**MEETING OF COUNCIL**

**Edited Minutes of the meeting held on Wednesday 8 February 2012**
**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 J-P W G van Besouw
Professor J R Sneyd
Dr A A Tomlinson
Dr J D Greaves
Dr R Laishley
Professor D J Rowbotham
Dr H M Jones
Professor J F Bion
Dr E A Thornberry
Professor R P Mahajan
Dr P J Venn
Dr A M Batchelor
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 P Nolan
Dr J R Colvin
Dr J R Darling
Dr I H Wilson
Dr M Nevin

Mrs I Dalton and Mr P Rees, RCoA Patient Liaison Group (PLG)
Dr A-M Rollin, Professional Standards Advisor

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

**Apologies for absence:** Dr A B H Lim, Dr S C Patel and Dr M Clancy.

**CEREMONIAL**

**C/1/2012 Retiring Council Members**

The President presented a certificate to Drs Tomlinson, Greaves and Moonesinghe. Dr Lim would be presented with a certificate at the Anniversary Dinner.

**COUNCIL IN DISCUSSION**

**CID/5/2012 President's Opening Statement**

(i) The President announced the deaths of Professor Doreen Vermeulen-Cranch, Dr Andrew Fraser and Dr Margaret Pickering-Pick. Council stood in memory.
(ii) Dr Patel had been offered an extension to his Fellowship in Canada until June 2012. Trainee input to Council would be co-opted as necessary until Dr Patel's return.
(iii) Dr Kwee Matheson would succeed Dr Hugh Seeley as Chairman of the Senior Fellows Club in June 2012.
(iv) The President had met Sir Neil Douglas and Professor Terence Stephenson to discuss Health Bill strategy. Council would debate the Bill following the formal Council meeting but there was still concern amongst Colleges about what they should be doing. A decision was awaited from some Colleges as to whether or not they would ballot their members.

(v) Dr D Nolan and Mr Storey would run induction sessions for new Council members on 17 and 24 February 2012.

(vi) The Centre for Workforce Intelligence's (CfWI) report would shortly be published. The report asked a lot of questions but did not start to answer questions posed. Professor Terence Stephenson's document on the benefits of consultant care started to answer some of the questions. The President enquired if Dr Mark Porter, of the British Medical Association (BMA), had given feedback on the Health Bill at the President's Dinner. Professor Sneyd reported that Dr Porter was very conscious that the BMA's duty as a representative organisation was to represent all its members and he was very concerned that pressing ahead may lead to the withdrawal of interim arrangements for those at the further end of their professional career.

(vii) With effect from March 2012, Council meetings would take on a new format and commence at 1000, with an expected finish time of 1500. The President would endeavour to formalise the ceremonial and strategic sessions.

(viii) The College of Emergency Medicine (CEM) had moved out of Churchill House. Mr Gordon Miles, Chief Executive of the CEM, had written to thank the Royal College of Anaesthetists (RCoA) for its help over the last few years.

(ix) Those who had not already done so were asked to inform Ms Robinson whether or not they would attend the Anniversary Dinner.

(x) The President reminded Council members that, whenever they are in the College, they should touch base with those providing secretarial and directorate support to their committees.

(xi) The President thanked those involved in ensuring the President's Dinner was a successful event: Ms Robinson, the caterers and Facilities staff.

(xii) Mrs Charley Hoey had decided not to return to her role as PA to the Chief Executive following maternity leave. Ms Sophie Lieven, who had provided cover during Mrs Hoey's absence, had therefore taken up the role on a permanent basis.

**CID/6/2012 Developments for the International Programmes**

Dr D Nolan presented a paper developed by Dr Kate Wark, Bernard Johnson Adviser for International Programmes, which presented an opportunity to pull together some of the current strands of activity. Dr Wark's paper outlined seven straightforward proposals for which Council's review and approval was sought. Professor Sneyd questioned whether it would be more appropriate for the Training Committee to approve the paper's contents rather than Council. Professor Sneyd added that the European Society of Anaesthesiology (ESA) operates a trainee exchange programme with seven participating centres in the UK; care should be taken to avoid reinventing the wheel. Professor Sneyd advised talking to those in the UK participating in the existing scheme before doing anything else. Professor Bion strongly supported the proposals but asked if anyone was aware of problems with the UK Border Agency in terms of bringing trainees in under Medical Training Initiative (MTI) or visa class two or five systems. Professor Bion went on to describe a case with which he was familiar. Dr D Nolan was unaware of individual cases but added that Dr Wark may have details. Dr Tomlinson expressed his strong support but was disappointed that Sri Lanka was not mentioned specifically in the document; the MTI was already established with Sri Lanka and the UK link was appreciated. Dr Tomlinson added that the Sri Lankans had pointed out that obtaining visas could cause significant difficulties and asked if the paper could include a proposal to assist in getting them. Mr Bryant responded that it was possible for the RCoA to canvas the Academy of Medical Royal Colleges (AoMRC) to go to the UK Border Agency and the RCoA would continue to do so. Mr Bryant cautioned against involvement with tier two visas which are more related to service provision than training. Mr Bryant pointed out that Dr Wark's proposal was related to tier five visas which cover the training perspective. Dr Venn added his support and asked if there would be any dispensation for the examinations. The President pointed out that the RCoA could not disadvantage its own trainees but could consider

dispensation. Dr Wilson was concerned that those brought in under the MTI were used as rota fillers rather than being trained. Dr Wilson stated that the Association of Anaesthetists of Great Britain and Ireland's (AAGBI) International Relations Committee would welcome the involvement of the RCoA's expertise. The involvement of the RCoA would be beneficial to anaesthesia as a whole. The President sensed willingness amongst Council that working with the AAGBI, rather than semi-independently, was the way forward. In view of Mr Bryant's comments regarding the UK Border Agency, Professor Bion summarised the case he had alluded to earlier whereby incorrect initial advice from the UK Border Agency had led to a chain of events which resulted in the doctor being ineligible for any type of visa. Dr Thornberry reiterated that using the AoMRC as a central point was the best way forward. Dr Whitaker highlighted that points three and four of Dr Wark's proposals supported the UK's global health policy.

