It improves safety, reduces cancellations, promotes efficient bed usage and can allay patients' anxieties. It does not replace the need for the anaesthetist's pre-operative visit.
- Anaesthetists should always have dedicated qualified assistance wherever anaesthesia is administered, whether in the operating department, the obstetric unit or any other area. The assistance is required by whoever is administering the anaesthetic, be it a medically qualified anaesthetist, or a Physicians' Assistants (Anaesthesia) (PA(A)s) during maintenance of anaesthesia.
- Recovery or post-anaesthetic care unit (PACU) areas should have sufficient numbers of trained staff available throughout all operating hours. If operating occurs over the whole of a 24-hour period, the PACU area must be open for the whole 24 hours.
- All acute hospitals providing inpatient surgical services should have an acute pain team.
- The primary focus of every member of the anaesthesia team should be the safety of the patient. If any member of the anaesthesia team is concerned that safe care may not be delivered because of issues relating to drugs, equipment, facilities or staffing, or the training, skills, competence, attitude or experience of a member or members of the anaesthesia team, they are duty bound to address these issues before initiating care, except in the presence of life-threatening emergencies.
- The Association of Anaesthetists believes the recommendations in this document should apply to all nations of the UK.

## 2. Introduction

It is a well-established principle that anaesthetists have trained assistance during the conduct of anaesthesia. This recommendation, by the Association of Anaesthetists, was the first development of the anaesthesia team concept. The team approach has become the foundation of safe and effective anaesthesia practice in the UK.

Anaesthetists increasingly work with other healthcare professionals in all aspects of patient care and these relationships within the team are described here. In the context of this document the term 'anaesthetist' includes all grades: consultants, SAS anaesthetists, locally employed doctors, and trainees. All sections of this document apply to PA(A), unless otherwise specified.

Pre-operative assessment clinics are now a feature of most hospitals and Trusts. These should be effective and efficient if they are to improve the safety and quality of patient care.

Since this document was last updated, the World Health Organization Surgical Safety Checklist has become embedded in UK practice and the concept of the Five Steps for Safer Surgery developed. This update recognises the importance of the pre-operative briefing and post session de-brief. These steps should be a routine team discipline afforded to all patients undergoing surgery and emphasises the importance of teamwork. Anaesthetic aspects are described in this document.

Devolution of nations within the UK has led to different emphasis in different areas of practice and has sometimes hindered the development of uniform national standards, particularly in respect of access to recognised training programmes for nurses wishing to become part of the anaesthesia team. We believe uniform standards should be the goal.

### 3. Organisation and management

Organisation of comprehensive anaesthetic services requires considerable knowledge, effort and expertise.

Each acute hospital facility should have a designated head of anaesthesia services responsible for all activities in which anaesthetists are engaged. This individual will usually be the Clinical Director and should have managerial and budgetary control of the service. In some hospitals, the Clinical Director of anaesthesia may be responsible for the whole of the operating services.

In some hospitals, the Department of Anaesthesia is part of another directorate. If this is the case, it is necessary to have an identified lead anaesthetist to take responsibility for all aspects of the anaesthesia service. For the sake of simplicity this publication refers to this individual as the Clinical Director.

Whatever the wider directorate structure, the budget for anaesthesia services should be controlled by anaesthetists.

#### **The Clinical Director's role**

The Clinical Director is responsible to the Chief Executive for the governance of the local service. He/she should ensure the recommended national standards of staffing and facilities are in place to provide a high-quality anaesthesia service throughout the peri-operative period and in all areas where anaesthesia is performed.

Sufficient resources should be committed to recruiting and training staff and to encourage continued professional development to ensure successful revalidation for all members of the anaesthesia team. The Clinical Director should be provided with management support, usually in the form of a business manager and clinical service manager, as well as having sufficient contracted time to undertake his/her duties. In addition to management responsibilities, the Clinical Director should offer support, guidance and encouragement to all members of the department and ensure staff keep up to date through regular training and professional development.

