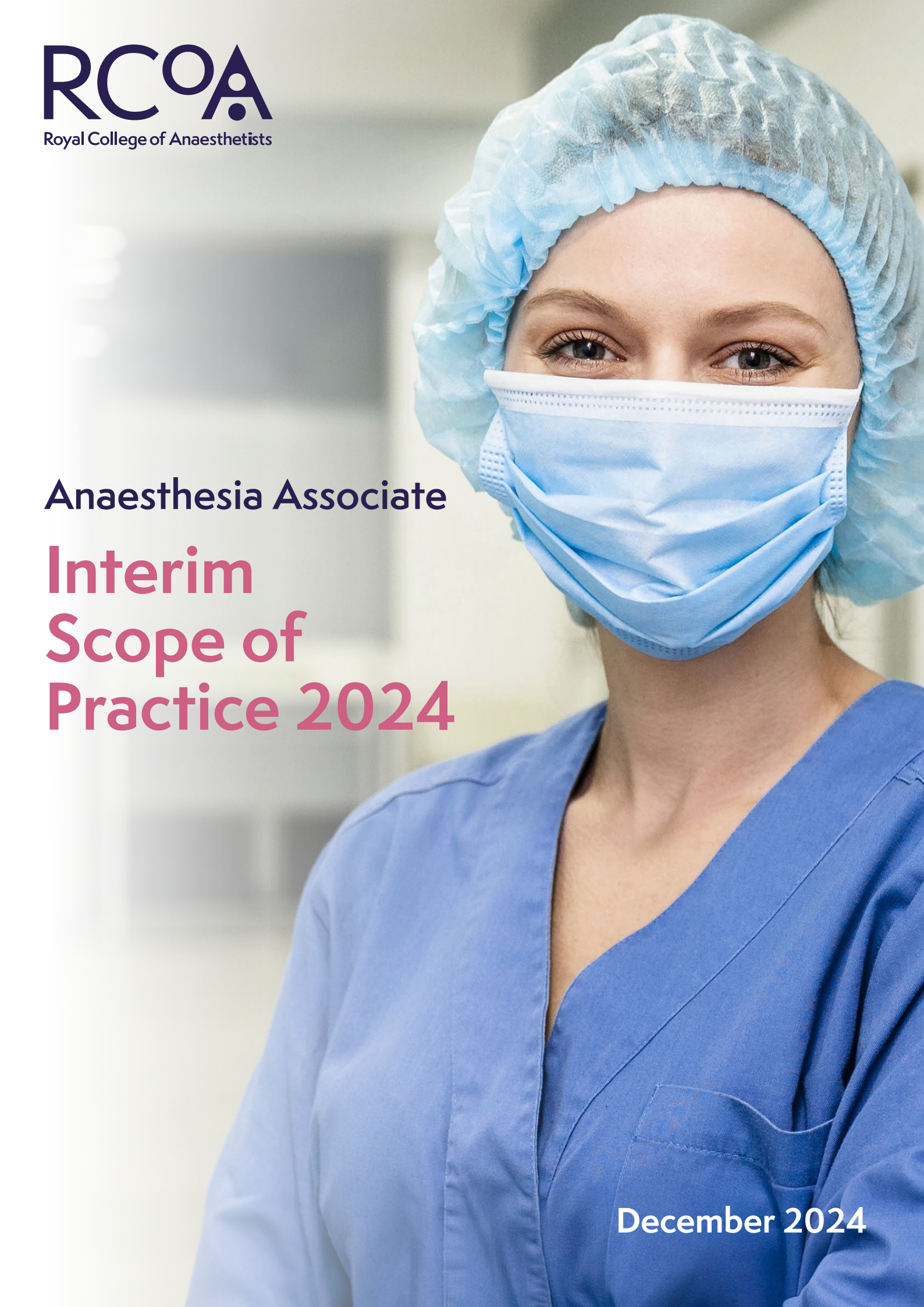
Royal College of Anaesthetists



Anaesthesia Associate

Interim Scope of Practice 2024

December 2024

Contents

Introduction

Anaesthesia associates (AAs), formerly known as physician assistants (anaesthesia), were introduced in 2004 and the role is now established within a number of NHS hospitals. AAs work within the anaesthetic team under the supervision of a consultant or other autonomously practising anaesthetist (from now on referred to as a clinical supervisor). The role of the AA is to assist with the overall service requirements of a department, as additional members of the team.