Dr D Nolan was asked to inform Dr Wark that the paper had the full support of Council. Professor Sneyd added that the paper should be welcomed by Council and sent back to the Training Committee. Professor Sneyd noted that the ESA has a similar programme in place and he was unable to approve the proposal without it being first discussed with them. Dr D Nolan was asked to summarise Council's comments and take the paper to the Training Committee.

**COMMITTEE BUSINESS**

**CB/13/2012 Council Minutes**

The minutes of the meeting held on 11 January 2012 were approved subject to the amendments discussed under item CB/14/2012.

**CB/14/2012 Matters Arising**

i. Review of Action Points

*CID/1/2012 President's Opening Statement* Discussions were ongoing regarding whether the President should write to the All Party Pharmacy Group or the Association of the British Pharmaceutical Industry about keeping old drugs on the market and nationalising drugs which do not make money.

*CID/2/2012 Intercollegiate Board for Training in Pre-hospital Emergency Medicine* Dr Thornberry reported that more versions of the transferable competencies document would come through the AoMRC. Dr Jones reported that in Wales there was a working group for Pre-Hospital Emergency Medicine chaired by Dr Ian Bowler. There was interest amongst the emergency medicine fraternity, anaesthesia and critical care to have these posts. It was hoped that one post in Bangor and one post in Cardiff would be up and running in August 2013. The Dean was supportive and had indicated that he was looking to fund two posts and take it from there.

*CB/2/2012 Matters Arising CB/171/2011 Matters Arising* Professor Sneyd was unable to find the General Medical Council's (GMC) notice stating that it would be possible to revalidate without undertaking any clinical activity with patients. Council members were asked to let Professor Sneyd or Dr Brennan know if they found it. Dr Brennan pointed out that medical members of tribunals are not required to hold a GMC licence to practise. If they do hold a licence they do not have to provide evidence of their work for tribunals for the purposes of revalidation.

*CB/8/2012 Royal College of Anaesthetists' Advisory Board for Scotland* Recruitment was currently taking place; Dr Colvin would therefore have the information regarding the percentage of external candidates by the end of the week.

*CB/12/12 Trainees' Committee* Dr Clutton-Brock had produced an initial draft document for medical students undertaking an anaesthesia placement which he had sent to Professor Bion for consideration.

*I/2/2012 Consultations* The President thanked those who had contributed to consultations. Dr Thornberry had written to the Chairman of the Royal College of Obstetricians and Gynaecologists' (RCOG) Quality and Safety Committee asking if it would be appropriate to discuss at the meeting what the RCOG was doing regarding maternity services in Wales. Dr Thornberry had asked that if it was not considered appropriate that she be put in contact with the relevant person. Dr Brennan informed Council that the consultation on perioperative pregnancy testing of teenage adolescent girls was relevant to anyone managing children of any age. Council was asked to feedback comments to Dr Brennan.

*CB/8/2012 Royal College of Anaesthetists' Advisory Board for Scotland* Council agreed that the penultimate sentence in paragraph two should be amended to 'NHS Education for Scotland (NES) continued to oppose the introduction of CT3 as a third year delivery for core training. As a consequence the specialty risks losing 15-20 posts from the total current cohort of 420.'

*CB/2/2012 Matters Arising (ii)* Council agreed that the minute should be amended to 'Professor Bion was concerned that the addition requested by Dr Whitaker would make it appear as though Council had not debated a statement which required further action. Professor Bion suggested that Dr Whitaker's phrasing be modified to reflect that the research indicates that emergency airway management complications can be reduced by a protocolised approach which includes two operators. Dr Batchelor pointed out that the practice of intensive care in Europe is different to the UK; some of the doctors may not be anaesthetists and this cannot necessarily be transplanted to the UK. Dr Whitaker said the minute 'patients requiring intubation on intensive care were often amongst the sickest that had to be treated and recent research from Europe recommended that two doctors should be present.' was correct and had been made in the context of a concern raised by Dr Greaves who said he had been told that an intensive care practitioner in one hospital was regularly intubating patients on the Intensive Care Unit without a consultant present.'

**CB/15/2012 Regional Advisers**

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

**West Midlands South**

*Dr Jo James, Regional Adviser for West Midlands South **Agreed**

**North Thames West**

Dr Michelle Hayes acting Regional Adviser for North Thames West until a successor is found for Dr Brodrick **Agreed**

**CB/16/2012 Deputy Regional Advisers**

Council considered making the following appointments:

**North Thames West**

Dr S Jaggar, Deputy Regional Adviser for North Thames West in succession to Dr M Hayes **Agreed**
Dr R Bacon, Deputy Regional Adviser for North Thames West **Agreed**

**CB/17/2012 College Tutors**

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

**West Yorkshire**

*Request for extended term of office for Dr J Burns, Airedale Hospital **Agreed**

**North Thames West**
Dr A Prabhu (Central Middlesex Hospital) in succession to Dr A Wijentung **Agreed**

**KSS**
Dr N C Forder (Eastbourne District General Hospital) in succession to Dr S Walton **Agreed**

**Oxford**
Dr M W Speirs (Oxford Radcliffe Hospitals NHS Trust) in succession to Dr C Grange **Agreed**

**Mersey**
Dr N Zaffar (Macclesfield Hospital) in succession to Dr D Banks **Agreed**

**CB/18/2012 Heads of Schools**
Council noted the following appointments:
Dr Peter Brodrick, Head of London Academy, in succession to Dr R Ginsburg
Dr S-A Phillips, Head of School for Northern Ireland, in succession to Dr Clive Stanley

Mr Bryant reported that he would meet Dr Brodrick every two months; Dr Brodrick sees his role as representing the College as well as the deanery.

