MEETING OF COUNCIL

Edited Minutes of the meeting held on Wednesday 9 February 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 R Laishley
Professor D J Rowbotham
Dr H M Jones
Professor J F Bion
Dr E A Thornberry
Professor J P H Fee
Professor R P Mahajan
Dr P J H Venn
Dr A M Batchelor
Professor J R Sneyd
Professor C M Kumar
Dr S R Moonesinghe
Dr D K Whitaker
Dr D M Nolan
Dr R Verma
Dr R J Marks
Dr T H Clutton-Brock
Dr L J Brennan
Dr J R Colvin
Dr M Nevin
Dr I H Wilson
Dr J Heyworth

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

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 A B H Lim and Dr S C Patel.

CEREMONIAL

C/1/2011 Retiring Council Member

The President presented a certificate to Professor Kumar.

COUNCIL IN DISCUSSION

CID/8/2011 President's Opening Statement

(i) The President announced the deaths of Dr Peter Simmons, Dr Yee-Kit Poon, Professor James (known as Alfie) Moore and Dr Stephen Allen. Council stood in memory.

(ii) The President thanked Miss Emma Bennett for organising a successful President's Dinner.

(iii) The President had discussed with Sir Neil Douglas the possibility of the Academy of Medical Royal Colleges' (AoMRC) document on sedation being updated. Sir Neil had suggested that the President propose an update to the document indicating the Royal College of Anaesthetists' (RCoA) willingness to act as lead.

(iv) The President had discussed with Professor Nigel Webster, incoming Chairman of the Directors of the *British Journal of Anaesthesia* (BJA) how he will take the Editorial Board forward in the light of recent Board discussions about strategy. The intention is to broaden the Editorial Board with more overseas members, do away with corresponding members and have a larger Associate Board. Currently, the President attends the Board of Directors and both he and the Vice-Presidents attend the Editorial Board. However, for a number of reasons, the Vice-Presidents are relatively transient; more continuity would be helpful. The

President explored whether the Vice-Presidents could be excused as ex-officio members from the Editorial Board and be replaced, as necessary, by academic Council members who could overlap the President's usual three year term; this has been agreed. The President asked Council if politically it is necessary for the RCoA to have three representatives on the Editorial Board whilst the President is a Director. Dr Tomlinson stated that his initial reaction had been that he would be happy to stand down. Upon reflection he thought a wider debate would be useful to consider whether there is value to both the RCoA and the Editorial Board in having three Council members attending. The President had suggested to Professor Webster that representation would be changed so representatives would consist of the President and up to two nominated representatives from Council, preferably with an academic leaning. Dr van Besouw stated that the decision would depend upon Council's view of the representatives' role; is it to ensure policies that Council wishes to see promulgated through the *BJA* are put into place or is it to act as external representation on the Editorial Board? Four or five members of the Editorial Board are Council members but that situation may not last in perpetuity. Dr van Besouw suggested that Council has to decide if the Vice-Presidents are there as a political force or to aid the Editorial Board and undertake work undertaken by the other journal editors. The President pointed out that Vice-Presidents are in office for one or two years; nominating from Council would facilitate continuity as the representatives could attend for a longer time. Dr Greaves explained that in his experience the virtue of Vice-Presidents attending was that they were not insiders. There were times when it could have proved difficult had there been an academic representative as they would have been in the company of peers. Professor Rowbotham felt that the RCoA should not give away the right to attend; a view shared by Dr Whitaker. The President hoped that a closer relationship between the RCoA and *BJA* would develop and hoped there would be moves made to having the editorial team based within the RCoA. The RCoA and *BJA* enjoy a relatively good relationship and the replacement of the Vice-Presidents with up to two President's nominated representatives would still allow the RCoA to input into the Editorial Board. Dr Venn asked whether or not there would be room in the future for the Editor of the *Bulletin* on the Editorial Board; the Editor could play a real role especially in light of changes the *Bulletin* has undergone in recent years. Professor Rowbotham pointed out that increased international representation may represent a risk in terms of changes being made to the *BJA* with which the RCoA may not agree. The President explained the reason for extra overseas members is to increase the impact factor and in particular North American circulation. The President stated that it would be beneficial to have nominated representatives who could serve for three years and span the time of the change of President. Dr Whitaker asked whether or not the RCoA should request four representatives in view of the increased size of the Editorial Board. Professor Mahajan felt that the RCoA should not reduce the number of its representatives. With more overseas members of the Editorial Board the ambassadorial role will increase; those from overseas may not be familiar with the College and its interaction with the *BJA*. Professor Sneyd supported the ambassadorial role, adding that he thought there would be no risk from overseas. The President concluded that Council felt that the RCoA should keep two representatives, not necessarily Vice-Presidents; perhaps one Vice-President and another nominated person such as the Editor of the *Bulletin*. The President would keep this in mind for future discussions.

(v) Mr Martin Else and Dr Clare Gerada had written to the President about the Faculty of Medical Leadership and Management; the first meeting will be in early 2011.

(vi) The President brought Council's attention to a letter from Mr John Nicholls regarding the freezing of clinical excellence awards in Scotland. The letter says that if an agreement cannot be reached with the British Medical Association (BMA) and managers in Scotland, changes to the contract will be implemented by ministerial direction through the issuing of

a circular. Dr Colvin added that the Scottish Academy has written again requesting a meeting to discuss the consequences of such a heavy handed approach.

