MEETING OF COUNCIL

Edited minutes of the meeting held on Wednesday 17 April 2013
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 J-P van Besouw, President
Dr H M Jones
Dr D M Nolan
Professor J R Sneyd
Professor D Rowbotham
Professor J F Bion
Professor R Mahajan
Dr P J Venn
Dr A Batchelor
Dr D K Whitaker
Dr R Verma
Dr R J Marks
Dr T H Clutton-Brock
Dr L J Brennan
Dr J P Nolan
Dr J A Langton
Dr J R Colvin
Dr N W Penfold
Dr V R Alladi
Dr S Gulati
Dr E J Fazackerley
Dr S Fletcher
Dr P Kumar
Dr R Darling
Dr I Johnson
Dr M Nevin
Dr A W Harrop-Griffiths

Mrs I Dalton, RCoA Patient Liaison Group (PLG)
Dr A-M Rollin, Professional Standards Adviser

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

Apologies for absence: Professor David Rowbotham, Professor M Mythen and Ms S Drake.

CEREMONIAL

C/4/2013 Election to Council

(i) The recently elected Council members, Professor Mahajan (re-elected) and Dr Fazackerley, were admitted to Council.

PRESENTATION

P/4/2013 Health Education England

The President welcomed Professor Wendy Reid, Medical Director of Health Education England (HEE). Professor Reid explained that HEE is currently a special health authority but will become an arm's length body. HEE currently reports directly to the Secretary of State (SoS) and is responsible for training all healthcare staff working in the National Health Service (NHS). Its work will be managed through 13 committees (previously known as Local Education and Training Boards [LETB]) named Health Education North West, Health Education KSS etc. The Colleges' help will be required in the forthcoming year during which the legislation that creates HEE will be formed. HEE will work primarily through the Colleges for medical advice and is keen to enhance the Colleges' power and influence. Each HEE local committee will have a postgraduate dean except the North West and South West which will each have two. Postgraduate deans have statutory

responsibilities. Deaneries will no longer exist and their functions are now part of HEE's functions. The structures to support training will look similar to existing ones. The role of the postgraduate dean will need developing. For example there is a significant disconnect between the postgraduate dean and general practice which is not helpful to patient care or the way in which training is undertaken.

Workforce and workforce planning is one of HEE's major roles and will sit in its Directorate of Strategy. A clear governance structure is required. Competitive workforce planning has to stop along with the silo of planning within medicine, nursing, midwifery etc. The Joint Workforce Group has been dominated by strategic health authorities and not well attended by Colleges. The Centre for Workforce Intelligence (CfWI) has the contract until the end of 2014 following which HEE will either take over its contract or renegotiate who will take over data analysis of workforce planning.

There is no existing model for the governance structure that is being used. For the first time, at the 13 local boards, trust chief executives, GP leaders etc. will come together. Their decisions will need to reflect local need and national imperatives. The Mandate, written by the SoS and Department of Health (DH), is what the SoS will hold HEE to account for in its first year and will contain national imperatives including some of the priority areas following the Francis Report. HEE was determined not to issue a five year detailed plan until it knew the content of the Mandate.

The two main players in the 13 local boards will be Managing Directors and Directors of Education and Quality. Professor Reid is very keen that HEE listens to the Colleges and anticipates off the record conversations with Presidents as required. HEE will look at the structure of the Medical Professional Board which is currently skewed towards the British Medical Association (BMA) and one or two Colleges. Help and advice will be required on how to structure the Board.

The 13 local boards will link into HEE via the Executive Director. Four country relationships are formally maintained through the UK Scrutiny Group. Underneath that the four equivalent management structures for education also meet.

HEE is a multi professional organisation and as such the General Medical Council (GMC) is not the only regulator. Although some work is distinctly HEE and others GMC, there is an element of overlap. Regular meetings with the GMC identify where crossover exists. HEE will ensure the relationship is very close but is mindful it has other regulators who will look at integrated care of patients.

Professor Reid anticipated that regular dialogue with the Colleges would include how their voice will be heard in HEE, how they link in with the HEE committees and current pressure points in their specialty.

Professor Bion sought assurance that the new structure is better than the old in terms of the division of responsibilities and separation of competing interests between service and training. Professor Reid explained that the DH had been working on a review of the tariff for training for more than a decade. It is likely the MADEL levy will be disrupted and there may be a tariff for training and a salary for the doctor. Professor Reid stated that there is a real opportunity to say what is in the mix and HEE will be consulting on how to incentivise training. Giving money in terms of grants is extremely difficult in the new system because of the way tariffs are set up. Professor Reid is acutely aware of the financial challenge but also the risk of moving trainees purely for high quality training when it is the service that provides the training. Professor Bion asked if the presence of trust chief executives on the HEE committees is an asset. Professor Reid explained that HEE had gone through a series of robust assurances with them. Behaviour at assurance visits was very positive but HEE is aware of the potential conflict in the organisation of a group of chief executives refusing to do something. Whilst HEE is aware of tensions, it hopes they will expose some organisations which would otherwise be hidden because of their size.

Dr Marks asked how HEE sees the position of training in service groups. With the reduction in training numbers there will be an increase in those who were trainees taking non-training jobs and then trying to claim equivalence in the future. Professor Reid explained HEE's ethos is about improving patient care. Those doctors work in the NHS and HEE would expect organisations to take their development very seriously. HEE's underlying ethos is that doctors at whatever level are employees of the NHS and HEE is responsible for education and training of NHS employees. Some will be the responsibility of employers and HEE will ensure chief executives sign up to standards.