**CB/19/2012 Training Committee**
(i) Training Committee
Council received and considered the minutes of the meeting held on 1 February 2012 which were presented by the Chairman, Dr D Nolan. Dr D Nolan explained that as a result of the wording in the 2007 curriculum there was a difference of interpretation in the delivery of higher training especially neuro, cardiac and in some schools paediatrics. Another letter had been sent to heads of schools stating that those still on the 2007 curriculum must have completed appropriate higher training. No trainees have been disadvantaged.

Assessment guidance for ICM had been included in the major change submission to the GMC. Assessment blueprints for intermediate and higher training had also been included.

The Committee had discussed whether or not trainees felt it appropriate for the RCoA to publish guidance on the assessment process. Dr Moonesinghe would raise the matter at the next Trainees' Committee meeting.

The President requested an update on the potential move to structured learning events (SLE), stating that many Colleges would be keen to move to such a system as it is less onerous and burdensome. The President asked how that would be taken through the RCoA. Dr D Nolan agreed to look at the matter.

The Committee had discussed a request for school administrative staff to review multisource feedback (MSF) on trainees.

The Committee had discussed an out of programme training (OOPT) proposal from Dervan, Maharashtra, India. It was felt that the proposal was poorly worked up especially with regards to trainee supervision which would come from the Medical Director who is a cardiologist. Further information would be required.

The GMC's consultation on trainers was underway.

There was disparity among regions regarding interpretation of the *Gold Guide's* guidance on remedial training extensions. Dr Carolyn Evans was of the belief that the RCoA should put together its own view on this. Dr Colvin stated that flexibility was fine. The Scottish view was that anyone in a third year of core training was in remedial training whether it was for six months or one year. The President enquired if a trainee was not in run through training and the *Gold Guide* stated they could have a year in total was that a year at core and a year at higher advanced level? Mr Bryant responded that a trainee could have a total of two years' extended training. Dr Marks added that this had been discussed at the Recruitment Committee. There were trainees who need a little bit longer. If this was not undertaken in a deanery funded and approved post the additional time may be carried out in a locum position and the individual may go on to fail. Dr Marks stated that an element of discretion was required; decisions should be made at local level depending on the needs of an individual doctor. Dr Thornberry stated that if the *Gold Guide* stated that individuals have a right to six months then the College should say they have a right to it and it must be because they have not ticked all the boxes and are not ready to move on. The RCoA should make a stand on the injustice whereby some deaneries fund and approve the training and others would not. Dr van Besouw suggested that it could be discretionary subject to robust documentation of progression through the training scheme.

The President informed Council that he is co-chair of the Medical and Dental Recruitment and Selection (MaDRaS) Working Group which would be further developing national recruitment. The President explained that UK offers would be at the bottom, with deanery and College recruitment and selection silos in the middle, on top of which would be one national portal where trainees would go which would feed into College and deanery systems. MaDRaS was not intended to replace College and deanery systems.

The Committee had acknowledged Dr Moonesinghe's major contribution to its work.

Dr Colvin, a corresponding member of the Training Committee, stated that the mechanism for corresponding members to feed into the Committee needed to be recorded. He had been asked specifically by the NES Specialty Board to bring points to the discussion but could not attend the meeting.

(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.

***London***

**South East**

Dr Nelun Wijayasinghe
Dr Barry Mark Featherstone
Dr Jonathan Adrian Short
Dr Samuel George Hillyard
Dr Rajib Dutta

**North Central**

Dr Simon Dun Shin Liu
Dr Suresh Babu Loganathan
Dr Simeon Jon West

**Bart's and The London**

Dr Stephen Robert James

***East Midlands***

**Leicester**

Dr Daniel Huw Rhys O'Neil *

**Nottingham**

Dr Mark Barley

***Mersey***
Dr Alison Margaret Hall *
Dr Sandra Kay Lawrence

***North West***
Dr Catherine Heidi Doherty

***Northern***
Dr Sian Helen Davies
Dr David James Pritchard
Dr Alistair William Cain
Dr Patrick Shiun Jye Chiam

***Oxford***
Dr Anwar Kandarumadathil Rashid
Dr Justin Craigie Mandeville *
Dr Christopher James George Green

***Severn/Bristol***
Dr Edward Ewart Bick
Dr Tobias Christohper Everett

***South West Peninsula***
Dr Fiona Hilary Martin
Dr Shahed Kaleem Kim Chishti

***West Midlands***
**Stoke**
Dr Michael William Greenway
Dr Martyn Peter Traves
Dr Lloyd Robert Craker
Dr Gaurav Kakkar
Dr Abir Doger
Dr James Fulton Neil

***Scotland***
***South East Scotland***
Dr Tarkeshwari Mane
Dr Emma Lynette Anderson

***North Scotland***
Dr Michelle Lamont

***West Scotland***
Dr Malcolm Archibald Broom

***Yorkshire***
***West Yorkshire (Leeds/Bradford)***
Dr Vanida Kathryn Na Ranong
Dr Neil James Allan *
Dr Matthew Philip Simpson
Dr Stephen John Hill
***East Yorkshire (Hull/York)***
Dr Sayed Tarique Kazi *

****Joint CCTs in Anaesthetics and ICM***
***#Trainees recommended for a CESR (CP)***

(iii) Medical Secretary's Update
Dr D Nolan had nothing further to report.