(vii) The National Patient Safety Agency (NPSA) has informed the RCoA of the postponement of the neuraxial connectors issue. The Association of Anaesthetists of Great Britain & Ireland (AAGBI) has been very proactive in this matter. The President stated that the question now is should the RCoA go even further and say it will not co-operate with several manufacturers making different products; they should work to the same standard. Dr Wilson pointed out that would take a long time. Cardiff is assessing different systems which will give a better knowledge of what is available. Dr Clutton-Brock added that the standard is very slow to develop and does not stop manufacturers producing other CE marked connectors. Dr Clutton-Brock expressed his concern about having even two different systems adding that the RCoA should consider very carefully what it is going to do. Dr Whitaker suggested a drive for pre-filled syringes; looking at connectors was the wrong solution to the problem as there would still be the possibility of the wrong liquid being in the syringe. Professor Sneyd pointed out that there are mechanisms through EU procurement for example; the problem is a political one and should therefore be passed back into the political domain pointing out the risk of serious harm to patients. The President and Dr Wilson would discuss the matter further.

(viii) The President had received a copy of Dr Wilson's letter to Sir Peter Rubin about needle stick injuries; a lot of occupational exposure is high risk for anaesthetists, especially those working in Intensive Care Units (ICU). Dr Wilson added that a Royal College of Physicians' (RCP) working party is looking into this.

(ix) The President asked Dr Nolan to update Council on discussions with architects in relation to the development of 34 Red Lion Square. Two firms have looked at the site and have been asked to provide cost estimates (within the nearest half a million pounds) by the end of February. Professor Sneyd was concerned by the speed with which the project appeared to be progressing without Council having seen any detailed proposals. Mr Storey assured Professor Sneyd that this was not the case; the costing exercise is to select an architect and there should be simple sketches for Council to view after the end of February.

(x) The President had received an e-mail from Mrs Rivett about Council's discussion regarding the National Confidential Enquiry into Patient Outcome and Death's (NCEPOD) report *An Age Old Problem*. Mrs Rivett had noted that no action had been taken by the RCoA. Mrs Rivett explained to Council that she still has many concerns about the report and wishes to effect change; the RCoA needs to do its bit to ensure the issues highlighted are addressed. Mrs Rivett said she would be interested to know if anyone has any ideas; a work plan and individuals to take it forward are required. Mrs Rivett sought the support of Council and added she would be happy to support the work from a lay point of view. The President suggested Mrs Rivett, Professor Sneyd and Dr Nevin should discuss ideas. Dr Venn fully supported Mrs Rivett and suggested it should be raised at the Clinical Directors' (CD) meeting. The RCoA had posted a tweet on Twitter saying it would not let the issues raised drop off the agenda; the RCoA has gone public and must ensure it delivers the goods. Dr Venn added that NCEPOD reports are an audit without a closed loop; he suspected no other organisations would follow-up the report and it would be a golden opportunity to promote the RCoA. Mrs Rivett stated that she would like to report progress at the March meeting of the Patient Liaison Group (PLG). Dr Greaves pointed out that NCEPOD reports feed into work that is subsequently undertaken; relevant guidelines and papers within ten years of a report all reference it. Dr Wilson highlighted the disconnect between what a report says and what happens on the shop floor; if anaesthesia wishes to make a difference there might be merit in considering working with the Royal College of Nursing (RCN) or others who work with the specialty. Dr Nevin stated that every trust is facing a need to make efficiency savings; the implementation of this should be viewed as improving the pathways and therefore outcome and reducing cost by length of stay. Two areas of

concern are dementia care and skin care. Dr Nevin added it would be a good topic to raise during the afternoon question and answer session at the CDs' meeting. The President thanked Mrs Rivett for raising the matter and agreed to convene a small group to consider the way forward.

(xi) The President reminded Council that at the last Away Weekend Professor Sneyd had proposed the use of a template for committee chairmen's summaries based on one used by the AAGBI. The RCoA had adapted the template for its own use and it had been used by the Chairman of the Examinations Committee as a pilot. Dr Wilson reported that the template had worked well for the AAGBI although it had been modified on the basis of the RCoA's template. The President asked that committee chairmen provide succinct information rather than copying text from the minutes.

(xii) Mr Ben Hedley has joined the Chief Executive's Office on a temporary and part-time basis as the new College Records Administrator.

CID/9/2011 Replacement FRCA Certificate

Council agreed to a request from Dr Timothy R Hucker for the replacement of his FRCA certificate.

CID/10/2011 National Honours Committee

Mr Storey explained that the Committee had tweaked its terms of reference at its first meeting to name the Faculties and to include an additional point to liaise with the Surgeon General. The first meeting was excellent and the Committee has subsequently benefitted from a tutorial which has helped with the process. Outcomes however will take some time. Dr Wilson asked how open the process is in terms of reporting to Council. Mr Storey responded that the process is open but the names going forward are confidential to the Committee. The President explained that one part of the process is getting names into the Committee. It is for the Committee to generate and germinate the support for the various people and push them forward; the latter is a relatively closed process because there is no desire to get people's hopes up. Dr Wilson expressed his unease at such a closed process; it would be useful to know which names are being considered in case support could be lent to the application. The President asked how that would be taken forward, e.g. if Dr Wilson had a question about an individual could it be discussed with Sir Peter Simpson and Mr Storey? Mr Storey responded that it would be possible to talk about types of application whereas once individuals are discussed it puts the person with the question in the position of having a little bit of information whereas the Committee has all the information. Dr Moonesinghe asked if it would help to have patient representation on the Committee. Mrs Rivett replied that she would have to think about that; a patient representative would be able to assess whether or not the process is fair but would not be able to distinguish between individuals. Dr Greaves was also concerned about the lack of transparency; it would be useful to know how other Colleges run their committees and ensure some degree of transparency. Mr Storey explained that the national honours system is closed for the Committee submitting into the process; the Committee will receive no feedback whatsoever. Dr Rollin asked if the Committee can nominate to the House of Lords; other honours are for work done but the House of Lords is where policy can be influenced. Mr Storey responded that the Committee knows the process but four recent medical appointments to the House of Lords make it unlikely that further action will be beneficial at present. Dr Wilson requested a brief synopsis of the system. Mr Storey explained that the system is transparent when it comes to process but not when it comes to nominations. Dr Whitaker suggested the RCoA should look towards other honours such as the Nobel Prize.