All qualified AAs undertake a two-year postgraduate qualification having a background as either a registered healthcare professional or a graduate in biological or biomedical sciences. From 2025 they will have to sit and pass the anaesthesia associate registration assessment (AARA)[1] and from December 2024 the General Medical Council (GMC) is their professional regulator. AAs are not doctors and are not qualified to deliver anaesthesia or sedation without supervision.

Role of the anaesthesia associate

AAs provide anaesthetic and perioperative patient care, with a clinical supervisor overseeing either one or two AAs depending on patient acuity and case complexity. In a 1:1 model, an AA works with their clinical supervisor to provide care for the patient. In a 2:1 model, one clinical supervisor takes responsibility for two AAs, or an AA and another anaesthetist, providing anaesthetic care in two operating theatres in close geographical proximity.

Within the scope of practice, and where a need is identified by local departments of anaesthesia, AAs can play a supervised role in preoperative assessment, provision of sedation, delivery of anaesthesia and a range of perioperative and non-perioperative support.

Changes to the 2016 Scope of Practice on qualification

Since the inception of the role, a number of anaesthetic departments have supported AAs to develop extended roles which sit beyond the scope of practice on qualification written in 2016[2]. Whilst this has been done to help support the delivery of patient care, concerns have been raised about the possible impact this has had on patient safety[3]. Clarification in relation to the role of AAs within the anaesthetic team is now required to provide assurance to all individuals involved in the delivery of anaesthesia and to the patients they treat. To this end the 2024 scope of practice has been written to provide:

1. a more detailed description of the role
2. clarity around the level of supervision required
3. detail on the governance required to support AAs to work safely and effectively within the anaesthetic team.

[1] https://www.gmc-uk.org/registration-and-licensing/join-our-registers/information-about-the-anaesthesia-associate-registration-assessment.
[2] www.rcoa.ac.uk/training-careers/working-anaesthesia/anaesthesia-associates/information-existing-aas-student-aas.
[3] www.rcoa.ac.uk/news/report-member-survey-anaesthesia-associates.

The Royal College of Anaesthetists does not support AAs working outside of this scope of practice (transitional arrangements have been created for AAs currently in post and working outside this scope of practice).

Guiding principles

This document is written to provide a background on the principles and structures which govern the way AAs work within the anaesthetic team. These are written to be clear and well-defined. They will encompass the role and requirements at qualification and the structures and timescales that will need to be in place to develop the role beyond qualification.

This document is written to provide clarity to those who work as AAs, their clinical supervisors, their employers and to provide assurance to the patients they treat.

AAs, when working within their scope of practice, provide a safe and valuable contribution to the anaesthetic care of the patient. This scope of practice has been compiled taking into account the evidence available at the time of writing.

This document has been written collaboratively between the Royal College of Anaesthetists and the Association of Anaesthetists, with input from specialist societies and external stakeholders including AAs. Our expectation is that departments of anaesthesia, and the organisations in which they work, will align working practices, employment and supervision of AAs to fit with those outlined within this 2024 Scope of Practice.

This document now replaces the Scope of Practice for PA(A) on qualification 2016 and will be under a cycle of three yearly review.

1 Phases post qualification for anaesthesia associates

Experience and capabilities, both clinical and non-clinical, are expected to develop over time. It is vital that AAs are provided with the support needed to ensure safe practice and the appropriate development of skills. The Anaesthesia Associate Scope of Practice 2024 has been written based on the following phases post qualification:

Phase 1: Scope of practice in first year post qualification (year 1).
Phase 2: Scope of practice for years 2, 3 and 4 post qualification.
Phase 3: Scope of practice year 5 post qualification and beyond.

2 Principles guiding capacity to support anaesthesia associates

2.1 In their published guidance NHS England has been clear that AAs are not doctors, are not a substitute for doctors and must not be used to replace doctors in the delivery of anaesthesia[4] or be used as replacements for doctors on any on call rota[5].

[4] www.england.nhs.uk/long-read/nhs-englands-position-on-physician-associates-7-february-2024/.
[5] www.england.nhs.uk/long-read/summary-of-existing-guidance-on-the-deployment-of-medical-associate-professions-in-nhs-healthcare-settings/ (Item 10).

2.2 AAs are non-autonomous practitioners. Within the anaesthesia team they will always remain under the supervision of a clinical supervisor. This remains the case in any extended role.