**CB/20/2012 Communications Committee**

(i) Council received and considered the minutes of the meeting held on 26 January 2012 which were presented by the Chairman, Dr Thornberry. The Committee had decided that news items should continue to be loaded manually.

The Committee had approved the new advertising rates as previously approved by the Finance Committee.
The Committee had previously had a presentation from an external company regarding developing College apps. The Committee had agreed that it would like to prioritise an app for booking events, paying online and linking the app to the Continuing Professional Development (CPD) portfolio. The Committee was also keen to speak to the AAGBI about its Winter Scientific Meeting app. Consideration would be given to a *Bulletin* app. Council agreed that Dr Thornberry should lead a discussion on the development of College apps at the Away Weekend. Council also agreed that Dr Thornberry should talk to Dr Sam Shinde at the AAGBI. Dr Wilson advised caution when choosing a company to develop the apps;

some of the enthusiastic amateurs may be good, others may not be so good. Dr Moonesinghe suggested that this should be prioritised and investment in a commercial company for such purposes would be worthwhile. Dr Moonesinghe added that a commercial sponsor of the RCoA Congress might be interested.

The Committee had discussed the RCoA's response to the Health and Social Care Bill and wished to know why the RCoA was not speaking more publicly about it. There was a discussion about how the RCoA communicates with its Fellows. The Committee's feeling was that a newssheet would not be appropriate. The summary of discussions at the weekly President's Meeting was helpful to Council and the Committee wondered if a half page summary of matters being discussed might be one way of communicating regularly by e-mail. The RCoA had just under 1,000 followers on Twitter and the Committee had discussed whether there should be more than one account, e.g. training and examinations and a general account. The possibility of each directorate publishing a blog was also considered. *The Bulletin* was too slow; a faster response time is required. The President was concerned that the RCoA did not overload Fellows and Members adding that there must be an option to opt out. Dr Wilson pointed out that the RCoA has a distinct population with which to communicate; for example regular e-communications to all trainees would be good and would not impact on the AAGBI's e-newsletter. Mrs Dalton suggested that the RCoA avoided overcomplicating matters by utilising too many methods of communication. The President was sympathetic to the view that the RCoA could communicate more to its Fellows and Members what it is doing, although they may of course not wish to know. The President added that more avenues of communication needed to be opened up. Professor Bion highlighted that privacy was more important than connectivity for some; the ability to personalise the level of communication should be fundamental. Professor Bion stated that it would be worth considering how best to allow two way communications. Professor Mahajan wished to avoid too many different messages and the potential for confusion through many channels and suggested that the RCoA's website should be its communication hub with other methods employed to direct people to it. Dr Moonesinghe explained that inaccurate or lack of e-mail addresses was frustrating when it came to distributing the quarterly e-newsletter to trainees. Dr Moonesinghe asked how many undeliverable messages were received when the AAGBI distributed its e-newsletter and asked if it would be possible to share information. Dr Wilson responded that the AAGBI had a similar problem. Dr Wilson stated that one third of recipients looked at the e-newsletter with 10 percent reading a story. E-mail addresses were a problem. Dr Marks pointed out that most blogs are written by a person or group and give a vague opinion; a difficult concept to accept for a College which has to give an informed definitive opinion. Dr Marks was worried about the logistics of how the RCoA decides what pieces of information are so important they go on the College front page yet are not important enough to tweet. Dr Marks stated that Council was elected to govern the College and set policy; is Council bound by the results of what essentially is a referendum on the Health and Social Care Bill? Mr Rees highlighted that from the patient's perspective it was important that the website provided the prime and major source of information and that the website was managed and looked after on an almost daily basis to bring it up to date. Professor Sneyd suggested that the question of which media to be used would change on a daily basis. Many of the RCoA's databases are mutually incompatible. Professor Sneyd had discussed with Dr Marks and the President's Meeting the need to ensure people can sign in and access everything from one place. As part of that the RCoA could communicate with them via the media of their choosing and also hear from them. A single sign-on project was required. Dr Marks explained that the difficulty was that some of the College systems required different levels of person authentication and different systems in the College had different methods of verification. A uniform identifier was also required; not everyone is part