COMMITTEE BUSINESS

CB/20/2011 Council Minutes

The minutes of the meeting held on 12 January 2011 were approved subject to minor amendments.

CB/21/2011 Matters Arising

(i) Review of Action Points

CID/1/2011 (x) Amendment to the Ordinances is work in progress.

CID/1/2011 (xiii) Mr Bryant would send dates of future College Tutors' (CT) meetings to the President later in the day.

CID/2/2011 The Simulation Working Group will meet again in a fortnight.

CID/3/2011 Professor Bion did not have secure information about reimbursement of the tariff; he had been directed to the National Specialised Commissioning Group's (NCSG) website. There are now seven centres and 25 beds for Extra Corporeal Membrane Oxygenation (ECMO); there is presumably a reimbursement process but Professor Bion was not sure how it is implemented. Dr Clutton-Brock added that there is an agreed fee per person but it does not include transport.

CID/4/2011 Dr Greaves apologised for not circulating the document from the RCoA and College of Emergency Medicine (CEM) Working Party on Anaesthesia, Sedation and Airway Management in the Emergency Department. Dr Greaves has written to the CEM stating that it is the view of Council that the two issues of sedation and rapid sequence induction should be separated. Dr Heyworth asked for a copy of the documentation so he could ensure a response was forthcoming. Dr Greaves is currently preparing a paper for the President and Vice-Presidents analysing the various roles in the provision of these emergency services and how critical care, anaesthesia and emergency medicine should relate to each other. The President had received further papers from Professor Jonathan Benger which he agreed to circulate to Council.

CID/5/2011 Dr Tomlinson is awaiting comments from the Society for Total Intravenous Anaesthesia, following which the guidance would be updated and circulated to Council.

CB/22/2011 Regional Advisers

Council considered making the following re-appointments:

Oxford

Dr Oliver Dyar, Regional Adviser for Oxford **Agreed**

North Thames West

Dr Peter Brodrick, Regional Adviser for North Thames West **Agreed**

CB/23/2011 Deputy Regional Advisers

Council considered making the following re-appointment:

Tri-Services

Dr David Birt, Deputy Regional Adviser for Tri Services **Agreed**

CB/24/2011 College Tutors

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

Oxford

Dr A J Ankers [Buckinghamshire Hospitals NHS Trust] in succession to Dr S P Snyders **Agreed**

Northern

*Dr S K Deshpande [South Tyneside Trust Hospital] **Agreed**

*Dr T Meek [James Cook University Hospital] **Agreed**

East Yorkshire

Dr E Hossenbaccus [Scunthorpe General Hospital] in succession to Dr G Thomas **Agreed**

Dr C R Snowden [Hull Royal Infirmary] in succession to Dr Z Rafique **Agreed**

North Thames West
*Dr J W Harris [Northwick Park Hospital] **Agreed**

North Thames Central
*Dr C N Ferguson [Royal National Throat, Nose and Ear Hospital] **Agreed**

Mersey
*Dr E J T Allsop [Royal Liverpool University Hospital] **Agreed**
*Dr S M Burns [Warrington and Halton Hospitals NHS Trust] **Agreed**

Wessex
*Dr I Rice [St Mary's Hospital, Isle of Wight] **Agreed**
Dr R M Heames [Southampton University Hospital] has resumed his post after 4 months military duty. Dr A P Mackie has been acting Tutor.

Severn
Dr P Ray [Weston General Hospital] has resumed her post after 8 months maternity leave. Dr I Tsagurnis has been acting Tutor **Agreed**

KSS
*Dr J J Dickens [St Richard's Hospital] **Agreed**
*Dr G Gould [Conquest Hospital] **Agreed**
*Dr H G Wakeling [Worthing and Southlands Hospital] **Agreed**

Wales
*Dr E B Howells [Princess of Wales Hospital] **Agreed**

CB/25/2011 Heads of Schools
There were no appointments for Council to note.

CB/26/2011 Training Committee
(i) Training Committee
Council received and considered the minutes of the meeting held on 2 February 2011 which were presented by the Chairman, Dr Thornberry. Spiral learning is still a concern to some; one particular school which has problems has requested a meeting with the RCoA. There will be a meeting with the Lead Regional Adviser (RA) to discuss strategy.

Dr Kate Wark had updated the Committee on progress with the international programme. There is concern that the Government is trying to reduce the visa from two years to one. This would make it unattractive for doctors to participate in the Medical Training Initiative (MTI); conversely, the AoMRC is seeking an extension for MTI doctors to three years.

With regards to intrathecal drug delivery the new syllabus is consistent with that of other specialties involved in this field; it will be taken to the General Medical Council (GMC) next time the RCoA submits a curriculum update.

Dr van Besouw had reported that some areas of the examinations were not blueprinted to the Certificate of Completion of Training (CCT) curriculum; this has now been resolved.

Certain specialties have noted that if doctors apply for an Academic Clinical Fellow post they do not have to apply for ST3 since these are still run-through posts. This is not a major issue for anaesthesia.