#### **The role of other consultants and SAS doctors**

The Clinical Director will usually delegate some operational aspects of the anaesthesia team. It is often helpful to have a lead consultant to provide medical supervision in specialist areas as recommended by Association of Anaesthetists Working Parties, RCoA Guidelines for the Provision of Anaesthesia Services (GPAS) and past National Audit Projects (NAP). A rota coordinator, who has a good knowledge of the local service and skill-mix of anaesthetists and non-medically qualified PA(A)s, should be appointed and supported in the role.

#### **The role of the clinical service manager**

Non-medical staff in the anaesthesia team are normally managed by a senior operating department practitioner (ODP) or a senior nurse, responsible to a clinical service manager.

Modern anaesthesia services are complex and the clinical service manager will usually work closely with other departments or managers. Responsibilities of the clinical service manager will include:

- Careful coordination of pre-operative assessment that requires communication with surgeons, the medical records department, outpatient clinics and all related departments. The individual leading this service should work closely with a lead anaesthetist
- Maintaining adequate staffing with trained anaesthetic assistants in the operating department
- Ensuring the PACU is appropriately staffed
- Ensuring an adequate skill-mix of staff is available 24 hours a day, 7 days a week. There may be advantages in rotating trained staff with common skills between theatres, PACU and high dependency and intensive care units depending on local circumstances

- Ensuring that the acute pain service, which should work closely with the Department of Anaesthesia, is adequately staffed by medical and non-medical staff trained in acute pain care, working with an anaesthesia lead
- A regular audit of all components of the anaesthesia service, not only for the efficient use of resources, but also for clinical quality and safety

There is therefore a need for close communication with all users of the service. A multidisciplinary theatre users' committee is often useful for ensuring common goals, cooperation and motivation across specialties. A theatre governance group should review all clinical incidents and safety guidance and ensure patient safety is seen as a priority by the hospital.

## 4. Pre-operative assessment

Assessment before anaesthesia is the responsibility of the anaesthetist. The responsibility should be shared with the patient's GP, who should ensure elective referrals are medically fit or optimised at the time of referral. This should include, but not be limited to, control of chronic conditions such as diabetes and hypertension. The science of 'prehabilitation' is in its infancy but concentrating on improving the physical fitness of patients is the responsibility of the entire healthcare community and should be encouraged.

Pre-operative assessment before the date of surgery achieves several desirable objectives. It ensures that patients are fit for anaesthesia and surgery, and that all likely investigations will be completed and available at the time of admission. It thus minimises the disruption caused by late cancellation or postponement and their adverse effects on theatre utilisation and bed occupancy, not to mention the distress and inconvenience to patients and their relatives or carers. It enhances efficiency and ensures a higher level of overall patient care. It also gives an opportunity for patients to express concerns they may have about anaesthesia and surgery.

Good practice dictates that all patients should be seen by an anaesthetist before undergoing a procedure that requires their services. Ideally, this should be the doctor who is to give the anaesthetic. Although it is the anaesthetist who is responsible for deciding whether a patient is fit for anaesthesia, other professional groups may be involved in the pre-operative assessment process.

Pre-operative assessment is now commonly carried out by a specially trained multidisciplinary team, which is overseen by a consultant anaesthetist, in the pre-operative assessment clinic. In the clinic, nursing, ODP and other trained staff play an essential role when, by working to agreed protocols, they screen and assess patients for fitness for anaesthesia and surgery [1].

It is important to be clear about the boundaries between the remit of the pre-anaesthesia assessment team and the responsibilities of the anaesthetist. The Association of Anaesthetists believes that it is inappropriate for a non-anaesthetist to promise a particular type of premedication, anaesthetic technique or postoperative pain management plan, and that the decision to proceed (with anaesthesia) cannot be delegated [2]. It is essential, in all but a dire emergency, that the anaesthetist actually providing anaesthesia should see patients pre-operatively in a quiet ward or theatre admissions unit rather than in a busy operating theatre. The environment should allow patient privacy and dignity to be maintained at all times.

It is not within the remit of this document to go into the details of the running of pre-operative assessment clinics. This is addressed in the Association of Anaesthetists publication on pre-operative assessment [1].