of the College or has a GMC number. Dr Venn suggested that the discussion about apps and communications should be separated as they are not quite the same thing. Dr Venn pointed out that since the introduction of Twitter on 19 October 2010 there had been 95 tweets and the RCoA had 1029 followers. Dr Venn suggested that this represented quite a high level of engagement, probably more than who vote in Council elections. There had been 103 responses to the survey regarding the Health and Social Care Bill. The President pointed out that the Royal College of General Practitioners (RCGP) had claimed that the vast majority of its members were against the Bill; the statement was based on the results of a survey of 2,600 responses from a membership of 44,000. Dr Venn asked how much effort the RCoA wanted to make to communicate with people who may not wish to be communicated with; if people did not want to sign up they did not want to sign up. The RCoA could keep modern methods of communications going and people could choose whether or not to engage. Ms Drake reported that a Twitter account had been set up for the Recent Advances course; it was a very quick exercise that had proved positive and would be worked up more for other meetings. Dr Thornberry stated that the idea behind blogging would be that each directorate would have a weekly summary of its activity with no detail about College views; it would literally be a slightly friendlier diary which would allow people to engage. Professor Rowbotham stated that the use of modern media was essential but the RCoA should only tell Fellows what they need to know; if there was nothing worth communicating then the RCoA should not be afraid to refrain from sending something for a couple of months. Dr Clutton-Brock reported that the University of Birmingham had surveyed undergraduates and postgraduates on, amongst other things, whether they wanted communication via the likes of Twitter; approximately 80% expressed a preference for reserving Twitter for social networking, with a website being the preferred option for professional communications. Dr Wilson asked Council members if they thought that doctors.net.uk did a better job of discussing anaesthesia issues than Council. Dr Marks responded that it did a different job in that it lets people chat; he would not use it as an authority source but what it does it does quite well. Dr Wilson pointed out that many topical professional matters were discussed. It was noted that there was a very small group who sometimes did this with negativity. Dr Moonesinghe asked whether revalidation, and the fear many Fellows have of it, would be an opportunity to improve the e-mail database. Dr J Nolan asked why the RCoA does not send out a monthly e-newsletter; people need to keep email addresses up to date. Dr van Besouw stated that different strata would utilise different types of communications; the RCoA must provide as many different types of communication but ensure that the headline message through all of them is the same. Fellows should be left to decide which method of communication they prefer to receive. Dr Thornberry sensed that the idea of a blog was not popular but a newsletter, like the BMA's, may be at the top of the list to consider. Dr Thornberry suggested that Twitter may be more popular if areas such as training had their own Twitter account. Dr Greaves pointed out the difficulty of making worthwhile statements on important issues with a limited number of characters. Dr Venn explained that, for example, when the RCoA made a statement about the Health and Social Care Bill, Twitter would be used to announce that the College's position was now available on the website. Dr Greaves stated that much of these things depend on the immediacy of the communication. The nature of the RCoA was for there to be a long delay and ponderous response which did not lend itself to quick and lightweight communications. Dr Moonesinghe suggested that rather than expressing an opinion the RCoA should provide a brief summary of the Health and Social Care Bill; many Fellows did not have the time or energy to digest what the Bill means.

The Committee would like to see progress on the appointment of a Press Officer.

The Committee had discussed promoting letters to the Editor of *The Bulletin*.

The Committee had looked at the contents of the Olympics themed July edition of *The Bulletin*.

The President asked Dr Thornberry to bring a paper on communications to the Away Weekend.

(ii) Council received and approved the terms of reference for the Website Steering Group.

**CB/21/2012 Royal College of Anaesthetists' Advisory Board for Scotland**

Council received and considered the minutes of a meeting with the Chief Medical Officer (CMO) for Scotland held on 12 January 2012. Dr Colvin reported that it had been a helpful and positive meeting. There had been discussion regarding issues around the appraisal system used and flexibility in the appraisal system. Remediation arrangements were not yet clear. The CMO had emphasised that the Scottish Government wanted revalidation to be consistent across Scotland and across specialties. Remediation must also be consistent. There was a requirement for a central reporting system to ensure cross-specialty consistency in the implementation of revalidation and remediation; it was thought that the Colleges should take a lead in this. Dr Colvin was asked to discuss this at the Scottish Academy.

Workforce issues had been rehearsed, noting the recruitment process and workforce modelling for 2012. The CMO had restated his view that the trained doctor service should be based on the consultant grade and supported disestablished posts being transferred into consultant posts, though at Board level there appears to be some reluctance. The CMO's position was that a trained doctor should become a consultant. The BMA had issues with the fact that the starting salary may be lower for a new consultant.

With regards to the transition to the new intensive care medicine (ICM) curriculum there would be a need to ensure a year on year supply of ICM CCT holders during the transition.

The Scottish and English trainee recruitment process was becoming more aligned; this was perceived to be a move in the right direction.

Clinical Excellence Awards were still discontinued in Scotland, although discretionary points had been reintroduced for an additional year. The Board was very positive about the CMO's work in developing a letter from the four CMOs, Sir Bruce Keogh and the General Medical Council (GMC) about releasing doctors for wider work for the National Health Service (NHS).

Patient safety was discussed under quality strategy. There is now some momentum in developing a way for Scotland to participate in the national critical incident reporting system.

The Scottish Audit of Surgical Mortality has been revamped into electronic format. The new Deputy Chair and Improvement Lead, Dr Andy Longmate, Consultant Anaesthetist, plans to broaden the remit to include morbidity data.

**CB/22/2012 Safe Anaesthesia Liaison Group**

(i) Council received and considered the minutes of the meeting held on 9 November 2011 which were presented by the past Chairman, Professor Mahajan. Professor Mahajan wished to thank Council for its help in establishing the Safe Anaesthesia Liaison Group (SALG).

(ii) Council received and considered the minutes of the meeting held on 5 January 2012 which were presented by the Chairman, Dr Clutton-Brock. Incident reporting in Scotland would be raised by the President with the Scottish CMO.

There had been a teleconference to discuss neuraxial connectors. Progress was being made with an international standard with a date of 2014 being suggested.

Many topics, similar to those being discussed by SALG, were being discussed by the Shadow Clinical Board for Surgical Safety. There was a need for better co-ordination of messages and Dr Clutton-Brock now attended the Board.

It had been agreed to issue advice regarding intravenous paracetamol in children in the next *Safety Bulletin*.

Dr Clutton-Brock had agreed to correct inaccuracies in a paper about device errors in laparoscopic cholecystectomy.

Dr Andrew Smith had given a presentation of an abstract submitted to the ESA which compared the quality of data submitted via the e-form with other routes of reporting. The abstract strongly demonstrated the value of specialty specific data over random data.