Dr Brennan asked how the College could return to the quality assurance (QA) process and regain some of its influence in that area. Professor Reid explained that there has been a change in the perception of the usefulness of Colleges and their input into QA. It needs to be formalised but Professor Reid is very anxious that the rules do not exclude ad hoc gathering of information. There is a big piece of work going on regarding where QA sits. Professor Reid explained her personal commitment to the professional expertise of Colleges at that level. However it was important that the Care Quality Commission (CQC), HEE and the Colleges did not visit at once; a joined up approach is necessary involving CQC and service.

Professor Sneyd challenged HEE to invite those specialties with three Colleges to identify one lead College. Professor Reid responded that this had already been done. Professor Sneyd stated that although a move towards a tariff based system is supposed to be happening he had heard about substantial cuts in Service Increment for Teaching (SIFT) funding being handed down. Professor Sneyd asked if there would be a prompt move to one flat tariff. Professor Reid responded that HEE did not know yet. It had only just had sight of all the tariffs. HEE is mindful of previous track records of changing flows of funding where disasters have followed. Professor Sneyd pointed out that not everyone is represented on the 13 HEE local boards; only one of four universities in his area is represented. How can acute trusts and universities, who are head to head competitors for core business, work equitably rather than relying on good local relationships. Professor Reid explained that HEE is aware of such issues and would want to see the governance of any controversial decisions. No decision can change the flow of money without sign-off by HEE.

Dr D Nolan asked Professor Reid for her view of Regional Advisers (RA). There is a lot of discomfort about their view of their role within the deaneries and a lot of confusion. Professor Reid replied that it might be helpful for her to understand how the role links with the schools. Professor Reid was interested in regional quality and strategic groups which were started in the wake of the Mid Staffs Inquiry. Professor Simon Gregory, in the East of England, would be the person to contact. That is where regionally Colleges should be saying they are aware of a problem in a particular hospital. Professor Reid had not considered RAs in the system; that would be something to discuss with postgraduate deans.

The President thanked Professor Reid for talking to Council and assured her that the RCoA looked forward to actively engaging with HEE.

COUNCIL IN DISCUSSION

CID/20/2013 President's Opening Statement

(i) The President announced the deaths of Dr Dilip Mukerji, Dr Alan Thorogood and Dr Ghandhimathi Krishnan. Council stood in memory.

(ii) Dr Clutton-Brock, as Chairman of the Safe Anaesthesia Liaison Group (SALG), has been appointed the RCoA's representative on the NHS Commissioning Board on Surgical Safety. The Association of Anaesthetists of Great Britain & Ireland (AAGBI) also has a representative.

(iii) Dr David Richmond has been elected President of the Royal College of Obstetricians and Gynaecologists (RCOG) with effect from the autumn.

(iv) Sir Richard Thompson has been re-elected President of the Royal College of Physicians of London (RCPLond).

(v) Professor Bion would speak about the Faculty of Intensive Care Medicine's (FICM) Collaborating for Quality proposals later in the meeting.

(vi) The e-Portfolio passed 100,000 assessments this month. Congratulations were offered to Dr Jasmina Perinpanayagam and her trainer Dr Jeremy Boyle. The President expressed Council's gratitude to Mr Andy Leabourne for his hard work in supporting the process.

(vii) The results of the 2012 Advisory Committee on Clinical Excellence Awards (ACCEA) round have been published. Anaesthesia received 18 new awards; 8 Bronze, 8 Silver and 2 Gold. The RCoA has now accepted applications for the 2013 round which are currently being scored by Regional Co-ordinators. The RCoA would be able to support two-thirds of the Bronze applications, one-quarter of the Silver and one-fifth of the Gold. Dr Harrop-Griffiths has invited Mr Martin Sturges from the DH to discuss the current state of anaesthesia, pain and intensive care medicine in the ACCEA system. Dr Peter Nightingale would represent the RCoA if the President was unable to attend.

(viii) Regulation 75, which allows the tendering for NHS work by any qualified provider, remains of concern to the Colleges. The Chairman of the Academy of Medical Royal Colleges (AoMRC) and the SoS had met to discuss the concerns. There is ongoing dialogue about the provision of the regulation and its potential implications. There are constant reassurances from government that there will not be an impact. Dr J Nolan explained that the South West is in a state of near collapse in terms of elective work. There is probably no choice regarding any qualified provider. Dr Whitaker suggested that the AoMRC should invite the Prime Minister to a meeting. The President explained that a letter had been sent to the Prime Minister and that dialogue is ongoing between the AoMRC and government.

(ix) The AoMRC has arranged a meeting on 23 April 2013 for a comprehensive review of the Francis Report. The RCoA has highlighted its top 10 areas and will work within those areas to address issues identified by the report.

(x) Council members were urged to nominate potential recipients for awards before the Nominations Committee's next meeting on 9 May 2013.

(xi) The e-Safe DVD will be launched on 29 April 2013 in the presence of HRH the Princess Royal. The programme will last approximately one hour and include an exhibition as well as the presentation of the President's Commendation to Mr Alan Ryan.

(xii) Those who had not already done so were asked to confirm their attendance at the Award Winners Dinner on 2 May 2013 to Ms Gail Samuel.