## 5. The operating department

### Management

The operating department should have a manager who is responsible for ensuring an efficient and effective service. This individual will be responsible for ensuring the provision of adequately trained staff and ongoing audit of activity, whatever the local directorate structure. Proper use of resources and optimum throughput of patients depends on maintaining good communication between anaesthetists, surgeons and operating department staff.

### NHS England Safety Standards for Invasive Procedures

In 2015, NHS England published National Safety Standards for Invasive Procedures (NatSSIPs) [3]. NatSSIPs are structured into two groups: organisational (the standards that underpin the safer delivery of procedural care) and sequential (a logical sequence of steps that should be performed for every procedural session or operating list and, for every patient).

In England and Wales, organisations are expected to produce Local Safety Standards for Invasive Procedures (LocSSIPs) based on the NatSSIPs [3]. All members of the anaesthesia team should be involved in developing the LocSSIPs in their own organisation and these should form the basis of practice. The Association of Anaesthetists recommends that anaesthesia teams in the rest of the UK develop and work with similar standards.

### Assistance for the anaesthetist

Trained assistance should always be provided wherever anaesthesia is carried out. PA(A)s should not double as an ODP or anaesthetic nurse. The safe administration of anaesthesia cannot be carried out singlehandedly; competent and exclusive assistance is necessary at all times.

The Clinical Director should insist on adequate resources to employ, train and develop sufficient numbers of assistants to ensure a safe anaesthesia service in accordance with good practice. The Clinical Director should ensure that routine situations are not created that compromise this principle. For example, out of hours staffing should be planned to ensure the anaesthetic assistant is not regularly called on to cover more than one clinical commitment at a time, such as an emergency theatre case and the obstetric theatre and/or hospital cardiac arrest service.

The anaesthesia assistant should not only be trained, competent and in current practice, but also familiar with the location and storage of key pieces of safety equipment and drugs and the process for seeking help in an urgent situation. This applies to temporary as well as permanent members of the anaesthesia team.

If appropriate basic resources are not available, the Clinical Director should limit clinical practice so that safe, quality-based patient care is ensured. A useful benchmark is included within the NHS England NatSSIPs document [3], which states 'The LocSSIPs must address workforce needs for procedures that take place outside of normal working hours. The workforce standards set for out-of-hours work should be no less than those set for equivalent procedures performed during standard working hours. The LocSSIPs should provide guidance on escalation processes and actions to be taken should a clinical situation overwhelm available resources'.

### Anaesthetic room or induction environment

A third member of staff assists the anaesthetist and trained assistant in some units. This may be for a high-risk elective patient, an emergency, or when there are carers with the patient. A third person should be available in close proximity to the anaesthetic room/induction environment to help with any unforeseen problems.

The Association of Anaesthetists recommends that a trained anaesthetic assistant should always be immediately available and present during anaesthesia. Only in extreme emergencies, as judged

by the anaesthetist, should anaesthetic intervention proceed without a trained assistant, e.g. acute unforeseen airway/bleeding problems. In units with both obstetric units and emergency surgery provision, it should reasonably be anticipated that two anaesthetists and two trained anaesthetic assistants might be required and these should be allocated appropriately.

## 6. The role of 'anaesthetic assistant'

A number of operating departments are working towards a multi-skilled workforce where registered practitioners in the operating department are able to work in more than one role, including anaesthetic assistance, scrub practitioner and recovery practitioner. The allocation of multi-skilled staff, however, should ensure that skills are maintained so staff remain up to date in each area of practice. Staff assigned to the role of anaesthetic assistant should not have any other duties that would prevent them from providing dedicated assistance to the anaesthetist and support to the patient during anaesthesia. This includes not providing distant supervision or delegation to support workers working in another capacity within the operating theatre.

All staff should have regular breaks. It is important that the anaesthetic assistant's role is passed on to an appropriate colleague who receives a formal handover and is properly briefed about the patient and the list to allow him/her to join the team effectively.