Professor Sneyd asked what the relationship was between what SALG does and the Medicine and Healthcare Regulatory Authority (MHRA) alerts when there was a drug related issue. Dr Clutton-Brock responded that SALG saw itself as having a role to reinforce some of these messages.

There had been a fall in the number of e-forms being completed; the main cause appeared to be that the majority of people were not keen on double reporting.

The anaesthetic e-form would be entered in the "Technology and IT to Improve Patient Safety" category of the Emap Patient safety Awards 2012.

SALG had received a leaflet about dental damage during anaesthesia; further work would be required.

An incident where rocuronium failed to produce adequate muscle relaxation after an unknown period of storage at room temperature was discussed; advice would be included in the next Patient Safety Update.

Kinking of guide wires used during Seldinger procedures had been discussed. It was agreed that the MHRA would produce educational material. Dr Clutton-Brock was keen to know if Council members had supporting evidence that it was more of a problem with ultrasound.

Inadvertent use of the Auxiliary Gas Outlet (AGO) on GE anaesthetic machines was discussed and the MHRA had issued a medical device alert. It was proposed that Dr Clutton-Brock would meet GE to discuss this.

SALG had been asked to quantify the risks of anaesthesia associated with breast implant removal. It was agreed that a single figure would be difficult to determine and would be influenced by the ASA grade of the patient though it was likely to be less than 1:200,000 cases.

SALG sought approval to ask the MHRA to provide another representative now that Dr Clutton-Brock was chairing SALG. The President agreed that a senior medical officer should be invited to attend.

Dr Wilson reported that with regards to neuraxial connectors the Welsh testing programme had stopped. The President and Dr Wilson would meet Professor Brian Toft to re-make the case for centralised testing. A letter had been sent to Sir Liam Donaldson regarding international issues but there had been no response. Dr Jones pointed out that there had been concern in Wales for a while. Rejection of products for testing was based entirely on the process for procurement and they had been rejected before testing on a practical level. The President asked whether Council needed to debate a source of funding for centralised testing if it was proposed. Dr Wilson stated that the profession would be very wise to say it wanted the connectors tested. Dr Wilson added that as it was an NHS issue, not a purely professional one, the funding should come from elsewhere. Professor Sneyd added that it was the NHS's responsibility and therefore its duty to commission and pay for research and to support the intelligent dissemination of results; the RCoA's duty was to assist with that job. Dr Clutton-Brock stated that it was important that the profession advised on testing and what it would like done but the purchasers should do usability testing and pay for it. Professor Bion asked whether there had been a legal opinion on the consequences of not evaluating these devices properly. Dr Wilson stated that as the devices will be CE marked they can be sold legally in the UK irrespective of independent testing. Professor Bion stated that the profession should say that it is not satisfied and perceived a patient safety risk. Dr Wilson replied that the AAGBI had sought legal advice when it issued a position statement. Dr Whitaker suggested that as this matter was started by the previous CMO it should be passed back to the current CMO to follow up. Dr Wilson referred Council to letters on the AAGBI's website.

**CB/23/2012 Career Grade Committee**

Council received and considered the minutes of the meeting held on 12 January 2012 which were presented by the Chairman, Dr Laishley. It was noted that the meeting was Dr Lim's last.

A self assessment guidance and check list for Staff and Associate Specialist (SAS) doctors aimed at assisting with career progression was now available on the website. There was reference to there potentially being an advisor for SAS doctors; this had not yet been formalised.

The Committee was concerned that the GMC's current proposal for approval of trainers appeared to exclude SAS doctors from having roles in training. A mechanism to formally recognise and quality assure SAS doctors may be needed. The SAS approved to teach register was in abeyance although Dr Laishley was keen that there be a mechanism to support SAS doctors in teaching roles.

There had been issues around administrative support for the Joint Royal Colleges Staff and Associate Specialist Committee. Members of the Joint Committee have been allocated roles within appropriate AoMRC committees.

It was noted that the Scottish Government had made £1million available for career development of SAS doctors to include top up training.

Regarding recruitment of the specialty doctor, it was noted that the Bristol Royal Infirmary had set up an induction programme and planned to survey the Severn Deanery on this issue.

A number of Committee members had been promoting the RCoA and what it could do for SAS doctors.

Council approved the Committee's amended terms of reference.

**CB/24/12 Audit and Internal Affairs Committee**

Council received and considered the minutes of the meeting held on 11 January 2012 which were presented by the Chairman, Professor Mahajan. The Committee had been asked to review the current College Regulations' wording on resigning from Council. The Committee had agreed that the wording as it stands was robust.

The Removal of College Officers document had been brought to the Committee with a view to including Council members. Council agreed that the process should be harmonised and agreed the document should be amended accordingly.

A consensus had been reached on the new proposal that the Committee would submit for the election of President and Vice-Presidents. Dr J Nolan and Dr Clutton-Brock had produced a first draft and submitted it to Professor Mahajan. It was hoped that the document would be ready to present to Council in March, although consideration would be given as to whether it should be discussed by Trustees only.

**CB/25/2012 Recruitment Committee**

Council received and considered the minutes of the meeting held on 16 January 2012 which were presented by the Chairman, Dr Marks. The online training tool would be available for testing approximately one week before the ST3 interviews.