2.3 The anaesthetist supervising the AA remains responsible for the safety and overall management of the patient[6]. The responsible anaesthetist must be confident that any AA they are supervising has the necessary knowledge, skills and training to carry out the tasks assigned to them and to ensure safe care. It also is the responsibility of the AA to function within their skill set and not beyond.

2.4 AAs are valued members of the anaesthetic departments in which they work. AAs must have appropriate support and career development. Prior to employing AAs, departments of anaesthesia and employing organisations should ensure the following:

2.4.1 All anaesthetists supervising the work and training of AAs must have the appropriate capacity and capability for the role and the organisation's medical leadership should assure themselves of this[7]. This assurance should include confirmation that the department of anaesthesia has capacity and is able to support the training and employment of AAs.

2.4.2 An assessment has been undertaken to ensure that the case mix within the hospital will be appropriate to enable AAs to work with appropriate supervision within their scope of practice.

2.4.3 A training capacity assessment (Appendix 2) has been undertaken to ensure that the training and employment of AAs will not impact negatively on a department's ongoing ability to train anaesthetists. This will include ensuring the access of anaesthetists to all aspects of the curriculum.

2.5 Departments should regularly review their ability to support all learners. This should be done with the understanding that existing commitments to the training of anaesthetists in training, SAS anaesthetists and locally employed doctors will ordinarily take priority where there is found to be insufficient capacity. This prioritisation reflects the need to meet the workforce challenges of the future[8] and the need to develop the next generation of clinical supervisors.

2.6 AAs should be supervised by clinicians who are provided with the time and training to do so[9].

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[6] www.england.nhs.uk/long-read/nhs-englands-position-on-physician-associates-7-february-2024/ (Item 3).
[7] www.england.nhs.uk/long-read/summary-of-existing-guidance-on-the-deployment-of-medical-associate-professions-in-nhs-healthcare-settings/ (Item 8).
[8] https://www.rcoa.ac.uk/policy-public-affairs/anaesthetic-workforce-uk-state-nation-report-2024.
[9] http://www.england.nhs.uk/long-read/summary-of-existing-guidance-on-the-deployment-of-medical-associate-professions-in-nhs-healthcare-settings/ (Item 8).

2.7 In line with GMC Good Medical Practice all clinicians, when on duty must be accessible to colleagues seeking information, advice, or support[10]. All clinicians in a department must attend and support a colleague in the event of an urgent or emergency situation.

2.8 It is in the best interests of the AA and their clinical supervisor that the supervisor has agreed to undertake the role. Departments should recognise that not all clinicians will wish to have this role included in their job plan. Clinical supervisors for AAs should only include those who have the knowledge, skills and capacity to undertake the role.

3 Principles underpinning the clinical supervision of anaesthesia associates

3.1 AAs must only work under the supervision of a consultant or autonomously practising anaesthetist.

3.2 AAs must not be supervised by an anaesthetist who requires supervision themselves, e.g. anaesthetists in training, non-autonomously practising SAS or locally employed doctors.

3.3 AAs must not be supervised by another AA.

3.4 Whilst responsible for supervising AAs and anaesthetists (under a 2:1 model), the clinical supervisor must not provide solo anaesthesia for another patient or undertake any duties they cannot leave immediately.

3.5 The clinical supervisor must not be responsible for more than two anaesthetised patients simultaneously, where one or both involve supervision of an AA. When supervising within a 2:1 model it is essential that the clinical complexity of the anaesthetic management is appropriate, and the cases should be within the same theatre suite.

3.6 Every AA must have immediate access to a clinical supervisor who must always be available within two minutes.

3.7 An AA should always know where their clinical supervisor is and how to contact them. Equally the supervisor should always know where their supervisees are and have detailed knowledge of the clinical activity they are responsible for. This can be assessed and monitored by a department through use of the Cappuccini Test[11].

3.8 If the clinical supervisor will need to be more than two minutes away for any reason, deputising arrangements must be made. A formal handover of the case to the new clinical supervisor must take place.

[10] www.gmc-uk.org/professional-standards/professional-standards-for-doctors/good-medical-practice/domain-3-colleagues-culture-and-safety (Paragraph 50 GMP).
[11] https://www.rcoa.ac.uk/safety-standards-quality/patient-safety/cappuccini-test.

3.9 Where a clinical supervisor is responsible for more than one anaesthetised patient (2:1 supervision model), and they become involved in closely supporting one supervisee (e.g. managing a critical incident requiring conversion to 1:1 supervision), another clinical supervisor must be mobilised to be available for the other supervisee. The local implementation for the supervision of AAs must take this into account and must explicitly plan for it.