### Training

Assistance for the anaesthetist may be provided by ODPs or adequately trained, registered nurses. Whatever the background, the training for all anaesthesia assistants must comply fully with national standards, such as the College of Operating Department Practitioners (CODP) curriculum and the Perioperative Care Collaboration [4, 5] or the competences being developed by NHS Education Scotland. Employment of staff without a qualification that complies with national standards is not acceptable. Learners are accepted for formal training as anaesthesia assistants, but they should be supervised at all times by a registered peri-operative practitioner who holds the approved qualification. There should be a programme of continuing professional development for all anaesthetic assistants that meets the requirements of their Regulatory Body (Health and Care Professions Council (HCPC) or Nursing & Midwifery Council). All should be able to demonstrate continued professional development related to anaesthetic care.

### Operating Department Practitioners

There are now more than 20 higher education institutes (HEIs) based in England and Wales providing pre-registration education for ODPs (as of July 2018, there is no institution providing this training in Scotland). ODPs must have completed an approved programme that confers eligibility to apply for registration with the HCPC. Currently the threshold qualification for an ODP to enter the HCPC register is a Diploma in Higher Education; however, most HEIs are now delivering pre-registration ODP education at degree level and entry to diploma programmes is likely to cease.

### Nurses

Qualified nurses are already registered professionals but require additional training before taking on the duties of an anaesthetic assistant. In England, until 2002, the recognised national qualification of competency for nurses as anaesthesia assistants was the English National Board qualification (ENB 182). Following the dissolution of the ENB, HEIs have developed post-registration anaesthetic education for nurses. There are no statutory competencies and therefore this anaesthetic education will differ in length and content. The Association of Anaesthetists, however, requires that anaesthetic nurses complete a programme that allows them to meet the competencies equivalent to those in the CODP pre-registration ODP curriculum documents. A nurse should not assist an anaesthetist until successful completion of a course which includes these competencies. (Further information about the ODP diploma and degree course curricula is available from the CODP.)

Qualified nurses can still train as ODPs and must successfully complete an approved programme to be eligible to apply for registration with the HCPC and hence use the protected title of ODP. It may



be possible for a nurse to use the accreditation of prior learning (APL) process on some modules on an ODP programme and hence reduce the duration of his/her ODP education; this will depend on review by an individual HEI. It is a legal requirement that an individual using the title of ODP must be registered with the HCPC; hence nurses should not be referred to as ODPs unless they have the appropriate registration.

In Scotland, nurses assisting anaesthetists now have to achieve a series of core competencies for anaesthetic assistance devised by NHS Education Scotland. The courses to achieve these competencies are administered by individual hospitals.

### **Professional associations**

Continuing education and support is offered by three organisations: the CODP, the Association for Perioperative Practice (AfPP), and the British Association of Anaesthetic & Recovery Nurses (BARNA).

### **Physicians' Assistants (Anaesthesia)**

The Association of Anaesthetists has previously stated that the highest standards of anaesthesia can only be achieved by a physician-only service. However, in response to a potential workforce crisis in 2002, the Royal College of Anaesthetists (RCoA) and Department of Health reported on the potential for development of a non-medical role as part of a consultant-led anaesthesia team to enhance flexibility and service provision while maintaining the highest standards of safety [6].

PA(A)s form a small proportion of the theatre workforce and the numbers employed in the future will be determined by local departments and their staffing needs. The Association of Anaesthetists reiterates its position, jointly published with the RCoA (available on both websites, updated in 2016; see 'Appendix E: AAGBI and RCoA Executive Summary: Scope of Practice for a PA(A) on qualification' [7]), that PA(A)s should practice within their current scope of practice, and consultants working with them should ensure they are supported to the required standard. PA(A)s should be directly supervised at both induction and emergence of anaesthesia, with a supervising consultant continuously available within the theatre suite and able to attend at all other times within a two-minute timeframe. PA(A)s should always be supervised in accordance with guidance published by the Association of Anaesthetists and RCoA. PA(A)s are not able to prescribe medicines but can administer drugs on the prescription of the supervising consultant under patient-specific directives.

At present there is no statutory regulation of PA(A)s and the RCoA holds a voluntary register for them. Voluntary registers are the first step towards statutory regulation, which would be a positive step forward in the development of PA(A)s.