The Chief Executive of the AoMRC is looking in more detail at the concept of Lead Employers.

The RCoA/Obstetric Anaesthetists' Association (OAA) survey had come about partly because of the Working Time Regulations (WTR). Trainees had been surveyed and some worrying concerns were identified. Trainers had also been surveyed and the results triangulated with those of the trainees' survey; many trainees are not being assessed formally before going on call. There is a need to publicise the outcomes of the survey, to clarify issues and to emphasise the importance of proper assessment.

The Committee had been asked to look at on call requirements for trainees with medical conditions. For a core trainee evening and weekend work could be seen as equivalent to that experienced during overnight on call. The Committee agreed that if a trainee had very good medical reasons with robust support from Occupational Health, the RCoA could not say that it was not possible to obtain those skills during the day. The RCoA could however question whether it would be wise to continue in a career in anaesthesia and could make it very clear that any alteration in the working pattern of an individual must not impact on other trainees. Dr Thornberry agreed to send the President a copy of the response she had drafted with Mr Craig Williamson.

Mr Bryant had updated the Committee on recruitment.

The Committee had reviewed its terms of reference.

The Committee had received reports from the devolved Administrations.

Ms Lorna Kennedy had updated the Committee on the E-portfolio.

Dr Carolyn Evans had briefed the Committee on the results of the survey undertaken by less than full time (LTFT) anaesthetic trainees.

The e-Learning Strategy Group had proposed that the first unit of e-Learning Anaesthesia (eLA) should form part of the Initial Assessment of Competence (IAC). The proposal was not supported but the Committee noted that those using eLA appear to perform better in the Primary examination.

The President reported that the surgeons will submit to the GMC a request to move from two to three year training at core level. The case would have to be made on an educational not workforce basis; it may be worth Dr Thornberry, in her role as College lead on broad-based training issues, talking to those concerned to see how they are putting the case together.

Professor Sneyd and Dr Heyworth left the meeting at 1100.

(ii) <u>Certificates of Completion of Training</u>

Council noted recommendations made to the GMC for approval, that CCTs be awarded to those set out in the enclosed document, 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 Mark Jeremy Shaffer
Dr John Luis Deloughry
Dr Ramchandran Krishnan Melarkode
Dr Claire Ellaine Williams

London
South East
Dr Mansoor Sange *
Dr Asootosh Barry
Dr Saju Sharafudeen
Dr Alvin Hoong Jin Yeo
Dr Ashraf Abdulla Molokhia *
Dr Hillel David Hope
Dr George Rupert Graham
Dr Quazi Al Mahmud Siddiqui

North Central
Dr Helen Elizabeth Agostini
Dr Irene Bouras
Dr Bernd Oliver Rose *

Bart's & The London
Dr Nilesh Randive
Dr Rosepal Kaur Dhesi
Dr Naomi Hancox
Dr Pauline Alicia Babb
Dr Peter Edward Berry
Dr David Anthony O'Hara
Dr Asif Nasib

Imperial
Dr Nisreen Khalid Eltom

St. George's
Dr Elaine Lesley Hipwell *
Dr Frederick Van Damme
Dr Russell William Hewson *

Kent, Surrey, Sussex
Dr Sanjay Saikia
Dr Timothy Robert Hucker

Leicester
Dr Marcus John Wood
Dr Nadia Ladak
Dr Nicola Jane Hames

Nottingham
Dr Zubair Mulla
Dr Christopher Robert Harber
Dr Rana Sirian

Mersey
Dr Rajagopal Vennila
Dr Esther Alison Strachan Docker
Dr Nirmal Rajadurai
Dr Lee Andrew Luke Poole *

North West
Dr Andrew Gwynne McWilliam
Dr Charanjit Singh Badh
Dr Harry Sifone Chan *
Dr Arabella Paula Stevens
Dr Ian Nicholas Richardson *
Dr Toby John Spencer Elkington *
Dr Ravishankar Natesan
Dr Krishna Mohan Devarakonda
Dr Paul Andrew Damon Clements
Dr Neil Gregory Ramsay
Dr Graeme George Flett
Dr Hamy Galal Shawkat
Dr Sachin Rastogi
Dr Juliane Maria Goeke-Glatzel
Dr Stephen James Washington

Northern
Dr Jothika Harogoppa Thimappa
Dr Steve Peter Thomas
Dr Henrietta Elizabeth Dawson
Dr Seema Pathare

Northern Ireland
Dr Sinead McGuirk
Dr Ganesh Sivasankara
Dr Esther Amanda Davis *

Oxford
Dr Kelly Place
Dr Sebastian Piers Murray
Dr Carl Timothy John Broadbridge

South West Peninsula
Dr David Leslie Adams
Dr David Stuart John Elliott
Dr Niraj Niranjan

Severn/Bristol
Dr Christopher Paul Bourdeaux *
Dr Andrew Christopher Dabell Thompson
Dr Benjamin William Howes
Dr Natasha Clark
Dr Hugo Arthur Lawrence Wellesley

South Yorkshire & Humber (Sheffield)
Dr Sughrat Siddiqui *
Dr Joanne Louise Butterworth
Dr Ananth Kasisomayajula
Dr Gillian Mairi Hilton

Tri-Services
Dr Mark Stephen Davies

Wessex
Dr Matthew Robin Cordingly
Dr James Alexander Lloyd
Dr Marilise Galea
Dr Jonathan David Miller
Dr Alison Caroline Schulte

