MEETING OF COUNCIL

Edited Minutes of the meeting held on Wednesday 13 April 2011
Council Chamber, Churchill House

Items which remain (at least for the time being) confidential to Council are not included in these minutes

Members attending:

Dr P Nightingale, President
Dr A A Tomlinson
Dr J-P W G van Besouw
Dr J D Greaves
Dr A B H Lim
Dr R Laishley
Professor D J Rowbotham
Dr H M Jones
Professor J F Bion
Dr E A Thornberry
Professor R P Mahajan
Dr P J H Venn
Dr A M Batchelor
Professor J R Sneyd
Dr S R Moonesinghe
Dr D K Whitaker
Dr D M Nolan
Dr S C Patel
Dr R Verma
Dr R J Marks
Dr T H Clutton-Brock
Dr L J Brennan
Dr J P Nolan
Dr J R Colvin
Dr J R Darling
Dr I H Wilson

Mrs K Rivett, RCoA Patient Liaison Group
Dr A-M Rollin, Professional Standards Advisor

In attendance: Mr K Storey, Mr C McLaughlan, Ms S Drake, Mr R Bryant and Ms A Regan.

Apologies for absence: Apologies were received from Dr M Nevin and Dr J Heyworth.

COUNCIL IN DISCUSSION

CID/15/2011 President's Opening Statement

(i) The President announced the deaths of Dr Angela Hooper and Dr Charlotte Gardiner. Council stood in memory.

(ii) The President and Council were pleased to welcome Dr Darling to his first Council meeting; Dr Darling had been co-opted to Council having succeeded Professor Howard Fee as Chairman of the Royal College of Anaesthetists' (RCoA) Advisory Board for Northern Ireland.

(iii) Council members were urged to look at the proposed plans for the possible development of 34 and 35 Red Lion Square which would be displayed during the coffee break.

(iv) An e-mail from the Academy of Medical Royal Colleges (AoMRC) about matched funding would be circulated to Council. Anyone wishing to apply for funds would have to do so through Council. Dr D Nolan and Mr Storey would review the financial aspect of bids and the possible effects on other areas of the RCoA's work.

(v) Committee membership would be reconfigured over the next few weeks. Council members wishing to have an appraisal or discuss their role on committees with the President should make an appointment via the President's Office.

(vi) The President had received an update from the AoMRC regarding its governance arrangements. Mr Walter Merricks CBE has been appointed Chairman of the Board of Trustees. The Board takes office on 1 April 2011 and meets for the first time on 26 May 2011.

(vii) There had been an update from the Association of Anaesthetists of Great Britain & Ireland (AAGBI) regarding checking anaesthetic equipment. Dr Wilson explained that the guideline had been reworked and would take the form of a checklist. The checklist is undergoing final testing by members of the AAGBI's Council; there are concerns about whether items appear in the checklist in the correct order.

(viii) The Association of Paediatric Anaesthetists (APA) has issued a position statement on anaesthesia and the developing brain following recent studies which have highlighted concerns. Dr Brennan explained that the position statement advises anaesthetists on how they may answer parents' questions.

(ix) The President, Dr Wilson and Mrs Rivett had written a joint letter to Professor Sir Bruce Keogh expressing concern about access to data from the National Reporting and Learning System (NRLS). The President had also discussed the matter in person with Sir Bruce. Sir Bruce is keen to get the matter sorted out as soon as possible. In the interim the reporting of incidents to the Care Quality Commission (CQC) will remain mandatory; Mr McLaughlan pointed out that this offers no opportunity for shared learning.

(x) The President and Dr Wilson had sent a joint letter to Dame Sally Davies, the Chief Medical Officer (CMO) for England, expressing concern about the possibility that continuation of the Confidential Enquiry into Maternal Deaths is under threat. Dame Sally had responded expressing support for the two Presidents' views. It was hoped the panel reviewing the submission will report by the end of July 2011. Dr Clutton-Brock informed Council that Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK (MBRRACE-UK) had been dissolved and there is a complete lack of clarity about what will happen. The President and Dr Wilson wondered if the halting of the procurement process for the Maternal and Newborn Clinical Outcomes Review Programme could be attributed to a bigger picture. There have been a lot of mortality studies in the medical press; what are the benefits of the Review Programme if it is just reporting mortality and it is very low? Professor Bion added that outcome measures are problematic; process measures where process can be linked to outcome is a much better method to employ. However processes like the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) remain a valuable way of understanding what is happening with clinical practice; it may be time however to revisit it in terms of using it as a quality measure.

(xi) Mr Alan Bennett, Chief Executive of the Royal College of Surgeons of England (RCSEng), had written to inform the RCoA that the NHS Evidence – surgery, anaesthesia, perioperative and critical care project was winding down. Mr Bennett wished to commend the work of Dr Verma who had served as Clinical Lead for Anaesthesia. The President thanked Dr Verma for serving the RCoA so well. Mr Bennett also wished to thank Mr Storey who attended the annual Oversight Committee meetings.

(xii) The RCoA had been invited by the General Medical Council (GMC) to attend the Routes to the GP and Specialist Registers Working Group; Dr Bernard Riley, Chairman of the Equivalence Committee, had represented the RCoA. The Group's review aims to reduce material submitted to Colleges to assess equivalence. The President was delighted that the RCoA had been invited as it is considered to be the gold standard on equivalence.