(xiii) The President's Meeting had discussed the publication of a novel by an anaesthetist which included an acknowledgement that "Hull and East Yorkshire Hospitals NHS Trust kindly paid me to write it while simultaneously giving anaesthetics'. Given the doctor's membership status it was not felt worth commenting further. Dr Harrop-Griffiths added that the doctor is not a member of the AAGBI.

(xiv) The President has signed up to a letter from the Alcohol Alliance in support of minimum unit pricing.

(xv) BUPA has asked the RCoA to collaborate on clinical outcomes associated with anaesthesia. The AAGBI received a similar invitation. It was agreed a united front was important and that Dr Venn and Dr Harrop-Griffiths should discuss this and whether to meet BUPA individually or together. Dr Whitaker urged caution regarding what BUPA might say after the meeting implying agreement to certain things.

(xvi) The GMC has produced a report on outcomes for continuing professional development (CPD) which will be circulated to Council.

(xvii) Professor Mahajan will represent the RCoA at the Health All Party Parliamentary Group's (APPG) Embedding Research in the NHS meeting on 15 May 2013.

(xviii) Following the BMA's production of a publication on drugs of dependence Professor Averil Mansfield wished to discuss the RCoA's view; specifically how the specialty treats drug dependent patients and how it deals with doctors with drug dependency.

(xix) The President will be seeking nominations for attendance at Hempsons' Clinical Disputes Forum in June.

(xx) The National Institute for Health and Clinical Excellence (NICE) has published a report on a specialist/expert advice forum. There is much concern about NICE technology

recommendations and widespread concern about the way NICE operates. An evaluation exercise is currently underway regarding people's perceptions of NICE; the President has expressed the RCoA's concern. The report will be circulated to Council.

(xxi) The Royal College of Paediatrics and Child Health's (RCPCH) report on standards attainment has highlighted some major areas of concern particularly around the availability of paediatric consultants in evenings and weekends.

(xxii) The Royal College of Psychiatrists' (RCPsych) report on parity of esteem has implications for anaesthesia in terms of dealing with patients with psychological disease and also dementia. The RCPsych has asked the RCoA how it deals with such patients within anaesthesia and critical care. The President suggested that the Faculty of Intensive Care Medicine (FICM) and the Professional Standards Directorate would be particularly keen to support the RCPsych. Dr Venn reported that as part of the work responding to *An Age Old Problem* he would discuss with the Training Committee the incorporation into the curriculum of education on dementia. The President asked Dr Venn to send a summary of the work to Professor Sue Bailey. The FICM was also asked to send a summary. The report will be circulated to Council.

(xxiii) The Royal College of Surgeons of England (RCSEng) has published a report on children's surgical services. Dr Brennan explained that the document was intended to assist commissioners of paediatric surgical services.

(xxiv) Positive feedback has been received following a successful Anniversary Meeting. The new venue also proved successful. The Anniversary Dinner has generated an exceptionally high number of compliments.

(xxv) Dr Paul Flynn, Chairman of the BMA Consultants Committee, is currently the lead negotiator for the renegotiation of the consultant contract and in June will discuss the implications of the renegotiated contract with Council.

(xxvi) The *British Journal of Anaesthesia (BJA)* Board meeting and retreat took place recently. Professor Mahajan reported a move for the *BJA* to become paperless. Consideration is being given to how the move from paper-based to paperless should be managed. The financial impact and the impact of how the *BJA* is perceived also need to be considered. Oxford University Press (OUP) may have an opinion too which has not yet been considered. OUP currently favours the way the journal is running at the moment. OUP cannot comprehend the impact on advertising if the *BJA* moves to a new model. Professor Mahajan stated that it would be useful to have feedback from Council. The President pointed out that there is a lot of pressure to move to an electronic format. Dr Brennan suggested that discussions also need to be held with *Continuing Education in Anaesthesia, Critical Care & Pain (CEACCP)* and the *Bulletin*. Professor Mahajan pointed out that postage is costly and it makes sense to send all three publications simultaneously. Professor Mahajan added that it is difficult to work out the financial impact. Once this is clear the *BJA* may be in a better position to develop a strategy. It would be undesirable to go completely electronic and sell that model if people do not want it. The President stated that enhanced interactivity of an e-journal has a lot of benefits for the RCoA and allows it to link it to other areas of its work. Dr Langton stated that from *CEACCP's* perspective development of the enhanced interactivity has been slow. Once that becomes more reliably embedded it will be easier for people to see the benefit. Dr Whitaker enquired whether or not there would be a half way stage, such as a summary journal. Professor Mahajan responded that this had not been excluded. Dr Jones stated that there seemed to be a little resistance from OUP regarding implementing changes and asked if this was because of cost, lack of technical knowledge or loss of income streams. Professor Mahajan's perception was that OUP has two publishing houses; the everyday function of publishing the journal works well but the strategic part of OUP is very old fashioned. OUP is trying to harmonise and sell one format to all the journals. Dr Jones asked if, following the retreat, OUP felt under more pressure to change as there are other publishers available. Professor Mahajan replied that the BJA should invite tenders when the time comes. Professor Sneyd pointed out that it is no trivial matter to change publishers. Dr J Nolan stated that it is not possible to influence publishers unless you are a major player.

(xxvii) Service reconfiguration is on the DH's agenda. The view is that political permission will be given to the profession to advise on service reconfigurations. The President had attended an event hosted by RCPLond where Andy Burnham had spoken about how the opposition sees healthcare developing should they be returned to power.