3.10 Levels of Supervision
The levels of supervision listed below relate to AAs working in clinical practice post qualification and are different to those described in the AA curriculum and AARA. Those used in training are supervision entrustment levels for student AAs and are used to assess progress during training.

Level of Supervision	Descriptor
1 (Direct)	Direct supervisor involvement – present in the same theatre and available to assist when needed (1:1 working)
2a (Close)	Supervisor in theatre suite, available to guide aspects of activity through monitoring at regular intervals and available within two minutes of being called (1:1 or 2:1 working)
2b (Local)	Supervisor within hospital for queries, able to provide prompt direction/assistance **NB: this level of supervision is not to be used the delivery of anaesthesia or deep sedation – it can be used for procedures such as fascia-iliaca block (FIB) placement or midline/PICC line insertion**

3.11 In addition to a clinical supervisor, there must be a dedicated trained assistant, i.e. an operating department practitioner (ODP) or equivalent, in every theatre in which anaesthesia care is being delivered, whether this is by an anaesthetist or AA.

3.12 AAs can undertake clinical activity during daytime, evenings, weekends or overnight. However, any clinical activity undertaken by AAs must occur under the same level of clinical supervision and by the same grade of supervisor outlined within this scope of practice.

4 The practice of clinical supervision of anaesthesia associates

4.1 AAs must work at all times with a clinical supervisor whose name must be recorded in the individual patient's medical notes.

4.2 Overall responsibility for the anaesthesia care of the patient rests with the clinical supervisor.

4.3 It is essential that a clinical supervisor, who has experience of supervising AAs, has direct input into patient selection for lists where AAs are working in a 2:1 model (ASA 1 and 2 patients – see Appendix 1 for ASA classification). Ideally, this selection process should happen early in the patient pathway e.g. when the patient undergoes their preoperative assessment. At this stage a patient can be deemed appropriate for an AA to be involved in their care under close supervision. This should also be reviewed as part of the list planning process and should ensure that the AA can be safely supervised within a 2:1 model.

4.4 Last minute changes to operating lists should trigger a review of the case mix and supervision levels and lists should not commence until appropriate supervision is in place.

4.5 The supervising clinician must take overall responsibility for preoperative patient assessment, suitability of the proposed anaesthetic techniques and patient consent.

4.6 The anaesthesia plan for each patient must be reviewed by the clinical supervisor before anaesthesia begins.

4.7 All staff must introduce themselves and their role clearly, to ensure that patients understand who is caring for them[12]. AAs should introduce themselves using precise language, and (unless the supervisor is present and introduces themself) should explain who is supervising them[13].

4.8 All patients should be supported to understand the role of each healthcare professional they are seeing and not be led to believe that the professional they are seeing has competencies beyond their scope of practice or skill set[14,15].

4.9 For AAs in Phase 1 it is recommended that the clinical supervisor should meet every patient before anaesthesia begins and should confirm the preoperative assessment.

4.10 In all phases, and for every case, the clinical supervisor must:

- be easily contactable and available to attend within two minutes
- be present in the anaesthetic room/operating theatre directly supervising induction of anaesthesia
- regularly review the intra-operative anaesthetic management
- be available (2a – close supervision) when emergence from anaesthesia is planned in non-intubated patients who are not deemed by their clinical supervisor to have a recognised difficult airway (AAs must notify

[12] www.england.nhs.uk/long-read/summary-of-existing-guidance-on-the-deployment-of-medical-associate-professions-in-nhs-healthcare-settings/ (Item 11).
[13] https://rcoa.ac.uk/sites/default/files/documents/2024-08/Principles-guide-HCPs-on-how-to-introduce-themselves-FINAL.pdf
[14] www.england.nhs.uk/long-read/summary-of-existing-guidance-on-the-deployment-of-medical-associate-professions-in-nhs-healthcare-settings/ (Item 12).
[15] www.rcoa.ac.uk/patients/about-anaesthesia-perioperative-care/anaesthesia-team.

their clinical supervisor when emergence from anaesthesia is due to occur)

- be directly available (1 – direct supervision) when emergence from anaesthesia is planned in intubated patients (AAs must notify their clinical supervisor when emergence from anaesthesia is due to occur)
- remain immediately contactable and able to attend within two minutes until control of airway reflexes has returned and airway devices have been removed
- remain immediately contactable and able to attend within two minutes until the on-going care of the patient has been handed on or delegated to other appropriately qualified staff.

