MEETING OF COUNCIL

Edited Minutes of the meeting held on Wednesday 12 February 2014
Council Chamber, Churchill House

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

Members attending:

Dr J-P van Besouw, President
Dr D M Nolan
Dr L Brennan
Dr H M Jones
Professor J R Sneyd
Dr A Batchelor
Professor R Mahajan
Dr P Venn
Dr D Whitaker
Dr R Verma
Dr R J Marks
Dr T H Clutton-Brock
Dr J Nolan
Dr J A Langton
Dr J Colvin
Dr N Penfold
Dr V Ramana Alladi
Dr S Gulati
Dr E J Fazackerley
Dr S Fletcher
Dr P Kumar
Dr I Johnson
Dr D Selwyn

Mrs I Dalton, RCoA Patient Liaison Group
Dr A-M Rollin, Professional Standards Advisor

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

Apologies for absence: Professor M Mythen, Dr K Grady, Professor D J Rowbotham, Dr M Nevin, Dr W Harrop-Griffiths and Dr B Darling.

PRESENTATION

P/1/2014 External Strategy Discussion

The President welcomed Mr David Prior, Chairman of the Care Quality Commission (CQC). Mr Prior noted that the first question to ask is why is a regulator needed. Mr Prior suggested that if anyone should regulate healthcare it should be clinicians; when an individual becomes a doctor they take on responsibility for patients. Mr Prior highlighted that a negative consequence of the *Francis Report* has been the belief that regulators are going to solve the problem. This is not the case, although regulators have an important role to play. Mr Prior highlighted a number of characteristics that are important for an effective regulator. A regulator must:

- be independent; of both the system and politicians.
- be credible, particularly with clinicians; when the CQC carries out an inspection it is important that it is believed that it will do so thoroughly. Mr Prior noted that it is for this very reason that Professor Sir Mike Richards, a clinician, has been appointed as the first Chief Inspector of Hospitals.
- be accessible; individuals must feel able to raise their concerns.
- have a fair process; when the CQC makes a judgement it may get it wrong and there needs to be a process in place which means that this judgement can be challenged.
- offer value; a regulator must be part of shifting the quality curve in the right direction.

Mr Prior explained that the CQC has developed an Intelligent Monitoring System that can be used to risk assess hospitals; it is hoped this will highlight early warning signs of a failing

organisation. Whilst Mr Prior questioned how relevant the College is to young doctors, he emphasised the importance of the College taking the lead on quality. It is hoped that one of the outcomes of the CQC inspections will be the development of a rating system for hospitals and individual specialties and the College will have a huge role in this as it can credibly say what is good in terms of anaesthesia.

The President highlighted that Inspectorate Teams are reliant on clinicians but that Trusts are reluctant to release doctors to provide this service to the regulator and questioned what could be done to resolve this. Mr Prior suggested that the best way for the CQC to help resolve this problem would be to improve its own processes, to improve its inspections so that they take less time and to plan them ahead to allow Trusts the time to arrange cover.

Dr Whitaker questioned whether the CQC considered medical negligence awards made against Trusts in the National Health Service (NHS). Mr Prior explained that the CQC works closely with the NHS Litigation Authority and that it looks at all Never Events. Mr Prior explained that the two key metrics that the better hospitals in America look at are clinician engagement and colleague engagement. Within the NHS people are treated dreadfully and the culture of the NHS has a huge way to go to rectify this.

Dr Selwyn raised concerns regarding the CQC releasing data on inspections; fundamentally this is a risk assessment and not a statement that a hospital is good or bad, this is not how it is perceived by the press. Mr Prior acknowledged that this was a serious issue and whilst the CQC feels it has a duty to publish the data it has and will continue to do everything they can to make the interpretation of the information clear. Mr Prior stated that once more inspections are done and more data released it will over time become of less interest to the press.