(xiii) The launch of the fourth National Audit Project (NAP4) had been successful. A second day will be held which will also be at full capacity. The President asked Council what action the RCoA should take now and how it should roll out the recommendations. Dr Whitaker had suggested to the President that a letter be sent to trust chief executives. Mr McLaughlan stated that consideration had been given to the most appropriate targets for the documents; it was concluded that clinical directors (CDs), Regional Advisers (RAs), College Tutors (CTs), audit reporters and local safety managers would be prime targets as those most likely to take action on the report's recommendations. Mr McLaughlan added that two or three copies of the NAP4 report should be sent to every trust specifically to those who can advance the recommendations. Professor Bion informed Council that the report

would be discussed by the Board of the Faculty of Intensive Care Medicine (FICM). One of the key recommendations is End Tidal CO_2 monitoring in intensive care. Professor Bion could see no reason, other than cost, why it could not be required in all intensive care unit (ICU) ventilated patients and hoped that the Board would make it a recommendation for intensive care. Dr J Nolan strongly endorsed Professor Bion's view and suggested that it should not be limited to critically ill patients; it should apply to intubated patients anywhere including pre-hospital care. Mrs Rivett endorsed it from a patient safety perspective offering to exert pressure through the Patient Liaison Group (PLG) or Safe Anaesthesia Liaison Group (SALG) as necessary. Dr Moonesinghe suggested that a letter to chief executives setting out the End Tidal CO_2 issue would help support CDs particularly with regards to funding. Dr Wilson agreed that a letter to chief executives would be ideal; reports could be distributed via the CDs network. Dr Clutton-Brock agreed that End Tidal CO_2 monitoring should be available but expressed slight concerns about using it as a routine continual monitor; would it be better to suggest that it should be immediately available but not necessarily used routinely? Dr Batchelor was not convinced that continual End Tidal CO_2 monitoring for every patient will make an improvement. Professor Bion responded that it should not be used as a continuous monitor; it should be used to ensure replacement of the tube and must be available instantaneously and therefore be available the whole time. Dr J Nolan stated that he had been using it continuously in ICU for some time with no problem whatsoever; it does offer extra safety. Dr Whitaker pointed out that it is a fundamental patient safety issue and should be there all the time. It is very important that every chief executive knows there should be continuous capnography in Accident and Emergency (A&E) Units. The President asked whether or not it is a mandated standard or whether it is down to local implementation; he did not want to write to chief executives asking them to achieve something that is not deliverable. Dr Marks stated that NAP4 highlighted that people do not act upon a flat capnograph trace on patients intubated in the oesophagus. Part of the problem is trainees are not getting enough exposure to intubations; they are exposed to less than a generation ago. Professor Mahajan pointed out that there is ignorance about interpreting capnography. The President hoped that the FICM and Intensive Care Society (ICS) would debate the issue of End Tidal CO_2 monitoring at length. Dr van Besouw stated that medicine is entering an era where not all intubations will be done by anaesthetists; the RCoA should mandate that continuous End Tidal CO_2 should be available. Dr Jones suggested a need to define immediately available. Dr Greaves felt that the RCoA should not be issuing rules that mean there has to be a stance for each ventilator mode; people must be able to make their own decisions. Dr Wilson stated that AAGBI Council would be strongly supportive of upping the End Tidal CO_2 standard. The AAGBI has a statement on its website regarding capnography which is due to be updated the following week. Professor Bion pointed out the important distinction between End Tidal CO_2 monitoring to confirm proper placement of a tube and to confirm cardiorespiratory interactions long term. Dr Clutton-Brock stated that one of the issues about continuous monitoring is its interpretation; an alternative would be to say that there should be End Tidal CO_2 monitoring for every intubated patient with a rider to say that people must be educated to interpret and understand it. The President expressed his slight concern about insisting that every area has to have it immediately available; he did not wish to mandate something which will not be deliverable or which will cause legal debate. The President would review the draft letter Dr Whitaker had sent to him.

(xiv) The President thanked Council members for their comments regarding the benefits of consultant care. Obtaining evidence is the problem; anyone who is able to provide evidence should send it to the President.

(xv) Mrs Patricia le Rolland of the GMC is taking retirement; the President had written to thank her for her input into the specialty. Mrs le Rolland would be replaced by Dr Vicky Osgood.

(xvi) The President updated Council on staff matters:
   a. Mr Philip Fey has joined the Communications Department on a part-time basis.
   b. Mrs Charley Hoey has given birth to a son, Thomas.

CID/16/2011 Change in the Regulations regarding Associate Fellowship

Council agreed to amend the College Regulations Part II (6) Associate Fellowship

From

*(1) Any person holding a substantive or honorary **NHS** consultant post in the UK with sessions in Anaesthesia, Critical Care or Pain **Management**…….*

To

*(1) Any person **on the GMC Specialist Register** holding a substantive or honorary consultant post in the UK with sessions in Anaesthesia, Critical Care or Pain **Medicine**……..*

CID/17/2011 Recruitment Update

Dr Marks explained that the fill rates distributed to Council were now out of date and were now 95% for CT1 Anaesthesia and 92% for Acute Care Common Stem (ACCS) (Anaesthesia). Not all posts will be filled. It looks as though 20 posts will be recruited in round two. Recruitment has commenced for CT2 and ST3. There are approximately 400 applicants for 300 posts at ST3 when the Category 2 applicants are removed.