In 2016 there were approximately 200 trained PA(A)s nationally. Trusts/hospitals training and utilising PA(A)s as part of the anaesthesia team have reported that the role can enhance flexibility and service provision. The work of trained PA(A)s has mainly concentrated on a team-based approach to the delivery of anaesthesia with a positive impact on theatre efficiency, and includes some enhanced roles performed by other practitioners in the NHS such as pre-operative assessment. There are some examples of working in the 2:1 model as was originally envisaged, either with one consultant supervising two PA(A)s, or one PA(A) and one medical trainee.

Whether in the NHS or private sector, two PA(A)s to one consultant anaesthetist should remain the maximum, and PA(A)s working in this way should each have their own qualified assistance. There is as yet no equivalence for those wishing to enter the PA(A) profession from abroad. The Association of Anaesthetists and RCoA do not recommend employing PA(A)s who have not trained in the UK programme.

Qualified PA(A)s are employed on Agenda for Change band 7 or 8. It is important that the recommendations for training and service set out by the Association of Anaesthetists and RCoA in the joint document are adhered to. A toolkit has been developed for those departments wishing to consider PA(A)s as part of the workforce [7].

At the end of their training PA(A)s are not qualified to undertake regional, obstetric or paediatric anaesthesia, or be involved in initial airway management of the acutely ill or injured (as described in the 2016 Scope of Practice document).

The impact of PA(A)s on the educational opportunities of trainee anaesthetists is unclear.

## 7. Recovery in the post-anaesthetic care unit (PACU)

The arrangements for patient recovery in a PACU are comprehensively covered in an AAGBI safety document entitled Immediate Post-anaesthesia Recovery 2013 and Supplement [8].

## 8. Postoperative pain management

### Background

All hospitals performing major surgery should have a multidisciplinary acute pain team with a consultant anaesthetist with overall responsibility. The provision of the service should be supported by a senior anaesthetist (consultant or SAS doctor) with a sessional commitment to acute pain, and a senior nurse running the service on a day-to-day basis, following predefined protocols [8].

A high quality acute pain management service should include identifying the patient's individual requirements on admission and then 'tracking' the patient from the surgical ward, through recovery, critical care if appropriate, and back to the ward.

### The acute pain team

Potential members of an acute pain team include:

- A senior anaesthetist with sessional commitments to the team
- Trainee anaesthetists, as part of the on-call team and as part of their modular training in pain management
- Locally employed doctors in anaesthesia
- A nurse/ODP team to manage the day-to-day follow-up of patients, made up of specialist ODP/nurse/nurse practitioners who have had specific training in the management of acute pain
- Nurses in training
- ODPs
- A pharmacist
- A physiotherapist
- Secretarial and audit department support

### Anaesthetists' responsibility

It is important that postoperative pain be controlled immediately on recovery from anaesthesia. The pain team should, therefore, be involved from an early stage with PACU staff and the senior anaesthetist responsible for the pain service has an obvious role in PACU and other critical care areas. This role will involve the design and implementation of pain management protocols and the education and training of staff.

### Roles of non-medical personnel

A lead nurse/ODP should be responsible for running the service on a day-to-day basis within the limits defined by protocols. The lead nurse/ODP is responsible for liaison between PACU, critical care areas and the wards, troubleshooting problems and referring patients with pain that is difficult to control to medical staff. They also have an important role in education. Potential additional roles

for the acute pain team are the administration of appropriate drugs intravenously and topping up epidurals. The appropriateness of the delegation of any of these tasks is obviously influenced by the location in which they are used, with different roles being appropriate in the HDU, recovery and general ward.

The pharmacy department has a role in the provision of drugs for the acute pain team. It should also be involved in maintaining the range of drugs required for the service, the evaluation of new drugs and education. This important role is enhanced by nominating a specific pharmacist to the team.

An important aim of postoperative analgesia is restoration of function and this can be assessed by the ward physiotherapist who should be involved with the acute pain team and may be a source of secondary referrals.

### **Standards of practice**

The majority of pain services are delivered on the basis of protocols that have been drawn up by consultation between anaesthetists, surgeons and staff from PACU and general wards. Because there are local differences in the role of nurses and the extent of their remit, there will be variations in the protocols between hospitals. The pain team should be responsible for the implementation of a system to introduce, disseminate and review protocols for all grades of staff caring for postoperative patients and for continuing audit of the service.

