Royal College of Anaesthetists

Explanatory notes to accompany the Interim Anaesthesia Associate Scope of Practice 2024

Note in relation to implementation and review

In November 2024 the Secretary of State for Health and Social Care announced an independent review of physician associate and anaesthesia associate professions, led by Professor Gillian Leng CBE. As the organisation responsible for clinical standards in anaesthetic care, the RCoA will play an active role in the review, which is due to report in Spring 2025. We are therefore publishing the 2024 AA scope of practice as an **interim document** with a view to reviewing its contents in the light of any recommendations produced by Professor Leng.

1. Executive Summary

The Anaesthesia Associate (AA) Scope of Practice 2024 has been created to provide:

- clarity around the role of AAs post-qualification
- assurance around the levels of supervision required to support the AA role
- guidance on clinical practice post-qualification.

The implementation of this scope of practice by departments in all four nations, will provide the first UK-wide accepted scope of practice for all AAs. It outlines clearly defined supervision levels and removes the widespread requirement for reliance on local governance alone to define the work of AAs post-qualification.

1.1 The Anaesthesia Associate Scope of Practice 2024:

- confirms the AA curriculum (once it has moved from draft to published form) and AA registration assessment (AARA) as the starting point for an AA's post-qualification clinical practice
- outlines phases of AA practice post-qualification and the clinical practice supported at each stage
- clearly defines supervision levels and provides detail on the role and responsibilities of the supervisor
- provides a RAG rating describing the aspects of anaesthetic practice that are included in the scope of practice and those that are excluded

- outlines the aspects of practice that require direct supervision
- describes the importance of a stable transition from the 2016 scope of practice onto the new 2024 AA scope of practice to ensure as little impact on patients as possible.
- gives detail on how experienced AAs who have developed established practice should be supervised in order to continue in that role if required
- emphasises the importance of appropriate clinical supervision and the need for adequate numbers of clinical supervisors to be in place prior to any expansion of the AA workforce.

Throughout the process of developing the 2024 AA scope of practice, the RCoA worked alongside representatives from the Association of Anaesthetists and with a wider clinical reference group of stakeholders who have provided both challenge and support in relation to available evidence.

We have also taken into consideration the views of the membership as expressed through the extraordinary general meeting (Oct 2023), the membership survey (Aug 2023) and the feedback received from members and stakeholders through the scope of practice consultation (Sept 2024).

A number of changes have been made to the draft scope of practice in response to the consultation with members and other stakeholders. These changes are detailed in Appendix 2. Also in response to feedback received, we feel it is important to clarify that the financial modelling of AA practice within departments sits outside of the remit of this scope of practice.

The AA Scope of Practice 2024 provides a foundation to enable ongoing safe clinical practice and clarity around the role of AAs within the anaesthetic team. It also ensures the College meets its charitable aims, particularly the requirement to maintain the highest possible standards of professional competence in the practice of anaesthesia for the protection and benefit of the public.

Our aim throughout has been to provide a framework that will allow AAs to continue to deliver patient care under supervision while also addressing the concerns we have heard from the anaesthetic community in relation to ensuring patient safety. We expect that all departments who train and employ AAs will work to this nationally agreed scope of practice.

The RCoA remains committed to supporting AAs currently training or working in the NHS. We have a duty of care to them as individuals and a responsibility to maintain service provision for patients.

2. Why have we published a scope of practice for AAs?

The last national scope of practice for AAs was written jointly by the RCoA and the Association of Anaesthetists in 2016 and only described the AA role at qualification. Since then, some trusts and health boards have developed extended roles for experienced AAs which sit outside of this scope of practice.

Following publication of the NHS Long Term Workforce Plan in 2023, members of the RCoA expressed concerns about the proposed expansion in the number of AAs. Member engagement and resolutions presented at an Extraordinary General Meeting in October 2023 revealed these concerns to be around patient safety, supervision of AAs, capacity to train both anaesthetists and AAs and the lack of a scope of practice beyond qualification. In response, the RCoA committed to a number of actions including the development of a scope of practice to provide clarity around the AA role and describe the levels of supervision that must be provided where AAs support the delivery of anaesthesia.