Proposals for 2012 recruitment had been distributed to Council. It had not yet been decided whether or not the RCoA will insist on applicants being restricted to a single unit of application; this will be decided at the Recruitment Committee's next meeting. Stakeholders have been invited to a workshop on 5 May 2011; the workshop is full but Council members would be welcome to attend. The value of interviewer training should be considered to help ensure consistency of questioning across the UoAs.

CID/18/2011 Possible Development to 34 and 35 Red Lion Square

Mr Storey explained that the RCoA is trying to select an architect with whom it feels it can work; two had produced plans though each had taken a different approach. The first architect's proposals had not been as objectively delivered as Mr Storey would have liked. However they have a good concept of moving the entrance to the middle of the building where the current loading bay is. In addition the reception area has been extended by building out over the electricity substation; it is not known how the planners will react to that as Red Lion Square is a protected area in terms of planning. A link across both buildings had been requested at the top which would provide a flat and a large meeting room that could be accessed vertically during the day and horizontally during the evening and weekend.

The second proposal was more expensive but was probably more believable than the first. The second architect has been conservative in areas where the planners may object. The proposal is to dispose of the plant and use the void above the ground floor for a staircase. Mr Storey stated that the RCoA would not move out whilst the work was carried out; building a new staircase whilst the building remained occupied would not be too disruptive. Mr Storey added that to fill in the void on all levels would provide even more space but would probably take the development into a different league with regards to cost. Removal of the existing staircase would result in larger hall space.

Both schemes provide two 13 person lifts and a suitable sized cafe. There will be a new lift at the back of the building subject to the architects not removing it completely.

Professor Bion asked whether the possibility of improving the lecture theatre had been explored and discounted. Mr Storey responded that he is not progressing it but the point of the discussion with Council was to establish what Council members want the building to give them for the future. Professor Bion saw the advantage of a 500 capacity lecture theatre which could also be rented out. However if space was not available then he would not take it any further. Mr Storey explained he could envisage a way whereby the RCoA could spend a lot of money and expand the lecture theatre to a capacity of 180/200; this would not give a very good lecture theatre and it would have to be balanced with the size of the café. Professor Sneyd urged Mr Storey to be ruthless with architect's fees. Professor Sneyd added that a decision about the lecture theatre should be a business decision; a large capacity lecture theatre would be empty for much of the year. Dr Jones explained that the trend is to move away from tiered lecture theatres; the current philosophy is that large lecture theatres must be able to be divided into small rooms so they can be used in a more cost effective way. The President stated that improving the layout of the lecture theatre would be helpful; moving it would provide an opportunity for complete redesign. Dr Verma suggested that any decision about the lecture theatre could be influenced by the Events Department. Ms Drake responded that in the last year there had only been one or two events where they had to turn people away; the Events Department is not struggling for space at the moment. Dr Patel suggested that Council should decide whether it wanted to invite people in to use the RCoA's facilities or whether they would be used primarily for anaesthesia and its partners. Mr Storey stated that although many other Colleges have gone down the income generation route, he is personally against it. The business model for the RCoA is that it had to afford what it wanted to do with zero income from others; any external use had been predominantly by medical organisations rather than private companies. Mr Storey strongly suggested that the RCoA continued to adopt its current business model. The President stated that the way Churchill House has been used has been a great success. The President further stated that having visited other Colleges, one of the most impressive assets is outside space along with a dining area for smaller dinners; the development of the top floor with an area which could be used for receptions and entertaining should be encouraged. Mr Storey responded that the second design delivers on both those points. Dr Clutton-Brock did not support a larger lecture theatre but suggested that the RCoA should look at the use of galleries for smaller group teaching and smarten up the appearance of the galleries. Dr Brennan added that noise in the galleries is a concern for examiners and candidates. Mr Storey responded that it was possibly time to consider the use of folding doors in the galleries.

The President asked Council members to e-mail their ideas to Mr Storey.

The College of Emergency Medicine (CEM) has exchanged contracts on its new building and would be moving out around Christmas 2011. The intention is that Ms Drake's staff from the 4th Floor will move to the space vacated by the CEM with Facilities and IT staff moving to the vacated space on the 4th Floor. Mr Storey is also in discussion with the British Pain Society (BPS). When the BPS' lease was renegotiated it was agreed that if the CEM moved the RCoA would talk to the BPS so both they and the 4th Floor staff could be relocated in harmony; the BPS is open to a review.

Mr Storey informed Council that the development would probably cost approximately £6million. The RCoA had paid £8.5million for Churchill House and had spent a further £7.5million developing it. £4.5million had been paid for 34 Red Lion square; the income from the flats is probably what would be achieved if £4.5million was placed on the money markets. Mr Storey pointed out that it was important for Council to justify that it was not expanding the London headquarters at the expense of other projects such as matched funding applications. Dr Batchelor enquired whether or not the RCoA would spend more than it could recoup. Mr Storey responded that although this was possible, London price increases would probably account for any overspend. Professor

Sneyd asked Mr Storey to circulate the consolidated list of things people may like to see in a new building before starting to work with an architect. The President added that he felt a slightly larger area should be available for Members and Fellows using the building, either near the café or on the 1st floor.