4.11 When AAs are involved in administering anaesthesia or deep sedation[16] outside of the theatre environment they must be working under 1:1 supervision. This would include (but is not exclusively limited to) working in the following sites:

1 endoscopy units
2 interventional radiology
3 interventional cardiology
4 emergency department.

4.12 When AAs are involved in anaesthesia or sedation for surgery which is not planned (for instance on emergency or trauma lists), they must work under 1:1 supervision. 'Planned' in this sense means surgery has been scheduled in advance (not on the same day), and the patient has been through formal anaesthesia pre-assessment or screening, meets starvation criteria for elective surgery and is otherwise fully prepared. Some types of non-acute, minor emergency and planned trauma lists may therefore fit the definition and can be undertaken with a 2:1 supervision model.

4.13 AAs should not normally be involved in the anaesthetic management of paediatric patients (<16 years of age) but if they are assisting in an operating list (e.g. trauma/emergency) and a paediatric patient needs to be anaesthetised or sedated, they can continue to be involved but must be directly supervised, working in a 1:1 model. If a clinical supervisor needs to leave the theatre, then another supervisor must take over the case.

[16] https://www.aomrc.org.uk/publication/safe-sedation-practice-for-healthcare-procedures-standards-and-guidance

Scope of Practice for Anaesthesia Associates 2024

Phase 1 Scope of Practice (year 1)

The following roles/activities are included within the scope of practice for anaesthesia associates in Phase 1

Preoperative Assessment	
Under supervision level 2b	▪ Taking a focussed medical/surgical history. ▪ Interpretation of relevant investigations. ▪ Current medication review. ▪ Respiratory and cardiovascular examination. ▪ Airway assessment. ▪ Consenting patients for anaesthesia and common anaesthetic interventions*. ▪ Agreeing the plan for anaesthesia with the supervising anaesthetist**.
Preparation for Anaesthesia	
Under supervision level 2a	▪ Anaesthetic equipment and machine check. ▪ Preparation of anaesthetic drugs. ▪ Preparation of IV fluids. ▪ IV cannulation.
Delivery of Anaesthesia	
Under supervision level 1	▪ Induction of anaesthesia. ▪ Securing of the airway. ▪ Insertion of spinal anaesthesia. ▪ Emergence from anaesthesia for all intubated patients and non-intubated patients with a potential or recognised difficult airway.
Under supervision level 2a	▪ Monitoring/documentation of patient vital signs. ▪ Maintenance of anaesthesia. ▪ Monitoring of patients during surgery under general, neuraxial or regional anaesthesia. ▪ Administration of IV fluids as required. ▪ Emergence from anaesthesia for non-intubated patients excluding those patients with a recognised difficult airway at the discretion of the clinical supervisor. ▪ Immediate post-operative care in recovery.
Under supervision level 2b	▪ Ultrasound guided peripheral venous cannulation.

Extended roles which can be considered for development in Phase 1***	
Under supervision level 1 progressing to level 2b	▪ Ultrasound guided insertion of midline and peripherally inserted central catheter (PICC) lines following appropriate locally agreed additional training. ▪ Infra-inguinal fascia-iliaca block (IIFIB) to provide analgesia following appropriate locally agreed additional training.
Exclusions from scope of practice at Phase 1	

	▪ Induction of anaesthesia including airway management without direct supervision (except emergence where outlined above).
	▪ Regional anaesthesia other than spinal and FIB.
	▪ Insertion of central venous lines (except PICC).
	▪ Insertion of arterial lines.
	▪ Subspecialty anaesthesia including:
	  ▪ paediatrics (patient <16 years) – see 4.12
	  ▪ obstetric anaesthesia
	  ▪ cardiothoracic anaesthesia
	  ▪ neuro anaesthesia.

*AAs can take consent for procedures for which they are suitably trained/qualified to undertake and where they have sufficient knowledge of the proposed investigation or treatment, and the risks involved.

**See note 4.9 - For AAs in Phase 1 it is recommended that the clinical supervisor should meet every patient before anaesthesia begins and should confirm the preoperative assessment and plan for anaesthetic.

***To enable the development of extended roles it is essential that there is a demonstrated clinical need for AAs to undertake this role within the employing organisation. It must also be confirmed that there are sufficient training opportunities for the anaesthetists within the department to have received this training if required[17].