3. How the 2024 AA Scope of Practice was developed

Following the EGM in October 2023, the College convened a working group comprising representatives from AAs, clinical leads for AAs, Higher Education Institutions (HEI) who train AA students, NHS England, the General Medical Council, the RCoA, the Association of Anaesthetists and the Association of Anaesthesia Associates (AAA).

This group met twice and collated a list of preferences for what the scope of practice should contain. These preferences were the starting point for the Core Writing Group (CWG) who drafted the scope of practice, and a Clinical Reference Group (CRG) who reviewed the draft and gave suggestions regarding its structure and content. Input and oversight were also provided by the RCoA Council and Board of Trustees who had the final sign-off on the document.

The final draft of the AA Scope of Practice 2024 was presented to the membership and external stakeholders for formal consultation in September 2024. The sources of evidence used in the development of the AA scope of practice 2024 are outlined in Appendix 1.

4. Specific aspects of the AA Scope of Practice 2024

The following sections of this document outline the approaches taken to specific aspects of the new 2024 Scope of Practice. They detail the rationale behind the decisions taken in including or excluding aspects of current AA practice. They also outline the process of transition.

4.1 Introduction of phases of practice post qualification

Following discussions with departments who have worked with newly qualified AAs, a common approach to introducing AAs into clinical practice emerged. This described a graduated introduction into 2:1 working over a period of between three to six months. To this end the CWG developed the principle of 'Phases' post qualification to better describe the graduated support that AAs may need as they develop their clinical competence and confidence.

4.2 Removal of the requirement to perform regional anaesthesia

The CWG and Regional Anaesthesia-UK (RA-UK), supported by discussions at RCoA Council and the Board of Trustees, have taken the view that regional anaesthesia does not need to be within the remit of AAs in clinical practice. The imperative should remain to train anaesthetists in training (AiTs), SAS anaesthetists and anaesthetic consultants in the delivery of regional anaesthesia while this recognised gap in training, experience and practice persists.

To protect patients from loss of important services, and to support AAs in established practice who are delivering regional anaesthesia, the scope of practice defines transition arrangements which will allow this to continue under specified governance structures, defined levels of supervision and confirmation that it does not conflict with the training and development of anaesthetists.

4.3. Inclusion of spinal anaesthesia

The draft AA curriculum, developed by the RCoA with input from and consultation with multiple stakeholders, includes the delivery of spinal anaesthesia by AAs and this has been included in the AA scope of practice 2024. It was difficult to reach a consensus position regarding the supervision level required for spinal anaesthesia, but it was agreed that, along with induction of anaesthesia, insertion of a spinal anaesthetic required direct supervision by the clinical supervisor. As with induction of anaesthesia, the involvement of the supervisor in delivering the procedure will become less as the AA becomes more senior, this is further described in the scope of practice.

4.4 ASA grade and required levels of supervision

A significant amount of time was spent discussing the use of ASA as an appropriate grading system for patient selection in relation to AA practice. While other options were considered, ASA grade was viewed as the most widely used system currently available. To this end it has been incorporated within the AA scope of practice 2024 to help departments plan ahead and select appropriate cases (ASA 1 and 2) for AAs to undertake within the 2:1 supervision model.

The decision on a patient's ASA grading for elective surgery should be made by a clinical supervisor and preferably ahead of admission. Whilst other tools are available, ASA remains the best understood and most widely used, but its use will be kept under review.