West Midlands
Birmingham
Dr Daniel Harrington Bailey

Warwickshire
Dr Andrew Niall Kelly
Dr Elinor Sian Powell

Stoke
Dr George Subeson

Scotland
South East Scotland
Dr Bridget Podmore

West Scotland
Dr Malcolm Astor Balfour Sim *
Dr Andrew David Mackay *
Dr Rosemary Jane Snaith
Dr Paul Christopher McConnell *
Dr Gordon Morrison Cowan
Dr Linzi Deborah Millar
Dr Alexander Puxty *
Dr Fiona Jean Gilmour

Yorkshire
Dr Louise Shrimpton Jolliffe
Dr Robert James Spencer
Dr Sandeep Verma
Dr Rachel Johnson
Dr Andrew John Carter *

(iii) Medical Secretary's Update

Dr Thornberry reported that RAF trainees have to undertake Critical Care Air Support Team (CCAST) work transferring patients from Afghanistan to Birmingham one week in eight and are therefore not achieving competences. There had been a meeting with those involved in their training to discuss the matter; the leads for anaesthesia and intensive care were asked to interview all their RAF trainees to identify if it is just a problem for those in the specialty training pinch points. There had been a follow-up meeting where it had been proposed that CCAST duties are counted towards the trainees' payback time. Career progression and salary scales would be looked at again. The written proposal had just been received; the RCoA's support was sought for when it is discussed with senior military personnel overseeing military training. Dr Thornberry explained that another suggestion is that trainees must be able to reach the airport to fly within six hours of being called; the possibility of trainees keeping their hand in at hospitals in the vicinity of the airport during quiet times is being explored.

Dr Thornberry reported that the President had received a letter from the Vascular Anaesthesia Society of Great Britain and Ireland (VASGBI). The letter refers to the centralisation of vascular services and VASGBI's concerns that the RCoA does not put enough emphasis on vascular anaesthesia in the curriculum. Dr Thornberry asked Council if more emphasis should be put on vascular anaesthesia. Dr Tomlinson reported that vascular anaesthesia was removed as an essential element of training following feedback from schools that it was increasingly difficult to deliver because of centralisation of vascular services. The RCoA must ensure that trainees get training in vascular anaesthesia although Dr Tomlinson acknowledged that the current curriculum could be better. Professor Bion pointed out that it is quite difficult to define the difference between a vascular and a non-vascular anaesthetist; everyone should be able to deal with an emergency vascular case. There are complex issues involved and before changing the curriculum it would be worth considering the article referred to in VASGBI's letter in more detail and identifying the key components which benefit patient outcomes. Dr Greaves pointed out that the number of vascular units is shrinking; this would make it impossible for schools to conduct rotations. Dr van Besouw stated that it would be for VASGBI to define the specific requirements it has to warrant an additional module which cannot be found in the existing curriculum. Dr Brennan suggested making the point that many skills required for vascular anaesthesia are generic but also achievable through the compulsory cardiothoracic element. Dr Batchelor stated that the reason for good outcomes in a vascular centre is because the whole team is there; team skills can be learnt in different branches of anaesthesia. As a consultant it is possible to learn the aspects needed for a particular branch of anaesthesia if an individual is a competent anaesthetist and also a good team player. Dr Marks pointed out that it would be quite difficult to organise a compulsory vascular module at programme director and trust level; it will present everyone with great logistical problems. Dr Thornberry suggested that market forces would drive this forward; the skills are there and those who want to apply for a job with an interest in vascular anaesthesia will pull together their existing skills and obtain the others. Dr Thornberry and the President would draft a response to the letter.

CB/27/2011 Career Grade Committee

Council received and considered the minutes of the meeting held on 13 January 2011 which were presented by Dr Laishley in Dr Lim's absence. Availability of the RCoA's courses and events to Staff and Associate Specialist (SAS) doctors continues to be difficult. Ms Drake agreed to obtain data on course attendance by grade. Professor Sneyd had forwarded a copy of the working arrangements for consultant anaesthetists in the UK which could be redrafted for SAS doctors.

The Committee had discussed the issue of helping SAS doctors back into training; both those with a long absence from clinical practice and those wishing to return from the SAS grade back into training. This will be discussed with CTs.

The Committee had discussed the WTR. A major change relates to flexible arrangements of working time and how out of hours on call time is counted. There is a proposal that this time is counted differently and that the reference period for averaging time might be extended; this will impact on all doctors, not just SAS. It will impact on Continuing Professional Development (CPD), teaching and training and there is concern about the potential outcome of the proposal. Dr Thornberry explained that the report is as a result of a consultation document; all member states and all types of jobs were consulted. The issue of opt-out was extremely divisive and will not be looked at; a solution is sought that makes opt-out something nobody wants to do. There was talk about a specific group of people, such as healthcare, around Europe sorting it out and going back to WTR; this will not happen unless it is agreed to make the opt-out not necessary. Dr Thornberry reported the suggestion that Miss Wendy Reid might represent the medical profession if

this were to happen although that stage is a long way away. The biggest worry is the effect of the SiMAP and Jaeger rulings.

CB/28/2011 Examinations Committee

Council received and considered the minutes of the meeting held on 1 February 2011 which were presented by the Chairman, Dr van Besouw. A pathway has now been mapped out for opening the FRCA to all anaesthetists practising in the National Health Service (NHS); the final document would be brought to the May meeting of Council.

Concern had been expressed regarding whether courses run to support candidates taking examinations were fit for purpose. A conflict of interest exists; the RCoA runs the examinations and also provides educational material to support them. If the RCoA is running examination related courses they must match the requirements of the examinations. Consideration is being given to more effective evaluation of this.

A proposal to carry out a short study of borderline candidate construct was supported by the Committee. Dr Roger Sharpe would carry out the work in conjunction with the Chairman of the Primary examination.