The current process was halfway through. Positive feedback had been received on the changes made in the summer. For CT1 there had been 1049 applications for 532 places - a ratio of 2:1. After interviews it was anticipated that the ratio would be 1.6:1. There would be some gaps in CT1 at the end of the process. In some areas there were fewer applicants than vacancies and it would be necessary to go to clearing. It would be necessary in future years to look at how recruitment to the specialty could be increased. The President commented that consultant expansion was approximately 1% so if lots of CCT holders were produced they would be forced into non-consultant posts. The President asked whether the College should suggest cutting CT1 and ST3 numbers even more. Dr Marks responded that CT1 numbers were required for the service, adding that the obvious approach to reduce the number of CCTs issued per year was to lengthen training. The President stated that Dr van Besouw was chairing a Workforce Group to address such difficult issues.

**CB/26/2012 Equivalence Committee**

Council received and considered the minutes of the meeting held on 12 January 2012 which were presented by Dr Clutton-Brock. The Committee considered three first applications, one of which was recommended for the Specialist Register. The Committee also considered a review which was recommended for the Specialist Register.

The Committee reviewed the RCoA's response to the GMC's consultation.

Following a meeting on data protection at the GMC, Committee members reviewed a draft confidentiality agreement and were satisfied that it was fit for purpose for the RCoA Equivalence Committee.

Professor Bion reminded Council that applications for equivalence in ICM should come via the Faculty of Intensive Care Medicine's (FICM) Equivalence Committee.

Professor Sneyd expressed his concern for the wellbeing and best interests of applicants in the equivalence process; very few get through easily and a larger number are destined never to get through. Professor Sneyd asked whether or not it would be possible to publish a summary of the last 12 or 24 months' applications and reasons for failure. Dr Clutton-Brock was sympathetic to Professor Sneyd's view stating that the guidance produced by Dr Ian Barker was very useful. It was noted that the GMC had improved its guidance. As a College the RCoA was much more supportive than others. Dr Clutton-Brock suggested that it might be possible to produce a short piece of information regarding where people commonly fall down. Mr Rees was concerned by the high proportion of applications that fail when they reach the RCoA; this suggested that the problem was somewhere in the gate keeping process. Dr Jones pointed out that there was a lot of information available, both generic advice from the GMC and specialty specific advice. Applicants were encouraged to contact the relevant people at the College. Dr Greaves pointed out that many applicants considered themselves to be specialist anaesthetists and it did not occur to them that their credentials would be queried. Dr van Besouw pointed out that there was insufficient information about the whole process, including what happened to successful applicants once they were granted access to the Specialist register.

Professor Sneyd sought clarification on the data protection issue. Dr Clutton-Brock reported that the issue specifically mentioned was the use of unencrypted memory sticks. Professor Sneyd stated that the RCoA needed to operate to a higher standard; it was unacceptable to store confidential documents on unencrypted laptop or USB sticks.

Dr Thornberry informed Council that changes coming through the AoMRC meant that improvement projects rather than audits needed to be taken into account in equivalence. Dr Clutton-Brock pointed out that applications were being matched against the published curriculum; the curriculum would need to change before assessment could. Dr Thornberry responded that the AoMRC was encouraging Colleges to do this as soon as possible.

The President agreed with Dr Wilson's suggestion that a video presentation might be more appropriate rather than long documents about the equivalence process.

**CB/27/2012 Revalidation Delivery Committee**

Council received and considered the minutes of the meeting held on 10 January 2012 which were presented by the Chairman, Dr Brennan. The Committee had been reconstituted to reflect its role in the countdown to the launch of revalidation in late 2012.

The Committee had revised its Terms of Reference. The FICM and Faculty of Pain Medicine (FPM) had raised the possibility of giving the Committee a wider role to cover the needs of ICM and pain medicine. This had been discussed at the President's Meeting and the proposal was that the committee would be the Joint Revalidation Delivery Committee of the RCoA and the FICM and FPM.

There had been increasing numbers of requests from the Fellowship regarding confusion with patient MSF. There was an issue regarding patient MSF tools not being very sensitive and useful especially to those with theatre based perioperative practice. Dr Moonesinghe had been asked to continue leadership of the Working Party to develop a robust patient feedback MSF tool for anaesthetists. A joint position statement with the two Faculties on patient feedback was on the website.

The AoMRC consensus view was that Colleges should provide a single point of contact for revalidation advice for all stakeholders. To support the work of revalidation staff at the RCoA would be a team of specialty advisers with appropriate training to advise on revalidation issues. Dr Nigel Penfold and Mr Don Liu had attended a preliminary training the trainers day at the AoMRC; this would be followed by an RCoA training day in May 2012. The Group would be relatively small at the outset to ensure consistency and a clear audit trail for the advice given. The proposed group had broad experience including all the major sub-specialties and representation from all four nations.

The RCoA's response to the GMC's proposed Responsible Officer Revalidation Statement was tabled and accepted. There was confusion over whether there should be two separate statements for trainees and non-trainees.

The GMC planned to revalidate all doctors within the first three years. Dr Brennan would attend a meeting on 23 February 2012 where the GMC would lay out some of its plans.

The Committee had asked Dr Mike Grocott to further prioritise revalidation issues by working on benchmarking outcome measures to assist individual anaesthetists in assessing the quality of their practice.