4.5 Consultation with the specialist societies in anaesthesia

As part of the development of the AA scope of practice a wide network of experts in the delivery of specialist anaesthesia were consulted. Each considered the role of AAs in the training, development and delivery of anaesthesia in their subspecialty area and provided guidance on the role. This guidance can be read on the RCoA website:

- Obstetric anaesthesia
- Paediatric anaesthesia
- Cardiothoracic anaesthesia
- Neuro anaesthesia
- Regional anaesthesia

4.6 Plan for transition to 2024 Scope of Practice for AAs post qualification

It is recognised that the changes written into the AA scope of practice 2024 will have an impact on AAs in current clinical practice and that any change or limit put on extended roles could have a significant impact on the delivery of services in some areas and on the availability of those services to patients who need them.

To manage and minimise this impact on services we will implement a graduated transition to the 2024 scope of practice. It is imperative that any extended roles which sit beyond this scope of practice are confirmed as essential for the support of patient services and do not impact on the ability of anaesthetists to access the training opportunities required to develop the anaesthetic workforce of the future. This will be kept under review by the Regional Adviser network in association with the local Heads of School.

Appendix 1

Approach to the use of evidence in developing the 2024 AA Scope of Practice

As part of the writing process, we have sought to collate the experiences of departments who work with AAs. We are grateful for those who were willing to submit evidence. We also took into consideration the following:

- RCoA member survey
- RCoA clinical leaders survey
- RCoA published statements following EGM
- RCoA commissioned Cochrane Response systematic review of the role of non-physician providers of anaesthesia
- RCoA consultation on the draft 2024 AA scope of practice
- Responses from the membership outlined in report from Research by Design
- Responses from external stakeholders (GMC, NHSE, NES, HEIW, NIMDTA, BMA, AAA and PatientsVoices@RCoA) including departments of anaesthesia
- Association of Anaesthetists position statement on AAs
- AA draft curriculum
- AA Registration Assessment (AARA)
- NHSE, GMC & AoMRC published statements on medical associate professionals (MAPs)
- GMC Good Medical Practice
- BMA published guidance on MAPs
- Discussions held between the AA Scope of Practice Clinical Lead and the Association of Anaesthesia Associates President, HEI representatives and Clinical Lead for AA representatives
- Documents describing locally produced scope of practice and governance processes submitted by departments employing AAs
- Consultation with the Boards/Executive Committees of:
    - Association of Anaesthetists
    - Obstetric Anaesthetists' Association (OAA),
    - Association of Paediatric Anaesthetists (APAGBI),
    - Neuro Anaesthesia and Critical Care Society (NACCS)
    - Association for Cardiothoracic Anaesthesia and Critical Care (ACTACC)
    - Regional Anaesthesia UK (RA-UK)

Appendix 2

Change log for the 2024 Scope of Practice in response to feedback from the consultation.

2024 AA Scope of Practice Change log (post-consultation)	
Section of draft Scope of Practice	**Changes made post consultation**
3.10	Clarification added to confirm the difference between supervision levels post qualification and entrustment levels used during AA training.
3.6; 3.10; 4.10	Removal of the wording requiring a clinical supervisor to remain within the theatre suite due to the geography of some smaller departments – NB: the requirement for a clinical supervisor to be immediately contactable and able to attend within two minutes remains embedded throughout the scope of practice.
4.13	Clarification/change of wording on the involvement of AAs in unplanned lists which include paediatric patients.
All Phases of Scope of Practice	
Regional anaesthesia in the AA curriculum and AARA	An application will be submitted to the GMC for a curriculum change to remove the requirement for AAs to learn to perform regional blocks. When this change is made it will also necessitate a change to the AARA. Sub-tenon blocks and infra-inguinal fascia-iliaca blocks remain described in the extended roles due to the delivery of this skill by other trained health professionals.
Notes to accompany Phases 1-3 of the Scope of Practice	*Progression between phases:* The following wording has been added in relation to the progression between phases: This review should also align with any published requirements for revalidation as outlined by the GMC. *Extended roles:* Wording in point 4 regarding extended roles has been changed to reflect the fact that the purpose of their development is to allow timely and effective patient care.