(xxviii) The recent Group of Anaesthetists in Training (GAT) meeting had offered the President the opportunity to speak to many trainees about the shape of training and the future for consultants in terms of ways of working.

(xxix) Representatives of the RCoA had given oral evidence to the Shape of Training Review. They had put forward the arguments in the RCoA's response but also took into account responses from FICM, AAGBI and GAT. Much of the discussion centred on the current undergraduate curriculum. There was also discussion around the value of the foundation programme and whether sub-specialty training should be offered inside or outside of the Certificate of Completion of Training (CCT). Dr D Nolan added that the emphasis had been on the bottom end of training. The RCoA had pointed out that fragmentation of the two years is probably having a negative impact on the specialty. Dr Brennan had gained the impression that the specialty was off the Shape of Training Review's radar in terms of having already implemented the generalist agenda.

(xxx) The President had attended the RCoA Advisory Board for Wales meeting. A meeting with the Chief Medical Officer (CMO) had also been arranged. The President has written to the CMO requesting regular meetings.

(xxxi) The President had attended the King's Fund Leadership Lecture where Mr Donald Berwick spoke on the clinical leadership of health care reform.

(xxxii) Council members were asked to indicate whether they planned to attend Congress and the Recent Advances meeting.

(xxxiii) The President updated Council on staff changes:

a. Mr Mark Blaney has joined the College as Financial Controller on a full time and permanent basis.
b. Ms Hazel Kwatia has joined the Events Team as Event Co-ordinator/Social Media Co-ordinator on a full-time and permanent basis.
c. Ms Maddy Humphrey has joined the Education Directorate on a permanent basis as Health Services Research Centre (HSRC) Administrator as Morgan Cenan will not be returning to the College following maternity leave.
d. Ms Paula Carroll has joined the Professional Standards Directorate on a temporary basis supporting the work on Anaesthesia Clinical Services Accreditation (ACSA).
e. Ms Laura O'Brien has joined the Training Team on a temporary basis supporting project work on less than full time (LTFT) working.
f. Ms Agne Pasiunaite has joined the College as Facilities Assistant on a 12 month fixed-term basis.

CID/21/2013 ***Collaborating for Quality***

Professor Bion explained that when he was elected Dean of the FICM it became clear that with the creation of the Faculty and ICM as a primary specialty the processes etc. were not good enough to meet the current challenges in terms of changes in health service and desire to improve patient care. The FICM had therefore asked Professor Sir John Temple, assisted by Dr Judith Hulf and Professor Jon Cohen, to lead an inquiry into the current state of ICM. Having taken evidence from stakeholders, the Steering Group published *Collaborating for Quality in Intensive Care Medicine* in March 2013. The FICM had produced a response and had hosted a teleconference with all but the Intensive Care National Audit & Research Centre (ICNARC) and the Paediatric Intensive Care Society (PICS). PICS had however made its views known in advance and a position was agreed during the teleconference.

The UK Critical Care Leadership Forum (CCLF), consisting of the leadership of the various participating groups, would provide a common voice and meet for the first time in July 2013. The model which has been accepted for the CCLF is appended to the FICM's response to *Collaborating for Quality in ICM*.

Some aggregation of the FICM with Royal Colleges, Specialist Societies, audit groups and nursing groups had been unanimously agreed. Paediatric ICM needs to be better integrated with adult ICM and the President, as Chaiman of the Trustees, had been asked to invite the RCPCH to become the eighth Trustee College. PICS had been invited to join the Faculty Board ex officio. The President and Dr Hilary Cass would meet to discuss the RCPCH becoming a Trustee College.

Dr J Nolan asked the difference between the Critical Care National Reference Group and the CCLF. Professor Bion explained that the Clinical Reference Group is part of a commissioning arm whereas the CCLF is an aggregation of professional organisations. Professor Bion offered to circulate a diagram he had produced of key NHS and critical care organisations. It is intended that the Clinical Reference Group would be represented on the CCLF. The Clinical Reference Group also has four professional organisations represented on it including the FICM. Professor Bion was keen to avoid duplication of effort. The FICM and other groups, through the CCLF, would create national standards for critical care.

The Critical Care Nursing Group had created a national critical care nursing care competency programme but there is no-one to adopt it. The commissioners had recommended that critical care nursing training be more closely linked to ICM physician training. The most likely scenario is that the Royal College of Nursing (RCN) would establish a faculty or forum for critical care nurses. This needs to be linked to the FICM. The President had pointed out that significant changes would require the approval of the Privy Council. The principle is that the FICM wishes to support critical care nurse training and would co-ordinate and host a meeting on the best way to do so.

A number of points were made in the report about the Case Mix programme held by ICNARC. The structure and processes upon which ICNARC was built are no longer fit for purpose for the future. There is a wish to see evolution of current structures and process. There is also a wish to see the Case Mix Programme governance come through a form of Trustee leadership. Equity of access to the programme for audit and research needs to be evident; access is currently not as clear and even-handed as might be wished for. Professional organisations should offer long term support of the Case Mix Programme. ICNARC wished to hold internal discussions before talking to the external group.

A working group would be convened to determine how best to support collaborative research in the UK.

The professional societies need to determine how they work together.

With regards to the FICM's relationship with the devolved nations it had been proposed that the FICM's RA in Wales and Northern Ireland be appointed as the FICM national representative. Plans for Scotland had not yet been discussed.