FileMaker Pro is now embedded in the examination structure. Representation had been received from both Faculties to use the software for their diplomas.

Council agreed that the Primary and Final FRCA Examinations (Selection and Appointment of Examiner) Regulations be amended to include the following paragraph:

"**Examining on a Less Than Full Time basis:** The RCoA are happy to consider applications from established FRCA examiners who wish to examine on a less than full time (LTFT) basis for legitimate personal reasons. In the first instance, examiners should discuss the details of their request with the Chair of the relevant examination who will then table the application for consideration at the next appropriate Exams Committee meeting. Each application for LTFT examining will be considered on its individual merits but the overriding consideration will be the staffing requirements of the relevant examining board. Recently appointed examiners will <u>not</u> be eligible for consideration for LTFT appointment until they have successfully completed <u>as a minimum</u> the probationary examining year. Once approved by the Exams Committee the LTFT appointment will normally commence at the start of the next academic year unless otherwise agreed with the Chair of the relevant examination. LTFT appointment will not extend the length of Examinership. All LTFT examiner appointments will be subject to annual review. "

Council agreed that the Primary FRCA Examiners listed below should move to the Final FRCA Board with effect from September 2011:

Dr Andrew Bailey
Dr Abhiram Mallick
Dr Christopher Hawksworth
Dr Claire Shannon
Dr Dermot Moloney
Dr Joseph Cosgrove
Dr Pauline Stone
Dr Ratan Alexander
Dr Simon Logan

Council agreed that the Fellows listed below should be appointed as probationary examiners with effect from September 2011:

Dr Mohamed Absullatif	Stepping Hill Hospital, Stockport
Dr Lawrence Azavedo	Royal Preston Hospital
Dr John Donnelly	Queen Margaret Hospital, Dunfermline
Dr Jonathan Hardman	Nottingham University Hospital
Dr Lucinda Hardy	Stepping Hill Hospital, Stockport
Dr Sian Jagger	Royal Brompton Hospital, London
Dr Andrew Klien	Papworth Hospital, Cambridge
Dr Arun Krishnamurthy	Princess Alexander Hospital, Harlow
Dr Nicolas Morgan-Hughes	Northern General Hospital, Sheffield
Dr Shankaranarayana Nagaraja	University Hospital Aintree, Liverpool
Dr Alexander Ng	Royal Wolverhampton Hospital

There is an ongoing consultation from the GMC on national professional examinations; a reply will be sent via the AoRMC.

The Examinations Review Working Party is looking at the construct, content and quality assurance of the examination. The GMC has been invited to visit examinations to see how they are delivered.

The Committee agreed to utilise Echo 360.

Dr van Besouw invited Council members to request annual examination reports from Mr Bryant if they wished to see them.

Council agreed that the under-mentioned doctors be awarded the Nuffield Prize for performing at the highest levels of distinction in all sections of the Primary examination at their first attempt at the January 2010 sitting of the Primary FRCA:

Dr Kris Benjamin Bauchmuller – Royal Cornwall Hospital Truro
Dr Benjamin Nicholas Harris – Queen Alexander Hospital Portsmouth

Two Prizes are to be awarded as both candidates scored maximum marks in the structured oral examination and performed equally outstandingly in both the OSCE and MCQ sections.

CB/29/2011 Equivalence Committee

Council had previously received the minutes of the December meeting. Professor Fee reported that the January minutes were not yet available. The President asked Dr Whitaker to liaise with Dr Bernard Riley regarding presenting Equivalence Committee minutes to Council.

CB/30/2011 Faculty of Intensive Care Medicine

Council received and considered the minutes of the meeting held on 25 January 2011 which were presented by the Dean, Professor Bion. 188 applications have been received for Foundation Fellowship thus far; the vast majority had been easy to approve.

The curriculum application had been submitted to the GMC at the end of January. Professor Bion paid tribute to the work of Dr Batchelor, Dr Simon Baudouin, Mr James Goodwin and the rest of the team for developing the document and submitting it to the GMC as required. The GMC's perception is that the primary specialty training, subject to GMC review and approval, would be implemented in a short timescale. Professor Bion pointed out that it had been made quite clear that this would not be achievable. It is anticipated that, subject to the GMC Review Committee on 1 March 2011, the primary specialty training programme for intensive care medicine (ICM) would be launched in August 2012. There is anxiety about how it will work and how it will

interdigitate with dual certification. If the GMC approves the primary specialty training programme there will be a lot of work to do with trustee Colleges regarding harmonisation of the curriculum with other specialty training programmes so that dual certification can be achieved in a reasonable timeframe. A number of activities have to be triangulated, such as more robust data on training posts; there are currently 318 trainees registered for the ICM programme and RAs think they could train an additional 100. There is a need to link training posts and who owns training opportunities within those posts with the workforce proposals coming from the Centre for Workforce Intelligence (CfWI). A short survey is required which it is hoped will result in more robust data regarding training opportunities and consultant opportunities at the end of training. Dr Alison Pittard, the Lead RA for ICM, has been asked to co-ordinate a small group looking at trainee pathways. It is hoped that within a couple of months the Faculty will have a clear view of how it thinks the dual certification programme will work.

Professor Bion reported that the Faculty Examination will be a two part examination. The first part will be based on the other specialty examinations or a new primary ICM examination focused mainly on basic sciences. The Faculty does not think it will get the latter off the ground instantaneously; another reason for starting primary specialty training in August 2012. The second part of the examination would be an exit examination into the final year of specialty training. It will be a knowledge based examination with OSCEs and some viva based examinations. Professor Bion thought it could be ready for the first diet of examinations at the end of 2012.