CID/19/2011 Guidance for the use of Propofol Sedation for Adult Patients undergoing Endoscopic Retrograde Cholangiopancreatography (ERCP)

Dr Tomlinson presented the guidance which had been updated following a two week consultation period. Professor Sneyd had since been asked to comment on the section about the use of non-anaesthetist administration of propofol in Europe and the guidance had been amended accordingly. The President asked Dr Tomlinson to send the final document to Council before it was signed off. Dr Greaves wished to congratulate Dr Tomlinson for stating the position so firmly.

The President reported that the AoMRC has asked the RCoA to lead the revision of the 2001 guidelines on sedation. A member of Council would be required to chair the committee; anyone interested should e-mail the President.

CID/20/2011 British Oxygen Company (BOC) Chair

Professor Sneyd reported that there had been 11 applications all of which had been peer reviewed. The panel had been chaired by Professor Sneyd and consisted of Dr van Besouw, Ms Drake, Professor David Menon, Professor Martin Leuwer and Mr David Hepworth (PLG). Council approved the outcome of the BOC Grant Committee; the award should go to Dr Mike Grocott. Council was asked to keep the outcome confidential for 48 hours. The President thanked Professor Sneyd for chairing the Panel. Dr van Besouw commended Professor Sneyd for operating a robust, transparent and fair system.

The President commented that the number of excellent applicants bodes well for the future of academic anaesthesia. Professor Sneyd added that he would like to see a career development award in future. Professor Mahajan informed Council that the National Institute of Academic Anaesthesia (NIAA) currently only awards one eponymous professorship per annum and asked if it was time to decide whether this should be increased for a year. Three or four eponymous professorships have previously been awarded but this had been reduced because of the lack of suitable candidates. The President agreed this should be reconsidered.

COMMITTEE BUSINESS

CB/53/2011 Council Minutes

The minutes of the meeting held on 15 March 2011 were approved.

CB/54/2011 Matters Arising

(i) Review of Action Points

CID/11/2011 President's Statement Drs Batchelor and Whitaker would meet during the lunch break to construct the Away Weekend agenda.

CID/12/2011 UK Launch of pan-European Launch of 'Pain Proposal' Dr Venn asked anyone with links with MPs or Lords to let the President know. Mr Storey suggested contacting Sir Bernard Ribeiro who is a Life Peer and Fellow by Election of the RCoA.

CB/43/2011 Revalidation Development Committee Dr Verma had volunteered to lead the work to develop a minimum data-set for logbook/record of clinical activity. The Revalidation Committee however held the strong view that it should be encouraging people to use the many logbooks already available rather than developing a new minimum data-set.

CB/47/2011 Equivalence Committee Dr Thornberry has agreed to write an article for the *Bulletin* later in the year. Dr Venn stated that it may be necessary to increase the size of the *Bulletin* again, possibly by eight pages. The President asked whether the frequency needed to be increased rather than the size. Dr Venn responded that there is a slight move away from using the *Bulletin* as a way of announcing future policy; it is now looking more at commissioned articles and there is currently little room for unsolicited articles. Twitter is now being used for announcing things the RCoA wishes people to pick up quickly. The President asked whether it was time to produce a newsletter. Dr Venn reported that it would be discussed at the next Communications Committee. Dr Venn felt it important to produce the *Bulletin* in hard copy rather than purely electronically. Dr Wilson stated that the AAGBI's e-newsletter had been very good for communicating announcements; it has a 30% opening rate and will remain fortnightly for now. Dr Venn added that he would like the RCoA's newsletter to complement the AAGBI's rather than compete with it. It was hoped that something would be up and running by late autumn.
All other actions had been completed.

(ii) Anaesthesia for Emergency Medicine

Dr Greaves had previously informed Council that the first issue to be dealt with would be sedation; that part of the document is being circulated to Committee members. The second issue is that of anaesthesia in the Emergency Department (ED) which is more contentious. A meeting was being arranged with the CEM to discuss this. Dr Greaves agreed to the President's suggestion that the data from NAP4 should be included to aid discussions. Dr Batchelor questioned whether it would be necessary to emphasise other areas; there is a lot of emphasis on airway management but it is about managing the entire patient not just getting a tube into the right place. Dr Greaves responded that that was precisely the issue. Anaesthetists have never gone to the ED and managed patients without the input of others whereas there are emergency medicine physicians who consider that they have the other skills and that they are managers of critically ill patients in the acute situation. Many patients go for surgery very quickly and there is a danger that the procedures set up between the ED and critical care will cut the anaesthetist out of the loop; patients will be resuscitated by emergency medicine physicians and intensivists without the involvement of an anaesthetist. Dr J Nolan stated that some of the concerns are already happening; critical care and emergency medicine doctors will deal with patients and hand them to the anaesthetist in theatre. The President pointed out that it is vital that communication and teamwork is at the fore. Dr Marks asked that the document be amended to include the child with a head injury who may need to be intubated for a CT scan and may not need to go to intensive care afterwards; Dr Marks agreed to further explain this to Dr Greaves outside of Council. Dr Moonesinghe asked whether the document should specify who provides the skilled assistance. Dr Batchelor asked whether patients who are critically ill in the ED need someone who is good or someone who is good enough; this overlaps with what is the role of an anaesthetist. It is necessary to ensure the skills-set and scope of anaesthetists gets larger; if there were doctors with broad-based core training who did emergency medicine training, better doctors would be produced to look after these patients. Dr Lim suggested that the biggest problem is training numbers; increasingly the trainee taking patients to theatre is a CT1 or CT2 who will require support if the consultant is not present.