The FICM's relationship with the defence medical services is already good but suggestions for enhancing the relationship would be gratefully received.

Dr Fletcher pointed out that it is quite clear that acute medicine will be developing enhanced care areas and probably require the support of FICM; had acute medical representation been considered. Professor Bion responded that the FICM has some preliminary relationships with acute medicine; how these evolve will come out of further discussions.

Dr Brennan stated that the report would be well supported by the paediatric anaesthetic and ICM community. Dr Brennan asked if discussion about perioperative care needed to be a part of the work. Professor Bion agreed that it should but added that he would prefer to focus on the patient journey.

Dr Whitaker was keen to ensure that the RCoA was adequately represented amongst the Trustees if an eighth Trustee College joined. The President explained that the Board was moving from co-opted to elected members and therefore representation would be decided by the electorate. It had not yet been discussed whether or not the RCPCH would have a seat.

CID/22/2013 Intercollegiate Board for Training in Pre Hospital Emergency Medicine

Council received a report of the meeting held on 15 March 2013. Dr J Nolan explained that the key issue was for pre hospital emergency medicine (PHEM) to be considered a subspecialty of ICM. An application had also been made for it to be considered a subspecialty of acute medicine. Those undertaking a dual CCT in anaesthetics and ICM would have to extend their training time by one year, something Mr Bryant wished to query. On the other hand there was evidence of strong interest amongst ICM trainees. The Intercollegiate Board for Training in Pre Hospital Emergency Medicine (IBTPHEM) had requested a letter from the President in support of its application to the GMC. The President suggested that this merited debate in the Training Directorate, Training Committee and the FICM. The current status of the review of medical training suggested that something as long as 10 years in gestation was unlikely to be acceptable to the GMC and the GMC may say it is post-CCT training. Dr Brennan pointed out that the validity of a test of knowledge pass is not endless and may be invalid when an individual seeks accreditation later down the line. The President suggested that this could be overcome through the revalidation process of the trainee. Professor Bion was very keen to support this and was opposed to truncating training. Dr Jones asked how the Royal College of Physicians of Edinburgh had been chosen to host the examinations. Dr J Nolan explained that it was by default; it is the lead organisation and the Faculty of Pre Hospital Medicine had already done a lot of work and was running examinations. Dr J Nolan added that to come up with an alternative would take quite a lot of effort. Mr Bryant stated that the RCoA would need to see the detail before writing a letter of support. Dr J Nolan pointed out that there was a time critical element. It was agreed that Dr J Nolan, Dr Brennan and Mr Bryant should discuss the best way forward. Mr Bryant suggested that there may not be as much time pressure as originally thought.

CID/23/2013 Anaesthesia Clinical Services Accreditation

The President reported that the Welsh CMO had been highly supportive of ACSA.

Dr Venn informed Council that the launch was two months away and asked Council members to respond to the invitation if they had not already done so.

The following day would be devoted to a whole informal day of Quality Management of Service Committee (QMSC) work.

All the standards had been written, weighted, given evidence the RCoA would like to see applied to them and cross-referenced to *Guidelines for the Provision of Anaesthetic Services (GPAS)*. The completed revised version of *GPAS* had been published on the RCoA's website. Dr Venn wished to thank, on behalf of ACSA, all who contributed to *GPAS*.

The second pilot study is almost complete and the programme of visiting is now pretty much known. A visit will probably be at least 1.5 to 2 days for a moderate to large hospital. Visits will include meeting as many consultants as possible and probably trainees too, with a walk round and feedback. Much of the time will be devoted to discussion about unmet standards and the gap analysis. Ideas will then be put together for the hospital to work on to close that gap up to accreditation. The application process and terms of accreditation need to be discussed. Further training for reviewers has been arranged.

Dr Venn circulated four possible designs for the Q mark and asked Council members to inform him if they objected strongly to any of them.

Mr McLaughlan explained that the involvement and discussion with trainees had been carefully discussed and managed under the eyes of College Tutors (CT) and Programme Directors; discussions would be solely about trainees' contribution to service and the support offered to them in their contribution to service. It had been made clear that ACSA would not impinge on the way trainees are developed through trainee mechanisms in the department.

Professor Mahajan enquired about the mechanisms for dealing with complaints or appeals. Dr Venn explained that there is an appeals process which needs to be finalised. There had been discussions about having an independent review panel from the College.

Dr Whitaker felt very strongly that all consultants in the department should sign up to the accreditation.

Dr Gulati asked what would happen if there were issues raised by a trainee. Dr Venn replied that it would depend on the issue. If it was an issue about the performance of an individual, under *Duties of a Doctor* ACSA reserved the right to involve the GMC if necessary. It is made clear under the rules of engagement that if something obviously unsafe or dangerous is discovered then it has to be brought to the appropriate authorities under *Duties of a Doctor*.

Professor Sneyd stated that the Francis Report requires medical students and trainee doctors to be whistleblowers and it has been agreed with the postgraduate dean that concerns will be shared; how does that fit in with the ACSA work? Professor Sneyd suggested the inclusion of a clause saying that where appropriate findings should be shared with the postgraduate dean. Dr Venn was acutely aware that if a department was accredited and there was a catastrophe the following day questions would be asked. Dr Venn added that ACSA is not looking at trainees but if, for example, there was a department making trainees behave in a strange way at night it would have to be drawn to the attention of the appropriate authorities. The general outcome from ACSA visits would be shared with the postgraduate dean.