Mrs Dalton was pleased to hear Mr Prior mention independence but questioned how the CQC was actually going to be independent. Mrs Dalton raised concerns over the potential quality of inspections, highlighting the Office for Standards in Education, Children's Services and Skills (OFSTED) as an example. OFSTED uses contracted teams which are of mixed quality. Mr Prior explained that the CQC model for inspections is very different to OFSTED in that the Chairman of all the inspection teams will be a senior practising clinician and most of the rest of the team are seconded specialist clinicians. Mr Prior acknowledged that the CQC is only as good as its inspectors and that getting consistency is hugely difficult and that the CQC will not get it all right first time but that they will get better with time.

Dr Brennan highlighted the importance of making it clear when failings are due to lack of resources and not the fault of the doctors and other clinical staff not doing their jobs. Some organisations such as NHS England, local healthcare providers or government may not want to hear this and it is important to know that the CQC will not be afraid to state when resourcing is the root of the problem. Mr Prior stated that whilst the CQC has to state if the level of care is inadequate it also has to state why, highlighting that it is impossible to divorce resources from care.

Dr Venn questioned Mr Prior on his statement that it is clinicians who must be responsible for care stating that doctors are disengaged as a result of Government beating the profession into submission. Consultants are regarded as employees of businesses who run healthcare in their own hospitals. Dr Venn suggested that clinicians need to be put back in charge, not doctors in management but doctors at the head of clinical teams on wards who actually have a say in what happens. Mr Prior explained that management and clinicians cannot be separated and have to work together, adding that historically one of the weaknesses of the NHS is that very few doctors go into management. Mr Prior stated that despite the erosion to the specialty there are some fantastic hospitals around and it is this variation across the system that can be

addressed. Dr Venn suggested that managers should be there to serve the needs of the medical profession but noted that this is often the other way round mainly for business driven needs. Often clinicians have a different agenda to management and politicians.

Dr Fletcher suggested that in some instances what is available in terms of service is of good quality but that there is not enough of it due to limited resources. Dr Fletcher also highlighted that the College is not irrelevant and has a huge quality agenda particularly in terms of the implementation of Anaesthesia Clinical Service Accreditation (ACSA).

Dr Colvin questioned how the CQC will be measuring professional engagement and whether it will look at adverse contractual arrangements. Mr Prior noted that the question of where does the CQC stop in terms of its inspections remains unclear. It is important to remember that this is the beginning of a long journey. At the moment the measuring of professional engagement is not as scientific as he would like and involves talking to people and trying to engage with them, what the CQC want to know is that the Trust is doing this.

Mr Prior noted that whilst the CQC will be rating hospitals overall the real prize will be rating individual specialties and that the College already has the blueprint for this and will hopefully be working closely with the CQC in the future.

Dr Marks highlighted the problem of a doctor being deemed a whistle blower and the negative implications of this. Mr Prior acknowledged that this was a difficult issue; there are some industries that have cracked the problem and individuals who raise concerns are seen as heroes but this is unfortunately not the case with the medical profession. Dr Marks questioned whether the CQC could do anything regarding strengthening the legislation protecting whistle blowers. Mr Prior remains unconvinced that legislation is the answer as an employer cannot be forced to take someone back or for colleagues to accept them.

Mr Prior stated that a close relationship between the College and the CQC is important and that the College has a huge role to play and has a responsibility to engage the younger generation.

COUNCIL IN DISCUSSION

CID/04/2014 President's Opening Statement

1. The Intensive Care National Audit & Research Centre (ICNARC) has announced that it is about to appoint a new Chief Executive Officer (CEO).
2. The President announced the deaths of Dr Stephen Vincent Lees, Dr Jean-Claude Otteni, Dr Ian Armstrong, Dr Ian Mair, Dr Alex Shearman, Dr Jack Silver and Dr Henry Rollin. Council stood in memory. The President informed Council of the details of Dr Geraldine O'Sullivan's wake which will be held on Friday 4 April between 6pm and 10pm.
3. The President noted that Professor Sneyd would speak to Item 3.9 National Institute of Academic Anaesthesia (NIAA) in Professor Mythen's absence.
4. Council had previously debated the issues in North Yorkshire and Humber Local Education and Training Board (LETB) in respect of anaesthetic trainees. The situation is more complex as management were informed that this was a potential problem some time ago and as a result there has been a change in senior management in one key Trust with the new CEO trying to address the situation in order to preserve the services.
5. The Perioperative Medicine Working Party is due to report to Council next month. The report will be sent to Council for their consideration in advance. The development of perioperative care is high on the College's agenda and merits consideration by Council.
6. Dr Bruce Campbell, Chair of the National Institute for Health and Care Excellence's (NICE) Devices Committee, has proposed a meeting between the College, NICE and the

Association of Anaesthetists of Great Britain and Ireland (AAGBI) to discuss the interaction between NICE and anaesthesia particularly in terms of the use of medical devices.