Notes to accompany Phase1 Scope of Practice

Progression from level 1 to level 2 supervision during Phase 1

It is expected that in the first three to six months post qualification an AA will be working with 1:1 (level 1) supervision for their clinical activity. During this time clinical confidence and competence will develop, and it will be appropriate for this level of supervision to move from direct (level 1) to close (level 2a) supervision. With increasing experience in the delivery of general anaesthesia an assessment should be made by the clinical lead for AAs in conjunction with the clinical director that the level of supervision can move towards 2:1 working. This review should take into consideration the AA's logbook of cases/procedures, case mix, reflections on any critical incidents and feedback from their clinical supervisors (e.g. via a Multiple Trainer Report). This review should also align with any published requirements for revalidation as outlined by the GMC.

[17] www.aomrc.org.uk/wp-content/uploads/2024/03/Consensus_statement_High_level_principles_concerning_PAs_040324.pdf.

General

1 Any clinical activity involving AAs in the delivery of general anaesthesia outside of the operating theatre complex will require 1:1 supervision by a clinical supervisor. This relates to all remote sites within a hospital.

2 It is expected that, within Phase 1 working, AAs can maintain anaesthesia in ASA 1 and 2 patients under 1:1 (level 1) or 2:1 (level 2a) supervision as guided by their clinical supervisor. Where a patient is deemed by the clinical supervisor to be ASA 3 or above then any anaesthesia delivered by an AA should be supervised through 1:1 working under either direct (level 1) or local (level 2a) supervision. See Appendix 1 for ASA classification.

Sedation

3 Where deep sedation[18] is required, an AA should be directly supervised (level 1).

Extended roles

4 Extended roles as highlighted within the Phase 1 scope of practice can be considered where required by the organisation to allow delivery of effective and timely patient care. All extended roles within Phase 1 will need to be performed under direct supervision unless otherwise stated.

5 Development of extended roles will require the department to clearly define the training support required and the governance in place to ensure safe delivery of patient care.

[18] www.aomrc.org.uk/publication/safe-sedation-practice-for-healthcare-procedures-standards-and-guidance/.

Phase 2 Scope of Practice (years 2-4)

The following roles/activities are included within the scope of practice for anaesthesia associates in Phase 2

Preoperative Assessment	
Under supervision level 2b	▪ As per Phase 1.
Preparation for Anaesthesia	
Under supervision level 2b	▪ As per Phase 1.
Delivery of Anaesthesia	
Under supervision level 1*	▪ Induction of anaesthesia. ▪ Securing of the airway. ▪ Insertion of spinal anaesthesia. ▪ Emergence from anaesthesia for all intubated patients and non-intubated patients with a potential or recognised difficult airway.
Under supervision level 2a	▪ Monitoring/documentation of patient vital signs. ▪ Maintenance of anaesthesia. ▪ Monitoring of patients during surgery under spinal, neuraxial or regional anaesthesia. ▪ Administration of IV fluids as required. ▪ Emergence from anaesthesia for non-intubated patients excluding those patients with a recognised difficult airway at the discretion of the clinical supervisor. ▪ Immediate post-operative care in recovery.
Additional Procedures	
Under supervision level 2a or 2b	▪ Infra-inguinal fascia-iliaca block (FIB) to provide analgesia following appropriate locally agreed additional training if not completed in Phase 1. ▪ Ultrasound guided peripheral venous cannulation to include midline and peripherally inserted central catheter (PICC) lines following appropriate locally agreed additional training.

Extended roles which can be considered for development in Phase 2**	
Under supervision level 1	▪ Insertion of arterial lines.
Exclusions from scope of practice at Phase 2	

	▪ Induction of anaesthesia including airway management without direct supervision (except emergence where outlined above).
	▪ Regional anaesthesia other than spinal and FIB.
	▪ Insertion of central venous lines (except PICC).
	▪ Subspecialty anaesthesia including:
	  ▪ paediatrics (patient <16 years) — see 4.12
	  ▪ obstetric anaesthesia
	  ▪ cardiothoracic anaesthesia
	  ▪ neuro anaesthesia.

*__Induction of anaesthesia and insertion of spinal anaesthesia:__ It is expected that as an AA gains experience, whilst still directly supervised for induction of anaesthesia and insertion of spinal anaesthesia, their clinical supervisor may be able to reduce their level of involvement in the procedure.