CID/24/2013 Association of Anaesthetists of Great Britain and Ireland President's Report
Dr Harrop-Griffiths reported that Smiths Medical had issued a statement which concluded that it had chosen not to market the epidural version of its CorrectInject Safety System. In the meantime ISO TC210 had approved a fast track process to take a recommended standard straight to the ISO Board. This means that the ISO standard for neuraxial connections can be enacted fully by the end of the year.

Dr Harrop-Griffiths clarified that the AAGBI's intern scheme was aimed at non-doctors.

COMMITTEE BUSINESS

CB/40/2013 Council Minutes
The minutes of the meeting held on 12 March 2013 were approved.

CB/41/2013 Matters Arising
(i) Review of Action Points
All actions were complete or had been discussed elsewhere on the agenda.

CB/42/2013 Regional Advisers
There were no appointments for Council to consider.

CB/43/2013 Deputy Regional Advisers
There were no appointments for Council to consider.

CB/44/2013 College Tutors

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

Oxford

Dr N Beale (Churchill Hospital) acting Tutor for Dr D Choi **Agreed**
Dr M H J Size (Wycombe General Hospital) in succession to Dr C Nightingale **Agreed**

North Thames West

*Dr S P Kemp (Hammersmith/Queen Charlotte's Hospitals) **Agreed**
*Dr T M Peters (West Middlesex University Hospital) **Agreed**
*Dr M A Stevens (Hillingdon Hospital) 3rd term **Agreed**

North Thames Central

*Dr R L Simons (Royal Free Hospital) **Agreed**

North Thames East

Dr B Krishnachetty (Southend Hospital) in succession to Dr C M Dempsey **Agreed**

Mersey

Dr P A Burford (Southport & Ormskirk NHS Trust) in succession to Dr O S Kehinde **Agreed**

West of Scotland

*Dr D Smith (Glasgow Royal Infirmary) **Agreed**

South West Peninsula

*Dr J-A Thurlow (Musgrove Park Hospital) **Agreed**

Sheffield

Dr R Kumar (Rotherham) in succession to Dr C Smith **Agreed**

Wales

Dr K M Woods (Royal Gwent Hospital) in succession to Dr T Sheraton **Agreed**
*Dr R Shobha (Glan Clwyd Hospital) **Agreed**
*Dr A G Rees (Withybush Hospital) **Agreed**

West Midlands North

*Dr C J De Klerk (Royal Shrewsbury Hospital) **Agreed**

Dr D Nolan reported that an application for a consultant who had been in post for less than two months had been rejected; the Training Committee felt it was too early for them to take on the role of College Tutor (CT) especially in a big department. Dr Venn asked why other consultants did not wish to undertake the role and what the RCoA needed to do about it. Mr Bryant believed there was no cause for concern.

Dr Fletcher felt that the RCoA needed to make it clear that it is not a deanery's role to appoint CTs. Dr D Nolan responded that, trying to be conscious of the fact that postgraduate deans were moving away from engagement with CTs and RAs in some regions, the RCoA had drawn up a suggestion, which was taken up by some regions, that the postgraduate dean, RA and a trust representative should appoint the CT, thus ensuring that the CT would be given appropriate time and resource to do the job. Postgraduate deans were unfortunately not interested in most regions. Dr Gulati asked if trainees had any voice in the appointment process for CTs. Dr D Nolan explained that when CTs are appointed informal soundings are taken from the trainees. Dr Fazackerley had recently completed time as an RA with a Deanery that was not very supportive, although the appointment of CTs was one area where there had been collaboration. Dr Fazackerley had made the point that although it is a College approved appointment it is

definitely a College and deanery appointment. Dr Fazackerley explained how people seem to be choosing a Clinical Director role instead of a CT role.

CB/45/2013 Heads of Schools
There were no appointments for Council to note.

CB/46/2013 Training Committee
(i) Training Committee
Council received and considered the minutes of the meeting held on 3 April 2012 which were presented by the Chairman, Dr Brennan, who drew Council's attention to the following:

- *TRG/06/13(a)Improvement Science*
- *TRG/06/3(b) Pain Training*
- *TRG/22/13d Pain Training Statement on Diagnostic Skills*
- *TRG/21/13 KSS Education Research Fellow*
- *TRG/23/13(e) GMC Good Medical Practice*
- *TRG/32/13(b) Lead Dean*

A meeting would be held with the new Lead Dean for anaesthesia, Air Commodore Alison Amos, on 4 June 2013.

- *TRG/23/13(h) Shape of Training Review*
- *TRG/30/13 Trainee e-Portfolio*
- *TRG/23/13(c) GMC Review of Routes to Specialty Register*

(ii) Certificate of Completion of Training
Council noted recommendations made to the GMC for approval, that CCTs/CESR (CP)s be awarded to those set out below, 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 Joint CCTs/CESR (CP)s in Anaesthesia and Intensive Care Medicine.