CB/55/2011 Regional Advisers

Council considered making the following re-appointment:

Leicester and South Trent

Dr Christopher Leng, Regional Adviser for Leicester and South Trent **Agreed**

CB/56/2011 Deputy Regional Advisers

Council considered making the following appointment:

Northern

Dr Gary Enever, Deputy Regional Adviser for Northern **Agreed**

CB/57/2011 College Tutors

Council considered making the following appointments/re-appointments (re-appointments marked with an asterisk):

West of Scotland

Dr W J Peel [Buckinghamshire Hospitals NHS Trust] in succession to Dr P G Jefferson **Agreed**

South Thames East

Dr A J Turvey [Princess Royal University Hospital] **Agreed**

Wales

Dr V Madhavan [Wrexham Maelor Hospital] in succession to Dr N M Agnew **Agreed**

West Midland North

*Dr S A Jurai [Princess Royal Hospital, Telford] **Agreed**

CB/58/2011 Heads of Schools

There were no appointments for Council to note.

CB/59/2011 Training Committee

(i) Training Committee

Council received and considered the minutes of the meeting held on 6 April 2011 which were presented by the Medical Secretary, Dr Thornberry. The draft programme for the CTs meeting was approved.

The final report of the RCoA/Obstetric Anaesthetists' Association (OAA) obstetric trainers' survey was accepted; it will be signed off and published on each organisation's website.

At its previous meeting the Training Committee had turned down a request to make e-learning a mandatory part of the Initial Assessment of Competence. This had been discussed further and it was agreed that all CTs should have access to e-Learning Anaesthesia (e-LA) to ensure they are able to demonstrate it to new trainees. The use of e-LA will be promoted but will not be compulsory.

A number of curriculum issues had been discussed. There are some real practical problems with spiral learning; a proposal has been agreed to allow some flexibility between intermediate and higher training within ST4 and ST5 to overcome difficulties in delivering the current curriculum in some geographical areas. The Committee had decided a specific statement on maintaining acute pain skills within higher and advanced training was not required. A modification of the wording about trainees working in remote sites was proposed and accepted to remove the anomaly that suggested only higher trainees could work in maternity units.

Professor Chris Dodds had explained to the Committee the new approved curriculum for pre-hospital emergency medicine. The curriculum will be promoted at the CTs' meeting.

Dr Thornberry informed Council that the Training Committee's membership has a tendency to grow; it is now a difficult size in terms of getting work done. It is therefore proposed that

membership be reduced to seven core members, six corresponding members who would attend when they wish or at the Chairman's request, six corresponding members who would attend upon invitation from the Chairman and three administrators. Dr Colvin agreed with the principle but questioned whether it was necessary to distinguish between two types of corresponding members. Mr Bryant accepted this was a valid point but explained the possibility of there being too many people around the table if all corresponding members wished to attend; having two categories of corresponding member allows the Chairman to control the Committee's size. Professor Mahajan reported that different categories of corresponding members worked well for SALG. Professor Sneyd pointed out that as a corresponding member of SALG he often feels excluded and urged the Training Committee to tread cautiously and to be particularly aware that it could not table papers or change the agenda if it were run in the proposed manner. Dr Marks agreed with reducing the Committee's size and asked whether or not the scope of the Training Committee needed defining. Dr Thornberry explained that although the scope is in the Terms of Reference to some extent, it is difficult to see what it is and a large number of corresponding members are required; the Committee tends to be a reactive rather than proactive Committee. Dr Thornberry explained that the meetings had been reduced from six to five per year; a smaller Committee could revert to more frequent meetings. Dr Tomlinson agreed that the Training Committee has become too large and has almost become an information dissemination committee. Training is core to the RCoA's business; reducing the size of the Committee will result in a more focussed group that can deal with issues. Although Dr Tomlinson shared the concerns about corresponding members potentially feeling disenfranchised he suggested it would be necessary to be strict and reduce the size of the Committee. Dr Tomlinson suggested that a representative of the PLG should be a core member. Mr Bryant explained that the paper had been written at a time when the PLG was under pressure to reduce attendance at committees. The President suggested that the changes be implemented with the PLG as a core member and with one group of corresponding members; the latter should be reviewed on a regular basis.