Phase 1 Scope of Practice (year 1)	
Preoperative assessment	Change overall supervision level to 2b. Retain the recommendation for the clinical supervisor to meet every patient before anaesthesia begins and confirm the preoperative assessment and plan for anaesthesia. (footnote)
Preparation for anaesthesia	Addition of iv cannulation
Delivery of anaesthesia	*Emergence:* Clarification of the requirement for level 1 supervision of emergence from anaesthesia for intubated patients and non-intubated patients with a potential or recognised difficult airway. Clarification of the requirement for level 2a supervision of emergence from anaesthesia for non-intubated patients, excluding those patients with a recognised difficult airway at the discretion of the clinical supervisor.
Extended roles	Confirmation that delivery of infra-inguinal fascia-iliaca blocks for analgesia can be developed as an extended skill post qualification.
Phase 2 Scope of Practice (years 2-4)	
Preoperative assessment and preparation for anaesthesia	Clarification of 2b supervision for these activities.
Delivery of anaesthesia	*Emergence:* Clarification of the requirement for level 1 supervision of emergence from anaesthesia for intubated patients and non-intubated patients with a potential or recognised difficult airway. Clarification of the requirement for level 2a supervision of emergence from anaesthesia for non-intubated patients excluding those patients with a recognised difficult airway at the discretion of the clinical supervisor.

Phase 3 Scope of Practice (>4 years)	
Delivery of anaesthesia	*Emergence:* Clarification of the requirement for level 1 supervision of emergence from anaesthesia in patients with a suspected or known difficult airway (intubated and non-intubated) Clarification of the requirement for level 2a supervision of emergence from anaesthesia for intubated and non-intubated patients excluding those patients with a suspected or known difficult airway at the discretion of the clinical supervisor.
Notes to accompany Phase 3 Scope of Practice	*General point 1 removed:* It is anticipated that after 4 years of clinical practice as an AA, a significant proportion of their clinical work will be under the 2:1 supervision model.
Additional notes covering the scope of practice in all phases	
Infra-inguinal Fascia-Iliaca Block for analgesia	*A note has been added for guidance:* Infra-inguinal Fascia Iliaca Block for the purposes of analgesia are administered by a range of trained practitioners including AAs. Where AAs are providing this service, they must be appropriately trained and supervised.
Prescribing and the administration of medicines	*Addition of the wording:* The Department of Health and Social Care has confirmed with the GMC that once AAs are regulated roles, individuals working in these capacities cannot lawfully prescribe using prescribing rights from another regulated role.
Plan for transition to AA Scope of Practice 2024	
2. AAs already in Phase 2 at point of regulation	Reduction in the expected timeframe for transition from 24 to 12 months. *Change of wording:* Transition to 2024 Scope of Practice will be expected to occur within 12 months of the commencement of regulation (and must occur by 24 months).

3. AAs already in Phase 3 at point of regulation	*Clarification (changes in bold) of the requirements for departments to allow experienced AAs to continue in extended roles:* Where a department employs an AA who is in Phase 3, and where the AA is delivering an extended role in an area of established practice which sits outside of the 2024 Scope of Practice, **the department should review the need for AAs to continue providing this service and the sustainability of this approach following the introduction of the 2024 SoP. Where removal of these extended roles will have a significant impact on patient services departments can consider supporting the AA to continue delivering the extended role under the following criteria**: The department and organisation can demonstrate the need for the AA to continue with that extended role **in order to maintain patient services.** AAs, regardless of seniority, must always be directly supervised during induction of anaesthesia and insertion of spinal anaesthesia AAs, regardless of seniority, must not be working beyond 2:1 (close) supervision when providing general anaesthesia, regional anaesthesia or sedation **Confirmation is received from the associated RAA and HoS that the ongoing undertaking of extended roles by experienced AAs does not impact the ability of AiTs and SAS anaesthetists to generate the experience required to complete their training and develop the required skills**. This will be assessed via a yearly review. This should be confirmed through a training capacity assessment (Appendix 2).

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