Anglia
Dr Namita Arora
Dr Aditi Modi

London
North Central
Dr Kolitha Seneviratne

Bart's and The London
Dr Hardeep Chahal
Dr Chiew Ng

St. George's
Dr Christopher Jones
Dr Suresh Anandakrishnan

Mersey
Dr Sheila Carey

North West
Dr Eva Campo-Garcia

Northern
Dr David Snell
Dr Thomas Haigh
Dr Kiran Koneti

Severn/Bristol
Dr Mark Migginton

Tri-Services
Dr Deborah Easby *
Dr Claire Park *
Dr Stephen Lewis *

Wessex
Dr Geoffrey Higenbottam
Dr Duncan McPherson
Dr Barnaby Kyle *

Birmingham
Dr Rohit Mittal

Stoke
Dr Jacquelyn Lewin
Dr Jon Bingham

Scotland
South East Scotland
Dr Karen Stevenson

South Yorkshire (Sheffield)
Dr Biju Charles

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(iii) Chairman of Trainee Committee's Update
Dr Brennan informed Council that a letter would be sent to Heads of Schools and RAs regarding engaging with HEE and offering College support to help facilitate this where possible.

Interviews for the Bernard Johnson Adviser would be held on 7 May 2013.

There is a 99% fill rate for CT1 recruitment but a lot of gaps for ST3.

Mr Bryant agreed to circulate the feedback from the Annual Specialty Report to Council.

CB/47/2013 Anaesthesia Related Practitioners Committee
Council received and considered the minutes of the meeting held on 14 February 2013 which were presented by the Chairman, Dr Batchelor, who drew Council's attention to the following:

- *ARPC04/2013 Recruiting PA(A)s from the APA(A) Voluntary Register*

Mrs Dalton expressed her support for the regulation of Physicians' Assistants (Anaesthesia) [PA(A)]. Dr Nevin had raised the issue of considering only employing PA(A)s on the Association of Physicians' Assistants' (APA) Voluntary Register at the Clinical Directors' Executive Meeting. There was overall support from the group but they wished to have an open debate via the Clinical Directors' Forum on the RCoA's website. Dr Brennan suggested that the Health Professions Council needed challenging, perhaps in a letter from the President to the relevant government representative, to sort out the matter of regulation for PA(A)s; it is a patient safety issue which needs acting on. The President responded that he could see that government objections relate to cost.

- *ARPC07/2013 Clinical Leads PA(A) – Update*

It had been agreed that the Chairman should discuss PA(A) Service Standards with the Chairman of the Professional Standards Committee. Dr Venn requested that a document be produced.

- *ARPC08/2013 Clinical Leads ACCP – Update*

Professor Bion strongly supported Advanced Critical Care Practitioners (ACCP) and saw them as a major contributor to improving reliability and safety in ICM.

- *ARPC04/2013 Matters Arising, Induction and Emergence, consider a short briefing document*

Rather than amend the scope of practice document for PA(A)s the Committee decided not to change the scope of practice at present. The Committee agreed to endorse a local change of practice for trained PA(A)s who demonstrate the appropriate competences. Dr Harrop-Griffiths pointed out that what Dr Batchelor had described as a fudge was a back door change to the

scope of practice that had been opposed by both the RCoA and AAGBI Councils. If it was a fudge, did it serve the best interests of patient safety? Dr Batchelor responded that if a PA(A) had completed the training program, passed the examination, is employed, is working in a department and is judged competent to undertake that practice then that should be satisfactory. Dr Harrop-Griffiths was of the opinion that it should not be a decision taken by an individual but should be taken by Council. Dr Clutton-Brock pointed out that this is not something PA(A)s would do when they leave training; it is advanced level practice. Changes had been made to the document as requested by RCoA Council. The scope of practice for PA(A)s does not include epidural blocks or regional anaesthesia because not everyone will perform them. Dr Whitaker stated that the RCoA had nothing to gain from being associated with this. The President summarised that there was a lot of concern around the room. The RCoA sets out the requirements for a trainee but beyond that there would not appear to be strong support for endorsement.

CB/48/2013 Royal College of Anaesthetists' Advisory Board for Scotland

(i) Meeting with Chief Medical Officer

Council received and considered the notes of the meeting held on 27 February 2013 which were presented by Dr Colvin. Dr Colvin drew Council's attention to the discussions on:

- *Workforce*
- *Shape of Training Review*

(ii) Advisory Board for Scotland

Council received and considered the minutes of the meeting held on 4 March 2013 which were presented by the Chairman, Dr Colvin, who drew Council's attention to the following:

- There had been one candidate for the vacancy left by Dr Heather Hosie's resignation; Dr Malcolm Daniel. This rendered it impossible to test the e-voting system.
- Inconsistencies in the use of patient feedback across Scottish Health Boards.

Council congratulated Dr Colvin on his re-election as Chair of the Scottish Academy for a further year.

CB/49/2013 Finance Committee

Council received and considered the minutes of the meeting held on 12 February 2013 which were presented by the Chairman, Dr Batchelor, who drew Council's attention to the following:

- *F08/2013 Additional Staffing*
- *F20/2013 Uganda*
- *F02/2013 Matters Arising; the final distribution of the Estate of the late Eric F Green*
- *F04/2013 Report on the College's Financial Position*
- *F07/2013 Financial Controller*
- *F11/2013 Energy Consumption*

CB/50/2013 Patient Liaison Group (PLG)
Council received and considered the minutes of the meeting held on 11 March 2013 which were presented by the Chairman, Mrs Dalton, who drew Council's attention to the following:

- *PLG/05/2013 Patient and Public Involvement*

- *PLG/06/2013 PLG Work Plan*

Mrs Dalton commended the work plan to Council and stated that it would be brought to Council on an annual basis. The President thought this an excellent idea and that all committees working in the College should have one. The President commended the Group for this piece of work.