Professor Sneyd rejoined the meeting at 1220.

The President asked how intensivists will be certified in the ensuing seven years if people enter single specialty ICM in 2012 and seven years later get a CCT. Professor Bion responded that there are 318 in training and this matter needs to be addressed through the GMC. The Faculty will also need to consider competitive application for a training programme and whether it can have a stepped process for competitive application at ST3. Dr Batchelor added that the Faculty had emphasised to the GMC that if it started training in 2012 there would be a hiatus in the output of intensivists. A very long transitional arrangement is required; the importance of this had been emphasised because of the need to continue delivering service and producing consultants. The Faculty hopes to produce a two stage process in that trainees will move to the content of the new curriculum at a 'soonish' stage but the process will have to remain in place for those trainees in a base specialty type of post which means they could undertake specialty training in ICM.

Dr Batchelor reported there are trainees in ST3 posts who are not the same and in the first couple of years have to become the same. The Faculty is trying to persuade the Lead Dean that money has to be found to fund one year as supernumerary. The problem is trying to fund this at a time of financial cutbacks. The issue of transferable competences is very important. Trainees with Acute Care Common Stem (ACCS) (Anaesthesia) have completed everything the Faculty wishes them to have done up to the end of ST3. For other specialties they do not require a whole year if they have undertaken ACCS and will only have a little bit to make up. The specialty should not be marketed as something into which a trainee comes at a later date; there should be a push to make ICM something trainees know about at foundation training and during core training and apply for at ST3. The option for those in fringe areas, e.g. hepatology, to enter at a later date should not be cut out.

CB/31/2011 Audit and Internal Affairs Committee

Council received and considered the minutes of the meeting held on 12 January 2011 which were presented by the Chairman, Professor Mahajan. The Charity Commission Checklist was completed as a group exercise. The RCoA ticked the right boxes in most areas. Areas where it did not were discussed and they were either not relevant to the RCoA's set up or were areas of such

a complex nature where to be able to tick the box the RCoA would have to go through an exercise not considered worthwhile. The President reported that the *BJA* provided training on financial Charity Commission matters for its trustees and asked if Council should receive training. It was agreed that the President, Professor Mahajan and Mr Storey should consider a presentation after Council, possibly including the checklist.

CB/32/2011 Communications Committee

Council received and considered the minutes of the meeting held on 13 January 2011 which were presented by the Chairman, Dr Venn. The Committee hoped that Dr Andrew Morley's application to the Wellcome Trust would be successful.

Dr Venn and the AAGBI would be speaking with the Royal College of General Practitioners (RCGP) which has run a specific profiling campaign. The President reported that the Press Officer of the Royal College of Physicians of London (RCPLond) had given a presentation to the President's Meeting; Mr McLaughlan agreed to show Dr Venn the material from the meeting.

The Committee approved the increase in advertising rates for 2011/2012 which had been suggested by the Finance Committee. The Bulletin is pretty much full for the whole year; it may be necessary to increase its size again next year or introduce a more frequent publication.

Dr Marks had given a presentation to the Committee about the website review. A meeting had been held with one potential new designer and there would be meetings with other designers; it is hoped a contractor will be appointed in May with the new website available by Christmas. Dr Marks informed Council that he will be seeking assistance in editing existing content before it is migrated to the new site. Professor Sneyd asked what the librarianship function is in the RCoA for the website; a permanent librarian is required to keep the website under control. The President responded that there would be financial implications.

The BBC has approached the RCoA about a series of films about anaesthetists. A holding response had been sent.

The President thanked Dr Venn for pressing on with the hard work. The President emphasised the need to work closely with the Faculties, AAGBI and Specialist Societies.

CB/33/2011 Joint Informatics Committee

Council received and considered the minutes of the meeting held on 13 January 2011 which were presented by the Chairman, Dr Verma. Dr Verma declared an interest in the development of on-line pre-operative assessment. The Department of Health (DH) now thinks it is an excellent project to develop and a business plan has been requested. Dr Verma will give a presentation to Council in March. Dr Verma would be seeking Council's support for the project; this would not include financial support. Dr Verma asked if anyone was aware of similar work in the UK or abroad. Professor Sneyd stated that there had been work over the last 20 years which almost reached the trial stage. Dr Whitaker added that Draeger has a system.

The President had attended the National Clinical Reference Panel – Summary Care Records; the Panel was dissolved at the end of the meeting!

CB/34/2011 Royal College of Anaesthetists' Advisory Board for Northern Ireland

Council received the minutes of the meeting held on 12 November 2010. The Chairman had given a verbal report of the meeting at the January meeting of Council and had nothing further to add.

Dr van Besouw reported to Council that the RCoA had been due to meet representatives of the Irish College to discuss and work through its application to the GMC. The application had not yet materialised and it was unlikely the meeting with the GMC scheduled for the following week would go ahead. The President added that the RCoA could not support the application if it has not seen it.

MATTERS FOR INFORMATION

I/4/2011 Publications
The list of publications received in the President's Office was drawn to Council's attention.

I/5/2011 Consultations
Council received, for information, a list of the current consultations.