7. An email has been received from the Innovation Team within the Medical Directorate at NHS England asking the College to endorse a consensus statement for the inclusion of Intra Operative Fluid Management (IOFM) into the surgical checklist. This will be circulated to Council for comment.
8. The European Union is intending to make changes to data protection which the medical profession is concerned will stifle population based research. The College had previously endorsed a letter lobbying the Ministry of Justice (MoJ) to oppose the changes on the basis that they are not in the best interests of patient care. The MoJ had replied stating that it understands the concerns and would actively lobby against some of the pervasive aspects of the legislation. The letter will be circulated to Council.
9. The President thanked those who attended the President's Dinner and thanked those who organised the dinner.
10. An after dinner speaker is required for Keele Course on Tuesday 8 April. Council members were asked to inform Ms Amanda Regan if they are available.
11. The President highlighted that as Trustees of the charity Council members have an obligation to declare a Register of Interests. It was asked that all those who have not done so send their Register of Interests to Ms Gail Samuel.
12. A pre-diplomates dinner will be held on 1 May 2014. The events team has a list of those who have been invited. Council who would like to attend should let Ms Gail Samuel know.
13. The College Annual Report is now available. Whilst the report has been circulated electronically, a limited number of hard copies are available from Ms Gail Samuel.
14. The General Medical Council (GMC) has strengthened its policy on ensuring the English language capability of doctors and this is available on the GMC website.
15. Council members were asked to suggest what makes the NHS 'great'. These recommendations have been sent to the Academy of Medical Royal Colleges (AoMRC) who will be forwarding them on to Sir Bruce Keogh, Department of Health, for consideration.
16. The AoMRC will be arranging seminars with Simon Stevens the incoming Chief Executive of NHS England.
17. The College has co-signed the *Chavesse Report* which has been published through the British Orthopaedic Association. The report sets out a requirement from Government to ensure that military personnel who transcend into civilian life have appropriate medical care delivered to them within the NHS.
18. The College met with the College of Anaesthetists of Ireland. It is apparent that the regulators of medical care in the Irish Republic and the UK are diverging. While there are still many areas of shared interests between the two Colleges it was recognised that in areas such as examinations and professional regulation there will be a divergence.
19. The AAGBI Winter Scientific Meeting was highly successful and was very well attended.
20. The President took part in a panel discussion at Doctors' Updates which was well attended with over 500 delegates.
21. Dr Batchelor will be attending an upcoming AoMRC Council meeting as an observer in light of the Faculty's desire to become a member of the AoMRC.
22. Both the President and Dr Batchelor attended the Intensive Care Society (ICS) Away Day in Leeds.
23. The GMC is currently looking at how people are selected into medicine and there is a desire to map people's progress from pre-admission assessment through medical school, through foundation, through training programmes into professional life. Whilst this a laudable project it is being dogged by data protection issues.
24. The Recent Advances meeting was well attended.
25. The President took part in a Q&A session at the Royal Society of Medicine (RSM) Section of Anaesthesia Meeting.

26. The Secretary of State is very keen on the Name over the Bed initiative and the AoMRC has been tasked with considering this. The College's comments have been sent to the AoMRC.
27. The College received an invitation from the Iraqi government to participate in a roundtable debate in Baghdad at the end of February, this has been declined.
28. Correspondence has been received from the Government regarding climate change and medicine. Dr Tom Pierce, the College's advisor on sustainability, has responded.
29. The Centre for Workforce Intelligence (CfWI) will be contacting Council members between 20th February and 17th March 2014 to take part in their Delphi process.
30. The President updated Council on staff changes:
    a. Ms Marcia Johnson had left the College.
    b. Ms Rebecca Bruns had been appointed as Management Accountant.
    c. Ms Rosemary Sayce had been appointed to the Research Assistant (Archives) role for two days a week in addition to her role as Membership Secretary.
    d. Ms Kathryn Randall had been appointed as Accreditation Co-ordinator.