Dr Wark had reported that there had been no progress in persuading the UK Borders Agency to protect the two year visa for Tier 5 Medical Training Initiative (MTI) trainees which will be reduced to one year for everyone. The President had written to the Home Secretary as had the AoMRC. Professor Sneyd suggested that the President and Dr Wilson could use their respective columns in magazines to urge Members and Fellows to write to their MPs about this. The President replied that it would certainly be worth a tweet, e-mail or letter.

(ii) Council noted recommendations made to the GMC for approval, that Certificates of Completion of Training (CCT) be awarded to those set out overleaf, who have satisfactorily completed the full period of higher specialist training in anaesthesia. The doctors whose names are marked with an asterisk have been recommended for Dual CCTs in Anaesthesia and Intensive Care Medicine.

Anglia
Dr Adrian James Varley

London
South East
Dr Danielle Carrie Factor
Dr Gautham Srinivasan
Dr Steven David Vidgeon *
Dr Azfer Usmani

North Central
Dr Marcus John Hickson
Dr Chi Hwa Ng *
Dr Jayant Nick Pratap
Dr Adnan Mustafa
Dr Jasmeet Kaur
Dr Edward Charles Coventry Burdett
Dr Basil Muhammed Almahdi
Dr Daniel Stuart Martin *

Dr Mayavaty Nagaratnam
Dr Ahmer Ali Mosharaf

Imperial
Dr Smitangshu Mukherjee
Dr Gopinath Balasubramanian Iyer
Dr John Gregory Myatt
Dr Lliam Edger *
Dr Aynkaran Dharmarajah
Dr Laurence Anthony Cohen

St. George's
Dr Ahmed Refaat Barakat
Dr Wolfgang Otto Bauer *

Kent, Surrey, Sussex
Dr Simon David Harris Finn
Dr Matthew Peter Lees
Dr Richard Charles Patrick Kennedy
Dr Rebecca Jane Wood
Dr Stephanie Jane Tilston

Nottingham
Dr James Alexander Martin Armstrong
Dr Myles Fintan Dowling

Mersey
Dr James Peter Golding
Dr Justin Daniel Ratnasingham
Dr Daniel Richard Broad
Dr Prashast Prashast *
Dr Ne-Hooi Will Loh *
Dr Andrew Richard Marchetti *
Dr Roy McLeod Williamson
Dr Helen Neary
Dr Sam Patrick Chandler Sandow

North West
Dr Daniel Robert Nethercott *
Dr Michael James Naisbitt *
Dr Vidya Kasipandian *
Dr Sophie Anne Kimber Craig
Dr Wael Mohammad Khalaf

Northern
Dr Peter Benjamin Messer *
Dr Matthew Richard Wayman *
Dr Monica Gandhi

Oxford
Dr Marcus Daniel Lucius Fletcher
Dr Amit Dharnidhar Kalla
Dr Asquad Sultan
Dr Amy Walker
Dr Sheridan Kathawaroo
Dr Elizabeth Clare Russell

South West Peninsula
Dr David Andrew Lacquiere
Dr Matthew William Harper

Tri-Services
Dr Sam David Hutchings *
Dr Timothy Edward Scott *
Dr Simon Jude Mercer

Wessex
Dr Andrew James Baldock
Dr James Edward Dinsmore
Dr Scott Bird

West Midlands
Birmingham
Dr Natish Kumar Bindal

Wales
Dr Edward Alexander Chubb

Scotland
East Scotland
Dr Ian David Peat
Dr Euan McDonald Thomson

South East Scotland
Dr Catherine Anne Theodosiou
Dr Neil Hugh Young *
West Scotland
Dr David Alick Wilson Reid
Dr Judith Todd
Dr Malcolm John Watson

Yorkshire
West Yorkshire
Dr Vicki Louise Higson

Dr Indu Sivanandan **** Dual CCTs in Anaesthetics and ICM***
Dr Ahmed Ahmed Mohamed Shehatta Labib *

(iii) Medical Secretary's Update

Dr Thornberry had circulated a draft publication *Providing equity of critical and maternity care for the critically ill pregnant or recently pregnant woman* by the Maternal Critical Care Working Party. Dr Alan McGlennan had represented the RCoA. Comments should be sent to Dr Thornberry.

CB/60/2011 Royal College of Anaesthetists' Advisory Board for Scotland

Council received and considered the minutes of the meeting held on 3 March 2011 which were presented by the Chairman, Dr Colvin. Dr Liz McGrady had been appointed Honorary Secretary and Dr Traven McClintock Honorary Treasurer.

Much of the Board's work and interaction with Government will be related to workforce. There is an emerging policy from employers in Scotland towards development of mid-point credentialing and production of a new sub-CCT service doctor; the Board opposes this. The next phase of the Board's input into workforce will be around the proposals for development of the specialty doctor grade. A meeting of the Medical Programme Board had received a draft paper from Medical Education England (MEE) about approving the length of training for medical specialties; it appears that it will stifle the ability to develop innovative ways of delivering training.

Work regarding revalidation continues slowly.

The National Clinical Assessment Service (NCAS) will not be functioning in Scotland.

The Board is pleased to have representation on SALG.

The Board has discussed further proposals for the inclusion of training in improvement science.

