**Anaesthesia Associates – Developing a Stronger Anaesthesia Team for the Future**

**Questions, Answers and Comments from MS Teams chat:**

**Can you describe the structure of indemnity please?**

***[Paul Forsythe]*** At the moment it is a process of vicarious liability with the Trust as described within a JD and local governance. Post regulation there may be a greater requirement for indemnity insurance moving forward.

**Is there any thought surrounding sharing of the curriculum with cons anaes trainers?**

***[Paul Forsythe]*** So the new curriculum has been developed by the RCOA to meet current GMC requirements and will be owned by them. I can't say for sure, but I would have thought that it would be available for trainers to review.

***[Nigel Penfold]*** Further to Paul’s comments: the new AA curriculum is going through final stages of GMC approval, so should be available soon. There was significant stakeholder engagement in its development. Its planned publication date is 29 September 2022.

**Who are the two new providers of blended training that were referred to please? And which training courses start in Jan-Mar 23?**

***[Nigel Penfold]*** 2 new providers are at UCL and Lancaster Univ. thus making 3 HEI in UK running AA courses along with Birmingham. Further info on their websites but both will have intakes by March 23.

***[Laura McEwen-Smith]*** Birmingham and UCL course directors speaking on the agenda late, they will be able to confirm their respective intakes.

**Can you confirm who you are currently regulated with? Is GMC regulation set up for AAs yet? Are those who were nurses or ODPs pre-AA still registered with NMC/HCPC? Thanks**

***[Paul Forsythe]*** So we are currently under a managed voluntary register (MVR) held by the RCOA that will move over to the GMC when statutory regulation is in place (hopefully 2024). Most HCP currently working as AAs will have maintained their original regulator from their background. However, this may change when registered with the GMC.

**With regards the link of non-prescribers, do the AA's get a signed SOP for drugs with parameter limits? What about opiates?**

***[Paul Forsythe]*** So most AAs work under an SOP and PSDs (including opiates) set up within their Trust with a sign off on the Anaesthetic chart by their supervisor. Patient Specific Directions (PSD) for most Trusts employing AAs.

***[Nigel Penfold]*** Our AAs administer all anaesthetic related drugs under a PSD - this is extremely easy for the supervising consultant to enter in our electronic anaesthetic system. Until GMC regulation comes in AAs cannot prescribe since to prescribe you need to be regulated. Chicken and egg scenario. This will be sorted post regulation even for ODPs who while regulated cannot undertake the NMP courses. In practice it causes us no issues.

**Could AAs participant in anaesthetic trainees on-call rotas?**

***[Nigel Penfold]*** At my hospital AAs do partake in the first on-call rota when needed. Consultant is on-site.

***[Wouter de Kroon]*** We cover weekend CEPOD and Trauma cover 2:1 if and when needed

**Do AAs work to specific job plans?**

***[Paul Forsythe]*** Yes, mostly as with any other HCP. Although there is a degree of flexibility within that. For example, in my Trust we in the main support the DSU but can be utilised across the whole anaesthetic rota as required and will often support trauma theatres etc.

**Do the panel have concerns training AAs will deplete potentially the pool of ODPS for instance nationally?**

***[Paul Forsythe]*** Not necessarily. I think post regulation there will be a greater number of science graduates employed as we will all be regulated by the GMC. I think in the past Trusts have (rightly or wrongly) felt more protected by existing HCP as they already had a regulator in place. I do think it should always remain as a career option for ODPs to go to. There is an argument to say though that by providing this as an avenue (career progression) in the future could encourage more people into the ODP profession.

**How long after completing ODP training can a practitioner apply to undergo AA training?**

***[Paul Forsythe]*** I think most of the HEIs stipulate around 3-5 years of relevant experience working as an HCP.

**With a novice anaesthetic trainee it is clear at what point they can be left in theatre. How do you work out when a trainee AA can be left? Is there clear guidance or local decision?**

***[Wouter de Kroon]*** Local training, individual development, consultant-AA relationship, and case dependent.

***[Paul Forsythe]*** AA students are directly supervised throughout their training. Of course, as they get to the end of their studies, they do need some time to be 'left' to manage cases. In the main this is a local decision, depending on the Consultant and student. Most can be managed very closely but still have the experience of managing the patient 'solo' as it were.

**How would AAs fit in departments with bulk ASA3 patients?**

***[Wouter de Kroon]*** ASA 3-4 is very common covered by AAs especially with more experience/time. there is always a discussion with the supervising consultant.