Council had received the Department of Health's (DH) report on remediation along with Dr Brennan's summary. A key recommendation called for Colleges to provide guidance, assessment, and specialist input into remediation programmes. Drs Brennan and Rollin, Mr McLaughlan and Mr Don Liu had met with the National Clinical Assessment Service (NCAS) to discuss engagement over remediation issues. There were approximately 1000 remediation cases in England at any one time; the RCoA was likely to see significant numbers of anaesthetists requiring remedial placements outside of their home organisation. Professor Bion stated that he would like to see NCAS adopt a systematical research based approach to identify those characteristics which might result in failure and use those as a diagnostic. Dr Nevin reported that from a trust perspective there was an increase in the numbers of doctors they are being asked about regarding performance. Dr van Besouw pointed out that one of the concerns about the remediation agenda was that it assumed everything was wrong with the doctor not with the environment in which they were working; how would remediation identify environmental factors contributing to doctors failing? It was noted that Mr David Hepworth had commented that the report was not particularly patient focussed and, was at times, insensitive to the needs of patients. "Patients under the care of a professional undergoing remediation should be informed" (page 46 of the report) □ Mr Hepworth questioned whether it was appropriate to do so as a patient was about to be anaesthetised. Council considered whether it would be valuable to take this discussion to the PLG; it was massive in terms of people's confidence in doctors. It was noted that the PLG was very interested in work on patient feedback and the PLG representatives asked at what point the PLG would become involved. Dr Moonesinghe reported that there had been no major progress since the guidance had been published. The issue was not so much the tool but the method by which it was distributed. In some respects the issue of how to address when the tool was administered was for the Working Group to discuss before taking to the patients.

An AoMRC Working Party had been formed to look at item five in the recommendations; Dr Rollin would represent the RCoA.

**CB/28/2012 Faculty of Pain Medicine**

(i) Council received and considered the minutes of the meeting held on 8 December 2011 which were presented by the Dean, Professor Rowbotham. The Board's Away Day was very successful in that it highlighted work the FPM needed to undertake, such as producing

a definition of what the Faculty is that would be understandable by those outside the pain world. There had also been discussions regarding whether it would be possible for pain medicine to be recognised as a sub-specialty of anaesthesia.

The Pain Summit had been attended by pain specialists and commissioners. A proposal had been submitted to develop a comprehensive e-learning package about pain for everyone in the NHS. This has been accepted and funded by DH.

The Board had discussed its lack of communication strategy and would discuss whether it needed its own Communications Committee.

(ii) Council approved the FFPMRCA Examination Regulations. Successful candidates would be offered the opportunity to attend Diplomates Day.

**MATTERS FOR INFORMATION**

**I/6/2012 Publications**

Council received, for information, the list of publications received in the President's Office. The President suggested that the *Benefits of Consultant Delivered Care* was worth reading as was the article on blast lung injury in the *Journal of the Royal Naval Medical Service*.

**I/7/2012 Consultations**

Council received, for information, a list of the current consultations.

**I/8/2012 New Associate Fellows, Members & Associate Members**

Council noted, for information, the following:

**New Associate Fellows – January 2012**

Dr Anil Kumar Gopalil Sivadas – Basildon & Thorrock University Hospital
Dr Ingo Hans Ernst Hille – Hinchingbrooke Hospital
Dr Maeve Patricia Curran – York Hospital
Dr Maria Barankova Hobrok – Bronglais General Hospital, Aberystwyth
Dr Jacek Sobocinski – Craigavon Area Hospital
Dr Devendra Kumar – Daisy Hill Hospital, Newry

**New Members – January 2012**

Dr James David Edward White – Primary FRCA
Dr Gyanesh Janardan Namjoshi – DESA (European Diploma)
Dr Jishar Abdul Kader – Primary FRCA

**To receive for information, the following doctors have been put on the Voluntary Register– January 2012**

Dr Zsolt Faluvegi – Russells Hall Hospital
Dr Manisha Rajesh – Weston General Hospital, Weston Super Mare
Dr Indre Kriukelyte – Gwynedd Hospital, North Wales
Dr Daniel Enchev Bozukov- George Elliot Hospital, Nuneaton
Dr Charu Sukhlecha – Queen's Hospital Romford, Barking Havering Redbridge NHS Trust
Dr Rosen Todorov Buhchev – Watford General Hospital
Dr Shankar Babu Rajamanickam – Basildon & Thurrock University Hospitals
Dr Hesham Mohamed Mahmoud Tahoun – Musgrave Park, Belfast
Dr Madhavi Chaitanya Naini – West Suffolk Hospital

**PRESIDENT'S CLOSING STATEMENT**

**PCS/2/2012 President's Closing Statement**

(i) Council members were asked to inform the President if they would like to join AoMRC working groups on working towards a seven day consultant delivered service, the impact of obesity and child sexual exploitation.

(ii) The President tabled a list of his diary appointments since the last Council meeting.

**MOTIONS TO COUNCIL**

**M/3/2012 Council Minutes**

**Resolved:** That the minutes of the meeting held on 11 January 2012 be approved.

**M/4/2012 Regional Advisers**

**Resolved:** That the following re-appointments/reappointments (re-appointments marked with an asterisk):

*Dr Jo James, Regional Adviser for West Midlands South

Dr Michelle Hayes acting Regional Adviser for North Thames West until a successor is found for Dr Brodrick

**M/5/2012 Deputy Regional Advisers**

**Resolved:** That the following appointments be approved:

**North Thames West**

Dr S Jaggar, Deputy Regional Adviser for North Thames West

Dr R Bacon, Deputy Regional Adviser for North Thames West

**M/6/2012 College Tutors**

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

**West Yorkshire**

* Dr J Burns (Airedale Hospital) extended term

**North Thames West**

Dr A Prabhu (Central Middlesex Hospital)

**KSS**

Dr N C Forder (Eastbourne District General Hospital)

**Oxford**

Dr M W Speirs (Oxford Radcliffe Hospitals NHS Trust)

**Mersey**

Dr N Zaffar (Macclesfield Hospital)

**M/7/2012 Faculty of Pain Medicine**

**Resolved:** That the FFPMRCA Examination Regulations be approved.