Difficulties in fulfilling paediatric competencies during ACCS training were noted. Dr Thornberry explained that there have been difficulties across the board. The curricula for ACCS (Anaesthesia) and the anaesthetic requirements for ACCS (EM) were now identical and the paediatric aspect has been taken out of the first six months. This will be a major change and should resolve the paediatric problem in ACCS.

CB/61/2011 Joint Committee on Good Practice

(i) Council received and considered the minutes of the meeting held on 4 November 2010 which were presented by the President. Future changes of chairmanship will be in September rather than January.

There are ongoing discussions about a mentoring scheme. Dr Wilson explained that over the last couple of years the focus of the AAGBI Welfare Committee had been helping doctors in difficulty. Dr Felicity Plaat is keen to move towards wellbeing and take a different focus for a couple of years. Dr Brennan informed Council that he had represented the RCoA at a seminar on mentoring earlier in the year and was now leading a mentoring scheme in his own trust; he had talked informally to Dr Plaat. Dr Marks highlighted the need to be conscious of the group of trainees who have finished training and are now moving between locum posts; it is a vulnerable group that needs a lot of attention.

The President thanked Mrs Rivett for writing to the Doctors and Dentists Review Body lending support regarding Clinical Excellence Awards.

Standards documents for revalidation should be equitable and equal thus avoiding conflicting standards between different organisations.

The Committee had noted that the review of the *Good Practice Guide* might need to take into account the findings of the AAGBI's Working Arrangements for Consultants Working Party.

The list of never events has now been published.

(ii) Council was asked to approve the paper "UK National Core Competencies for Post Anaesthetic Care". The President asked Council to inform him of any problems with the paper. If there were no major problems highlighted in a few days the President and Dr Wilson would approve the paper. Dr Whitaker paid tribute to Dr Heather Hosie who had undertaken much of the work.

CB/62/2011 Examinations Committee

Dr van Besouw informed Council that on 16 March 2011 the RCoA had received the College of Anaesthetists in Ireland's (CAI) submission to the GMC for scrutiny of the FCARCSI for approval towards a UK CCT; the submission was 300 pages with a submission date to the GMC of 24 March 2011. The RCoA believed it was not possible to look through and support the document in that timeframe so the CAI contacted the GMC and the submission date has been postponed. The Examinations Committee and Examinations Directorate analysed the application and raised a number of areas of concern. A meeting was held where the RCoA explained to the CAI that it could not support the application in its current form. It was agreed that the CAI will respond to the concerns and amend the submission accordingly. Subsequent to that it has been discussed by the Examinations Committee. Dr van Besouw explained to Council the concerns about long term sustainability if the RCoA or Irish Regulator makes changes. Dr Brennan had been asked to put a discussion regarding how the RCoA should proceed on the Away Weekend agenda. The CAI is also considering if it will be sustainable in the long term. Dr Darling reported that the matter had been discussed by the RCoA Advisory Board for Northern Ireland; the Board would like to keep moving forward but there is realisation that sustainability may be a real problem.

CB/63/2011 Patient Liaison Group

(i) Council received and considered the minutes of the meeting held on 14 March 2011 which were presented by the Vice-Chairman, Mrs Rivett. Following the recruitment of a further five lay members to the PLG it is proposed that some lay members will be re-allocated to College committees. Mrs Rivett thanked Drs Tomlinson and Jones for participating in the induction morning.

The PLG was asked to consider the role of multisource feedback from patients in respect of anaesthesia and to feedback their comments to Dr Moonesinghe.

The NCEPOD *Age Old Problem* Short-life Working Party had met and would meet again in May.

The PLG welcomed the opportunity for the patient information resource to be based within the PLG. Mrs Rivett hoped it would be possible to move forward with patient information more proactively working closely with the Communications Committee.

Mr David Weatherill will assist with the revision of the *Audit Recipe Book*.

Concerns remain about the Enhanced Recovery Programme; although these have diminished over the years the PLG still believes that there are some areas regarding patients which need addressing.

The President thanked Mrs Rivett and the PLG for their hard work.

(ii) Council agreed that the PLG's Terms of Reference should be reworded to reflect the increase in numbers and also to reflect a change in the section relating to employment in the NHS and application for PLG membership.

CB/64/2011 Education Committee

Council received and considered the minutes of the meeting held on 9 March 2011 which were presented by the Chairman, Dr Clutton-Brock. It was agreed that a small working group should be formed to support the development of the Final FRCA course to bring it in line with modern education and changes in the examination.

The Committee proposes to combine the Core Topics days and the CPD Level 2 Study Days under the same heading.

It was agreed that Dr Steve Yentis should be invited to present the Clover Lecture at the 2012 Anniversary Meeting. Dr Gernot Marx will be invited to take up the Rank Lectureship.

Dr Clutton-Brock sought Council's opinion on whether the Becoming a Consultant event should include a lecture on working in independent practice. Council agreed it should be included. Dr Rollin pointed out that both in GMC hearings and queries via the website there is a growing expectation that standards are different; it is important to say that clinical standards are the same wherever you are.

Dr Tomlinson asked for an update on the Samuel Rowling Lecture. Dr Clutton-Brock responded that the plan is for it to be delivered locally.

The introduction of an online feedback system for events is in process.