***[Paul Forsythe]*** AAs are very flexible and can fit into most departments. They may not always be utilised in multiple theatres if it is deemed not suitable. The scope is on qualification and the ASA 1/2 only refers to the 2:1 model and so ASA 3 is not out of scope for newly qualified AAs on other models such as 1:1. Experienced AAs can and do manage ASA 3 patients on a 2:1 model. Of course, with appropriate input from their supervisor.

**What proportion of the two years training time spend in work-based learning?**

***[Tom Clutton-Brock]*** For Birmingham, about 70% work-based training.

**UCL website says course starts in Sep 22, Lancaster website says it is available to trainees in north-west, north-east and Yorkshire & Humber. Can you clarify where are the national blended learning options for spring 2023 intake?**

***[Kyna Houston]*** UCL has a national intake in spring 2022. Imminently confirming whether January/March.

***[Laura McEwen-Smith]*** The national blended learning delivery contracts for AA programmes are across three geographical lots, the North lot was awarded to Lancaster Medical School.  The other two lots, covering the rest of England, were awarded to UCL.  Both Lancaster and UCL have cohorts commencing in the Spring (as Kyna points out, UCL still to confirm whether this will be January or March). University of Birmingham do not hold a blended learning delivery contract with HEE but do have an programme offering (with no geographical restrictions) which Trusts can consider. Trusts would need to contact UoB to find out more about cohort intakes.

***[Tom Clutton-Brock]*** The University of Birmingham will have an intake in March 2023 with some flexibility for existing healthcare workers (ODPs etc.) There are no geographical restrictions -[https://www.birmingham.ac.uk/postgraduate/courses/taught/med/anaesthesia-associate.aspx](https://protect-eu.mimecast.com/s/Rh6kC4zPmsEm8k3iOVOV3?domain=birmingham.ac.uk)

**Will the expectation be to drop base registration or pay dual once GMC registration comes in, or will the option remain for base registration to remain? Given the National workforce for medical nursing and AHP staff.**

***[Nigel Penfold]*** I would envisage AAs who already have registration with the HCPC or NMC to have to option to remain on those registers providing they meet the requirements. They will have to be on the GMC register to practice as an AA.

***[Jonathan Harrison]*** We are not sure at the moment. It seems likely that GMC registration will be mandatory, but if some AAs wish to keep their base registration active then they can. This is analogous to the way MaxFax surgeons have had dual registration with GMC/GDC for many years.

***[Lisa Churchill]*** I believe this is currently being discussed with the GMC and NMC.

**Where did you get the 3-year timeline from? Is this just a realistic assessment of the time it takes to engage stakeholders, business case etc? Is there any way to accelerate this given the crisis in workforce?**

***[Jonathan Harrison]*** I'm not sure who mentioned the 3 year timeline. In Portsmouth we went from first serious discussions at job planning in Oct, to then get business case approved and recruitment under way for start the following Sept - so 11 months. In theory you could move faster than this if your Dept is on board and you have funding identified. It is then 27 months of training, so it is about 3 years from start of project to first qualified AAs in post. We made a case for 8 AAs, 4 per year for 2 years and I think now we have momentum we will continue to recruit 2 or more trainees every year from now. If you start off with only 1 or 2 you will have a more cautious ramp up, a shallower learning curve and a smaller workforce impact.

**Is there potential benefit of a ‘complexity score’ over and above the good old ASA score?**

***[Nigel Penfold]*** I’m unsure what ‘complexity score’ the question refers to. If such a score was adopted it would need to be applicable to all patients and all anaesthetic provider groups e.g. consultants, trainees, SAS and AAs. While the ASA score wasn’t designed for this purpose and has limitations, it is simple and widely used and works well for these purposes.

***[Jonathan Harrison]*** I think this would be great but is a bit beyond the scope of these discussions. Depts that have AAs decide to use them in certain areas with specific types of patient e.g. trauma lists. They get very good at managing these patients as they do it repetitively. So, ASA or complexity is not necessarily the barrier - we visited Eindhoven and their AAs do the oesophagectomy lists essentially solo as they do them all the time. What you can't necessarily do is then put that AA in Preop the next day and maternity the day after - their scope of practice tends to be narrower than a medical anaesthetist (as a generalisation).

***[Lisa Churchill]*** I agree that a complexity score is more appropriate- the ASA grade1/2 is mentioned as an example (in the scope of practice for an AA on qualification) of ensuring the complexity of the case and the anaesthetic management is appropriate for the AA. This will vary with training and experience.