**To enable the development of extended roles it is essential that there is a demonstrated clinical need for AAs to undertake this role within the employing organisation. It must also be confirmed that there are sufficient training opportunities for the anaesthetists within the department to have received this training if required.

Notes to accompany Phase 2 Scope of Practice

Progression from Phase 1 to Phase 2

Following the completion of the first year post-qualification an AA should move into Phase 2. With increasing experience in the delivery of general anaesthesia an assessment should be made by the clinical lead for AAs in conjunction with the clinical director that the AA is able to progress into the next phase. This annual review should take into consideration the AA's logbook of cases/procedures, case mix, reflections on any critical incidents and feedback from their clinical supervisors (e.g. via a Multiple Trainer Report). This review should also align with any published requirements for revalidation as outlined by the GMC.

General

1 It is anticipated that after one year of clinical practice AAs may be working more regularly under 2:1(level 2a) supervision.

2 It is expected that, within Phase 2 working, AAs can maintain anaesthesia in ASA 1 and 2 patients under 2:1 (level 2a) supervision as guided by their clinical supervisor. Where a patient is deemed by the clinical supervisor to be ASA 3 or above then any anaesthesia delivered by an AA should be supervised through

1:1 working under either direct (level 1) or local (level 2a) supervision. See Appendix 1 for ASA classification.

Sedation

3 Where deep[19] sedation is required, an AA should be directly supervised (level 1).

Extended roles

4 Extended roles as highlighted within the Phase 2 scope of practice can be considered where required by the organisation to allow delivery of effective and timely patient care. All extended roles within Phase 2 will need to be performed under direct supervision unless otherwise stated.

5 Development of extended roles will require the department to clearly define the training required and the governance in place to ensure safe delivery of patient care.

[19] https://www.aomrc.org.uk/publication/safe-sedation-practice-for-healthcare-procedures-standards-and-guidance/

Phase 3 Scope of Practice (year 5 and beyond)

The following roles/activities are included within the scope of practice for anaesthesia associates in Phase 3

Preoperative Assessment and Preparation for Anaesthesia	
Under supervision level 2b	▪ As per Phase 1 and 2.
Delivery of Anaesthesia	
Under supervision level 1*	▪ Induction of anaesthesia. ▪ Securing of the airway. ▪ Insertion of spinal anaesthesia. ▪ Emergence from anaesthesia in patients with a suspected or known difficult airway (intubated and non-intubated).
Under supervision level 2a	▪ As per Phase 1 and 2. ▪ 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.
Additional Procedures	
Under supervision level 2b	▪ Infra-inguinal fascia-iliaca block (FIB) to provide analgesia. ▪ Ultrasound guided peripheral venous cannulation to include midline and peripherally inserted central catheter (PICC) lines once appropriately trained.
Extended roles which can be considered for development in Phase 3**	
Under supervision level 2a	▪ Insertion of arterial lines. ▪ Insertion of central venous access following additional locally agreed training and assessment.
Exclusions from scope of practice at Phase 3	

	▪ Induction of anaesthesia including airway management without direct supervision (except emergence as outlined above).
	▪ Regional anaesthesia other than spinal and FIB.
	▪ Subspecialty anaesthesia including:
	  ▪ paediatrics (patient <16 years) – see 4.12
	  ▪ obstetric anaesthesia
	  ▪ cardiothoracic anaesthesia
	  ▪ neuro anaesthesia.

*__Induction of anaesthesia and insertion of spinal anaesthesia:__ It is expected that as an AA gains experience, whilst still directly supervised for induction of anaesthesia and insertion of spinal anaesthesia, their clinical supervisor will be able to reduce their level of involvement in the procedure.

**To enable the development of extended roles it is essential that there is a demonstrated clinical need for AAs to undertake this role within the employing organisation. It must also be confirmed that there are sufficient training opportunities for the anaesthetists within the department to have received this training if required.

Notes to accompany Phase 3 Scope of Practice

Progression from Phase 2 to Phase 3

Following the completion of four years post qualification an AA should move into Phase 3. With increasing experience in the delivery of general anaesthesia an assessment should be made by the clinical lead for AAs in conjunction with the clinical director that the AA is able to progress into the next Phase. This review should take into consideration the AA's logbook of cases/procedures, case mix, reflections on any critical incidents and feedback from their clinical supervisors (e.g. via a Multiple Trainer Report). This review should also align with any published requirements for revalidation as outlined by the GMC.