I/6/2011 New Associate Fellows, Members & Associate Members
Council noted the following:
New Associate Fellows – January 2011
Dr Kathryn Louise Spence – Antrim Area Hospital
Dr Neal Beckett – Musgrave Park Hospital, Belfast

New Member – January 2011
Dr Louise Anne Carter – Primary FCARCSI

New Associate Member – January 2011
Dr Yuvaraj Doraiswamy – West Wales General Hospital

To receive for information the following doctors have been put on the Voluntary Register – January 2011:
Dr Thomas Alistair James Ballantyne – Ninewells Hospital, Dundee
Dr Abdulrahman Ihsan Abdulrahman Al-Bakri – Heart of England NHS Foundation Trust
Dr Paul Timothy Maclure – University Hospital, Coventry & Warwickshire
Dr Sara Jane Churchill – Royal Gwent Hospital, Newport
Dr Srinivasan Jegarakshagan – North Manchester General Hospital
Dr Udesh Supun Perera – Freeman Hospital, Newcastle-upon-Tyne
Dr Sumithre Bandara Gunethilake – Queen Mary's Hospital, Sidcup
Dr Noreen Deirdre Guerin - Portland Hospital for Women & Children

I/7/2011 Academy of Medical Royal Colleges
Council noted, for information, the Executive Summary of the meeting held on 25 January 2011.

PCS/2/2011 President's Closing Statement
(i) The President thanked Professor Kumar for his hard work especially on the Education Committee and in establishing the RCoA Congress.

MOTIONS TO COUNCIL

M/6/2011 Minutes
Resolved: The minutes of the meeting held on 12 January 2011 were approved subject to minor amendments.

M/7/2011 Regional Advisers
Resolved: That the following re-appointments be approved:
Oxford
Dr Oliver Dyar, Regional Adviser for Oxford

North Thames West
Dr Peter Brodrick, Regional Adviser for North Thames West

M/8/2011 Deputy Regional Advisers
Resolved: That the following re-appointment is approved:
Tri-Services
Dr David Birt, Deputy Regional Adviser for Tri Services

M/9/2011 College Tutors
Resolved: That the following appointments/re-appointments be approved (re-appointments marked with an asterisk):
Oxford
Dr A J Ankers [Buckinghamshire Hospitals NHS Trust]

Northern
*Dr S K Deshpande [South Tyneside Trust Hospital]
*Dr T Meek [James Cook University Hospital]

East Yorkshire
Dr E Hossenbaccus [Scunthorpe General Hospital]
Dr C R Snowden [Hull Royal Infirmary]

North Thames West
*Dr J W Harris [Northwick Park Hospital]

North Thames Central
*Dr C N Ferguson [Royal National Throat, Nose and Ear Hospital]

Mersey
*Dr E J T Allsop [Royal Liverpool University Hospital]
*Dr S M Burns [Warrington and Halton Hospitals NHS Trust]
Wessex
*Dr I Rice [St Mary's Hospital, Isle of Wight]
Dr R M Heames [Southampton University Hospital] has resumed his post after 4 months military duty

Severn
Dr P Ray [Weston General Hospital] has resumed her post after 8 months maternity leave

KSS
*Dr J J Dickens [St Richard's Hospital]
*Dr G Gould [Conquest Hospital]
*Dr H G Wakeling [Worthing and Southlands Hospital]

Wales
*Dr E B Howells [Princess of Wales Hospital]

M/10/2011 Examinations Committee

Resolved: That the Primary and Final FRCA Examinations (Selection and Appointment of Examiner) Regulations be amended to include the following paragraph:

"**Examining on a Less Than Full Time basis:** The RCoA are happy to consider applications from established FRCA examiners who wish to examine on a less than full time (LTFT) basis for legitimate personal reasons. In the first instance, examiners should discuss the details of their request with the Chair of the relevant examination who will then table the application for consideration at the next appropriate Exams Committee meeting. Each application for LTFT examining will be considered on its individual merits but the overriding consideration will be the staffing requirements of the relevant examining board. Recently appointed examiners will not be eligible for consideration for LTFT appointment until they have successfully completed as a minimum the probationary examining year. Once approved by the Exams Committee the LTFT appointment will normally commence at the start of the next academic year unless otherwise agreed with the Chair of the relevant examination. LTFT appointment will not extend the length of Examinership. All LTFT examiner appointments will be subject to annual review. "

Resolved: That the Primary FRCA Examiners listed below should move to the Final FRCA Board with effect from September 2011:

Dr Andrew Bailey
Dr Abhiram Mallick
Dr Christopher Hawksworth
Dr Claire Shannon
Dr Dermot Moloney
Dr Joseph Cosgrove
Dr Pauline Stone
Dr Ratan Alexander
Dr Simon Logan

Resolved: That the Fellows listed below should be appointed as probationary examiners with effect from September 2011:

Dr Mohamed Abdullatif	Stepping Hill Hospital, Stockport
Dr Lawrence Azavedo	Royal Preston Hospital
Dr John Donnelly	Queen Margaret Hospital, Dunfermline
Dr Jonathan Hardman	Nottingham University Hospital
Dr Lucinda Hardy	Stepping Hill Hospital, Stockport
Dr Sian Jagger	Royal Brompton Hospital, London
Dr Andrew Klien	Papworth Hospital, Cambridge
Dr Arun Krishnamurthy	Princess Alexander Hospital, Harlow
Dr Nicolas Morgan-Hughes	Northern General Hospital, Sheffield
Dr Shankaranarayana Nagaraja	University Hospital Aintree, Liverpool
Dr Alexander Ng	Royal Wolverhampton Hospital

Resolved: That the under-mentioned doctors be awarded the Nuffield Prize for performing at the highest levels of distinction in all sections of the Primary examination at their first attempt at the January 2010 sitting of the Primary FRCA:

Dr Kris Benjamin Bauchmuller – Royal Cornwall Hospital Truro
Dr Benjamin Nicholas Harris – Queen Alexander Hospital Portsmouth