### **Educational implications**

Educational implications are two-fold: education of the team members and education by the team members.

Anaesthetists should play a major role in educating the members of the acute pain team, in collaboration with the lead nurse. Appropriate aspects of training should also be addressed by other members of the team.

## **9. References**

1. Association of Anaesthetists Safety Guideline. Pre-operative assessment and patient preparation - the role of the anaesthetist 2. London: Association of Anaesthetists, 2010 (<https://www.aagbi.org/sites/default/files/preop2010.pdf>; accessed 10/07/2018).
2. Association of Anaesthetists. Consent for Anaesthesia 2017. London: Association of Anaesthetists, 2017 ([https://www.aagbi.org/sites/default/files/AAGBI\\_Consent\\_for\\_anaesthesia\\_2017\\_0.pdf](https://www.aagbi.org/sites/default/files/AAGBI_Consent_for_anaesthesia_2017_0.pdf); accessed 10/07/2108).
3. NHS England. National Safety Standards for Invasive Procedures (NatSSIPs) 2015 (<https://www.england.nhs.uk/wp-content/uploads/2015/09/natssips-safety-standards.pdf>; accessed 10/07/2018).
4. College of Operating Department Practitioners. Bachelor of Science (Hons) in Operating Department Practice: Curriculum Document. London: CODP, 2011 (<https://www.unison.org.uk/at-work/health-care/representing-you/unison-partnerships/codp/>; accessed 10/07/2018).
5. National core curriculum for perioperative nursing. London: Perioperative Care Collaboration, 2017 (<https://www.afpp.org.uk/careers/Standards-Guidance>; accessed 10/07/2018).
6. Royal College of Anaesthetists. Role of non-medical staff in the delivery of anaesthesia services. London: RCoA, 2003.
7. Association of Anaesthetists/AfPP/APAA/CODP/RCoA. Planning the introduction and training for Physicians' Assistants (Anaesthesia). Considerations for your anaesthetic department London: Royal College of Anaesthetists, 2016 ([https://www.aagbi.org/sites/default/files/Planning-introduction-training-PAA-2016\\_0.pdf](https://www.aagbi.org/sites/default/files/Planning-introduction-training-PAA-2016_0.pdf); accessed 10/07/2018).
8. Association of Anaesthetists Safety Guideline. Immediate Post-anaesthesia Recovery 2013. London: Association of Anaesthetists, 2013 ([https://www.aagbi.org/sites/default/files/immediate\\_post-anaesthesia\\_recovery\\_2013.pdf](https://www.aagbi.org/sites/default/files/immediate_post-anaesthesia_recovery_2013.pdf); accessed 10/07/2018).

## Safer, for everyone

Every anaesthetist aims to keep their patients safe. We aim to safeguard every anaesthetist – by educating, supporting and inspiring them throughout their career.

**We represent** the life-changing, life-saving profession of anaesthesia – by supporting, informing and inspiring a worldwide community of over 11,000 members.

**Our work and members** span the globe, yet our voice is local and personal. We stay in close contact with our members, look after their day-to-day wellbeing, and act as their champion.

**Our world-class conferences**, journal and online resources educate and inform, and our respected guidelines continually improve standards of patient safety.

**We preserve and learn** from the history of anaesthesia. We use that to inform the present, and facilitate vital research and innovation into its future.

**As an independent organisation**, we speak up freely and openly for the interests of anaesthetists and their patients. We influence policy, raise public awareness and are at the forefront of safer anaesthesia across the world.

Published by the Association of Anaesthetists  
21 Portland Place, London, W1B 1PY  
Tel: +44 (0)20 7631 1650  
Email: [info@aagbi.org](mailto:info@aagbi.org)  
[www.aagbi.org](http://www.aagbi.org)

Association of Anaesthetists is the brand name used to refer to both the Association of Anaesthetists of Great Britain & Ireland and its related charity, AAGBI Foundation (England & Wales no. 293575 and in Scotland no. SC040697).



**Association  
of Anaesthetists**