- *PLG/12/2013 Any Other Business; Revalidation – Multi Source Feedback*

CB/51/2013 Education Committee
Council received and considered the minutes of the meeting held on 20 March 2013 which were presented by the Chairman, Dr Clutton-Brock, who drew Council's attention to the following:

- *EC/04/13a Educational Resources on the College Website*

- *EC/03/13b Training the Trainers, RCoA and RCSEng*

- *EC/03/13C Anniversary Meeting 2014, BJA Delphi Session*

- *EC/06/13a Webcasting*

- *EC/06/13c e-Learning*

- *EC/07/13c Jubilee Current Concepts Symposium, 10-11 October 2013*

- *EC/10/13b Planning Future Events*

The Committee continued to struggle to populate all of the meetings and was looking at the process of trying to find and engage speakers. It is suspected that time away from trusts is a problem. The President observed fewer and fewer anaesthesia based speakers populating meetings in general which probably reflected the body of experienced speakers.

- *AEG/13/2013*

Simulation would come under the Anaesthetists as Educators Committee.

- *AEG/08/2013*

OSTEs had been well received.

MATTERS FOR INFORMATION

I/11/2013 Publications
Council received, for information, the list of publications received in the President's Office.

I/12/2013 Consultations
The list of consultations was now published in the *Bulletin*. The President was concerned about the lack of feedback received following response to consultations.

I/13/2013 New Associate Fellows, Members & Associate Members

Council noted, for information, the following:

New Associate Fellow

Dr Elonka Maria Theodora Elisabeth Bergmans - Birmingham Children's Hospital

New Member

Dr Aneel Julian Thakurdas – Primary FCARCSI
Dr Hind Saeed El-Mahdi – MSc in Anaesthesia & Intensive Care

New Associate Members

Dr Ambitabh Lahkar – Milton Keynes NHS Foundation Trust
Dr Manoj Bhaskaran Prappanadan – Withybush General Hospital, Haverfordwest

New Affiliate - Veterinary

Dr Evodokia Psatha

New Affiliate - Physicians' Assistant

Miss Gemma Muse – Bradford Teaching Hospitals Foundation Trust

To receive for information the following doctors have been put on the Voluntary Register

Dr Shashidhar Sakkaragoudra – Darlington Memorial Hospital
Dr Ihaab Matabdin – Northampton General Hospital, (Northampton)
Dr Danish Siddiqui – Leicester General Hospital, (Leicester)
Dr Nicholas James Shields – Monklands Hospital (North Lanarkshire)
Dr A Vinogradovs – Royal Hallamshire Hospital (Sheffield)
Dr Yavor Rossenov Metodiev – Kettering General Hospital
Dr Lohita Rilesh Nanda – Bedford Hospital NHS Trust
Dr Antonio Pablo Albaladejo Serrano – Basingstoke and North Hampshire Hospital
Dr Matthew Harry William Thompson – St Mary's Hospital Paddington
Dr Radha Uday Kunta - Bedford Hospital NHS Trust
Dr Brett Doleman – Royal Derby Hospital
Dr Robert John Neal –Bradford Royal Infirmary
Dr Clara Violeta Morales Munoz – Royal Hampshire Hospitals
Dr Kinga Izabela Niweinska – London Hyperbaric Centre Whipps Cross Hospital
Dr Samuel Maximilian Khanna – Bristol Royal Infirmary
Dr Parameswari Chockalingam – Lister Hospital
Dr Chun Kwong Eric Chung – Addenbrookes Hospital
Dr Katarina Belicova – NHS Hampshire Trust, Winchester
Dr Shwetank Sharma – Northampton General Hospital
Dr Nauman Muhammad Akhtar – Barnsley Hospital NHS Foundation Trust
Dr Mihaela Alina Balint – Princess Royal University Hospital, Orpington

Moved into this category as doctor was in wrong membership category

Category	Name	Hospital or Qualification
Associate Member	Dr Catherine O'Neill	Unknown

PRESIDENT'S CLOSING STATEMENT

PCS/4/2013 President's Closing Statement

The President had no further matters to raise.

MOTIONS TO COUNCIL

M/17/2013 Council Minutes
Resolved: That the minutes of the meeting held on 12 March 2013 be approved.

M/18/2013 College Tutors
Resolved: That the following appointments/reappointments be approved (reappointments marked with an asterisk):

Oxford
Dr N Beale (Churchill Hospital)
Dr M H J Size (Wycombe General Hospital)

North Thames West
*Dr S P Kemp (Hammersmith/Queen Charlotte's Hospitals)
*Dr T M Peters (West Middlesex University Hospital)
*Dr M A Stevens (Hillingdon Hospital)

North Thames Central
*Dr R L Simons (Royal Free Hospital)

North Thames East
Dr B Krishnachetty (Southend Hospital)

Mersey
Dr P A Burford (Southport & Ormskirk NHS Trust)

West of Scotland
*Dr D Smith (Glasgow Royal Infirmary)

South West Peninsula
*Dr J-A Thurlow (Musgrove Park Hospital)

Sheffield
Dr R Kumar (Rotherham)

Wales
Dr K M Woods (Royal Gwent Hospital)
*Dr R Shobha (Glan Clwyd Hospital)
*Dr A G Rees (Withybush Hospital)

West Midlands North
*Dr C J De Klerk (Royal Shrewsbury Hospital)