CID/05/2014 Association of Anaesthetists of Great Britain and Ireland President's Report
This item was deferred until March 2014.

CID/06/2014 Collaboration with Hong Kong College
Dr Colvin noted that three months have lapsed since the Hong Kong delegation visit. The College agreed to collaborate in a number of ways. This will be done in a stratified way and an implementation framework will be included in a report to be brought to the next meeting of Council. The meeting was helpful in clearing up misunderstanding around examinations and what the College will and will not do and it is understood that the Royal College of Anaesthetists (RCoA) will not be exporting its examinations. The College will be taking part in an international scientific meeting between the RCoA, Irish College, Hong Kong College and China in November.

Professor Sneyd noted that information on the meeting will be going in the *Bulletin* and *British Journal of Anaesthesia (BJA)* and will be published on the website. Professor Sneyd urged Council to encourage attendance at the meeting. Dr Brennan suggested that it may be worth publicising to the Australasian Colleges.

Professor Mahajan noted that the impression he gets from China is that they want the ideas but that they want to do their own business. They now have two journals which are published in English.

COMMITTEE BUSINESS

CB/13/2014 Council Minutes
The minutes of the meeting held on 8 January 2014 were approved with minor amendments.

CB/14/2014 Matters Arising
(i) Review of Action Points
All actions were complete.

CB/15/2014 Regional Advisers
Council received an update on the Regional Adviser for Oxford.

CB/16/2014 Deputy Regional Advisers
There were no appointments/re-appointments this month.

CB/17/2014 College Tutors
Council considered making the following appointments/re-appointments (re-appointments marked with an asterisk):

North Thames Central
Council noted that Dr R E Bartlett has agreed to become Acting Tutor at St Mary's Hospital, Paddington, covering for Dr J Lowe, maternity leave.

North West
Council received a request from Dr Ian Geraghty for Dr N A Mahmoud (Royal Albert Edward Infirmary), to serve an extra year as College Tutor.

South East of Scotland
Dr J D Antrobus (Borders General Hospital) in succession to Dr J Montgomery **Agreed**

South West Peninsula
Dr R A Price (Royal Devon & Exeter NHS Foundation Trust) in succession to Dr E Hartsilver **Agreed**
Dr M Khakhar (Taunton & Somerset NHS Foundation Trust) in succession to Dr J-A Thurlow **Agreed**

South Thames East
Dr P Kelly (St Thomas' Hospital) in succession to Dr I Ahad **Agreed**

Wales
*Dr V Madhavan (Wrexham Maelor Hospital) **Agreed**

West Midlands South
Dr A N Kelly (University Hospitals Coventry and Warwick) in succession to Dr A Runke **Agreed**

CB/18/2014 Head of Schools
There were no appointments/re-appointments this month.

CB/19/2014 Training Committee
(i) Chairman of the Training Committee's Update
There had been an enquiry regarding cardiothoracic training and as a result Dr Penfold noted that minor changes would be made to one of the competencies.

The AoMRC are in the early stages of looking into commercialised Medical Training Initiative (MTI) posts where another country is going to buy two years of training. There are reservations surrounding this and there is no formal information from Health Education England (HEE) yet.

The Royal College of Physicians have advertised a number of unpaired applications for MTI posts without a named Trust quite successfully and Dr Jo James has proposed to carry out an MTI survey.

Dr Penfold attended the London Academy of Anaesthesia meeting in January. It was highlighted that in the north and Central areas of London some anaesthetic foundation posts have been sacrificed in favour of Acute Care Common Stem (ACCS) in EM. This was deemed to be the least damaging solution. Exact numbers are not known.

There is a change on the recruitment website regarding the length of core training required. There was a trainee who had only completed 23 months and not the required 24 months but had fulfilled all the competencies, the requirements have been changed to allow for this.