An interactive voting system in the lecture theatre is being looked at. Ms Drake reported that the RCoA has been offered 40 pads on permanent loan from e-Learning for Health. Professor Sneyd counselled against such a system claiming it can ruin lectures.
The Committee received an update on the future purchase of a lecture capture software system.

CB/65/2011 Quality Management of Training Committee

Council received and considered the minutes of the meeting held on 6 April 2011 which were presented by Dr Nolan. RAs and External Advisers will be advised of issues highlighted by GMC surveys in advance of formal or pastoral visits.

A new quality improvement document from the GMC should be published in early summer.

The CT in Jersey is keen to maintain College links despite there being no trainees. The President stated that it was agreed by Council some time ago that the continuation of tutorships in hospitals without trainees was beneficial. The President asked Ms Regan to check the Council minutes.

MATTERS FOR INFORMATION

I/11/2011 Publications
The list of publications received in the President's Office was drawn to Council's attention.

I/12/2011 Consultations
Council received, for information, a list of the current consultations.

I/13/2011 New Associate Fellows, Members & Associate Members
Council noted the following:

New Associate Fellow – February 2011
Dr Mary Nichola Wall– Heartlands Hospital, Birmingham

New Associate Fellows - March 2011
Dr Abdul Nazar – Whipps Cross University Hospital NHS Trust
Dr Joanna Clare Marriott – Worcester Royal Hospital,
Dr Eschtike Schulenburg – Addenbrookes Hospital, Cambridge University Hospitals
Dr Louise Shrimpton Jolliffe – St. James University Hospital

New Member – February 2011
Dr Talakad Narasappa Sudarshana – European Diploma in Anaesthesiology and Intensive Care

New Members – March 2011
Dr Derek John McLaughlan – Primary FFA
Dr Sethu Subramanian Veerabadran – Primary FRCA, Final FCARCSI

New Associate Members - 2011
Dr Barbora Parizkova – Papworth Hospital NHS Foundation Trust
Dr Nabil Mansuri – Kettering General Hospital
Dr Welhenage Dimuth Amithodana Silva – The Lister Hospital

New Affiliate – Veterinary - February 2011
Mr Alan Hugh Taylor

New Affiliate – Physicians' Assistant - March 2011
Mr Bryan Steven Charles Gray – Sheffield Teaching Hospitals

To receive for information the following doctors have been put on the Voluntary Register – February 2011
Dr Ana May Bonell – University Hospital Lewisham
Dr Ilans Lisagors – Lancashire Teaching Hospitals
Dr Benjamin Gibb Freeman – Oxford Radcliffe Hospitals
Dr Sarah Grace Freeman – Oxford Radcliffe Hospitals
Dr Timothy Asibey-Berko – West Wales General
Dr Andras Antal Farkas – Nuffield Health Hospital, Taunton
Dr Manesh Dewshi – Queen Elizabeth II Hospital, Welwyn Garden City

To receive for information, the following doctors have been put on the Voluntary Register – March 2011

Dr Ashwin Neelavar Udupa – Dewsbury District Hospital
Dr Andrea Streicherova – West Middlesex University Hospital
Dr Shaukat Raza – Chesterfield Royal Hospital
Dr Amit Bhargava – North Manchester General Hospital

I/14/2011 Academy of Medical Royal Colleges

Council received, for information, a summary of the meeting held on 28 March 2011.

I/15/2011 Joint Royal Colleges Ambulance Liaison Committee

Mr Storey reported that the Joint Royal Colleges Ambulance Liaison Committee is changing its status as a legal entity; the enclosed paper gave full details.

I/16/2011 RCoA Simulation Survey

Dr Greaves informed Council that the Simulation Working Group has surveyed what facilities are available. It is an incomplete snapshot of what goes on and what is available. The RCoA wants to be certain it does not ask people to embark on training and assessment schedules which they do not have the equipment for. Dr Thornberry added that MEE had done a survey which revealed a lot of facilities, many of which are not used.

PRESIDENT'S CLOSING STATEMENT

PCS/4/2011 President's Closing Statement

There were no matters to raise.

MOTIONS TO COUNCIL

M/15/2011 British Oxygen Company Chair

Resolved: That the outcome of the BOC Grant Committee be approved.

M/16/2011 Minutes

Resolved: That the minutes of the meeting held on 15 March 2011 be approved.

M/17/2011 Regional Advisers

Resolved: That the following re-appointment be approved:

Leicester and South Trent

Dr Christopher Leng, Regional Adviser for Leicester and South Trent

M/18/2011 Deputy Regional Advisers

Resolved: That the following appointment be approved:

Northern

Dr Gary Enever, Deputy Regional Adviser for Northern

M/19/2011 College Tutors

Resolved: That the following appointments/re-appointments be approved (re-appointments marked with an asterisk):

West of Scotland

Dr W J Peel [Buckinghamshire Hospitals NHS Trust]

South Thames East

Dr A J Turvey [Princess Royal University Hospital]

Wales
Dr V Madhavan [Wrexham Maelor Hospital]

West Midland North
*Dr S A Jurai [Princess Royal Hospital, Telford]

M/20/2011 Joint Committee on Good Practice
Resolved: That the paper "UK National Core Competencies for Post Anaesthetic Care" be approved unless serious concerns are highlighted to the President.