General

1 It is expected that, within Phase 3 working, AAs can maintain anaesthesia in ASA 1 and 2 patients under 2:1 (level 2a) supervision. Where a patient is deemed by the clinical supervisor to be ASA 3 or above then any anaesthesia delivered by an AA should be supervised through 1:1 working under either direct (level 1) or local (level 2a) supervision. See Appendix 1 for ASA classification.

Sedation

2 Where deep sedation is required, an AA should be directly supervised (level 1)

Extended Roles

3 Extended roles as highlighted within the Phase 3 scope of practice can be considered where required by the organisation to allow delivery of effective and timely patient care. It may now be reasonable for extended roles within Phase 3 to be performed under level 2b supervision.

4 Development of Phase 3 extended roles will require the department to clearly outline the training required and the governance in place to ensure safe delivery of patient care.

Additional notes covering the scope of practice in all phases

Regional Anaesthesia:

Sub-tenon block for ophthalmic surgery

Sub-tenon blocks for eye surgery are administered by a range of trained practitioners including AAs. Where AAs are providing this service, they must be appropriately trained and supervised under either a 1:1 or a 2:1 model.

Infra-inguinal fascia iliaca block for analgesia

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 administration of medicines:

Within the operating theatre, any administration of drugs by AAs is regarded as being on the order of the clinical supervisor. AAs can administer medicines but are not able to act as independent or supplementary prescribers. A robust mechanism for regulating this arrangement should be devised locally. Many hospitals have adopted a route of generating patient-specific directions (PSD) as evidence of prescription by the supervising anaesthetist. Robust governance utilising PSDs for drug authorisation and administration by AAs should be in place.

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.

Please note that the clinical supervisor remains responsible and accountable for all medicines administered by the AA.

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

It is recognised that the changes written into the 2024 Scope of Practice will have an impact on those AAs in current clinical practice. This will be greatest for those who have been in practice the longest and who have developed extended roles beyond those outlined in the 2016 scope. We are aware that any change or limit put on extended roles in the AA Scope of Practice 2024 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 from the 2016 to the 2024 AA Scope of Practice as outlined below:

1 **AAs in Phase 1 (1st year post qualification)**
Transition to 2024 Scope of Practice at the point of regulation.

2 **AAs already in Phase 2 (years 2,3 and 4 post qualification) at point of regulation**
Transition to 2024 Scope of Practice will be expected to occur within 12 months of the commencement of regulation (and must transition by 24 months)

3 **AAs already in Phase 3 (year 5 and beyond post qualification) at point of regulation**
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 enhanced 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:

- **a** the department and organisation can demonstrate the need for the AA to continue with that extended role in order to maintain patient services
- **b** AAs, regardless of seniority, must always be directly supervised during induction of anaesthesia and insertion of spinal anaesthesia
- **c** AAs, regardless of seniority, must not be working beyond 2:1 (close) supervision when providing general anaesthesia, regional anaesthesia or sedation
- **d** 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).

Appendix 1

ASA Classification

Assigning an ASA Physical Status (PS) classification level is a clinical decision based on multiple factors. While the Physical Status classification may initially be determined at various times during the preoperative assessment of the patient, the final assignment of Physical Status classification is made on the day of anaesthesia care by the clinical supervisor after evaluating the patient[20]. It is recognised that ASA is not the most sensitive tool for patient assessment, however, at the time of writing it is widely used and understood. Its use within this document will be kept under review.

Current Definitions and ASA-Approved Examples

ASA PS Classification	Definition	Adult Examples, Including, but not Limited to:
ASA 1	A normal healthy patient	Healthy, non-smoking, no or minimal alcohol use.
ASA 2	A patient with mild systemic disease	Mild diseases only without substantive functional limitations. Current smoker, social alcohol drinker, pregnancy. Obesity (BMI 30<BMI<40) Well-controlled DM/HTN, mild lung disease.
ASA 3	A patient with severe systemic disease	Substantive functional limitations. One or more moderate to severe diseases. Poorly controlled DM or HTN, COPD. Morbid obesity (BMI ≥40). Active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, ESRD undergoing regularly scheduled dialysis, history (>3 months) of MI, CVA, TIA, or CAD/stents.

[20] www.asahq.org/standards-and-practice-parameters/statement-on-asa-physical-status-classification-system.

Appendix 2

Training Capacity Assessment

A training capacity assessment (TCA) should be undertaken prior to the introduction of anaesthesia associates into a department. Full details of the TCA can be found here.

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