There is now another route into Emergency medicine, called Defined Route of Entry into Emergency Medicine (DRE-EM). The implications of this for anaesthetics could be an increase in the number of novices and create an increased workload.

The Examination Committee had received a presentation from the GMC on mapping trainees through training. The College is involved in a pilot.

The examinations review will take place this year and the number of people on the review team has increased, they have requested a member of Council join the team and Dr Penfold has agreed to do so.

The exam results show a 66% final pass rate. The data from the Primary Multiple Choice Question (MCQ) is interesting as it is now possible to look at the impact of the single best answer and it seems there is less swing in the pass rate since it has been introduced.

The Objective Structured Clinical Examination (OSCE) is being developed to incorporate computerised unmanned systems for some stations.

Dr Langton clarified that the ACCS extra EM posts incorporate salary and on call so are free to Trusts. Dr Penfold does not believe any have been taken up by HEE yet. Dr Langton believes that the DRE-EM pathway that focuses on core surgery is focusing on the wrong group as they will need to get not only EM competencies but also anaesthesia in one year. Trainee anaesthetists would have already got a number of the competencies so the DRE-EM route may appeal to core anaesthetist into EM. The President noted that this can be raised with Dr Cliff Mann at the RA meeting.

Professor Sneyd noted that there is a big join up between the GMC and medical schools and the Royal College of Physicians about looking at the run through based on GMC numbers into postgraduate training. A pilot has managed to successfully match between undergraduate and postgraduate at about 85% so the data matching can be done. Professor Sneyd questioned whether the College was involved in this. Professor Sneyd also raised the issue that there has not yet been an analysis of the College's own data by ethnicity corrected for country of training and that as this is a live issue it should be addressed as a matter of some urgency.

Dr Penfold noted that this is one of the things that the GMC are looking at as to whether we can do it with the data.

Mr Bryant asked for a steer from Council on the priority of producing this data given limited resources. The President noted that it should be included as a key piece of work as part of the current global review of the FRCA examinations.

(ii) Certification of Completion of Training

Council noted recommendations made to the GMC for approval, that CCTs/Certificate of Eligibility for Specialist Registration (Combined Programme) [CESR(CP)] be awarded to those set out below, who have satisfactorily completed the full period of higher specialist training in anaesthesia. The doctors whose names are marked with an asterisk have been recommended for Joint CCTs/CESR (CP)s in Anaesthesia and Intensive Care Medicine.

Anglia
Dr Lucy Pearmain *
Dr Anne Booth

London
South East
Dr Fauzia Hasnie
Dr Mubeen Khan
Dr Ashok Nair
Dr Philippa Webb

North Central
Dr Julian Barnbrook
Dr Matthew Henley
Dr Anita Sugavanam

Bart's and The London
Dr Clare Taylor
Dr Seema Randive
Dr Nusrat Usman
Dr Michael Cunningham

Imperial
Dr Sadie Syed
Dr Shilpa Patel
Dr George Bostock
Dr Jonathan Martin *

St. George's
Dr Karthik Somasundaram *
Dr Richard Curtis
Dr Anna Riccoboni
Dr Yvette Coldicott
Dr Hasmita Bagia
Dr Moein Tavakkolizadeh

Kent, Surrey, Sussex
Dr Emma Glasgow

Mersey
Dr Gemma Redmond

North West
Dr Arun Jala Venkataraju

Northern
Dr Sarah Russ *
Dr Peter Ricketts

Oxford
Dr Caroline Walker *
Dr Antony Ashton *

South West Peninsula
Dr Nicola Campbell

West Midlands
Birmingham
Dr Ruth Francis
Dr Simran Minhas
Dr Robert Glasson

Warwickshire
Dr Akilan Velayudhan

Scotland
South East Scotland
Dr Usman Bashir

West Scotland
Dr Wolfgang Weidenhammer
Dr Rahul Karve

Yorkshire
West Yorkshire (Leeds/Bradford)
Dr Louise Jobling
Dr Laura Walton *
Dr Andrew Baker

East Yorkshire (Hull/York)
Dr Muthuraj Kanakaraj

CB/20/2014 Audit and Internal Affairs Committee
Council received and considered the minutes of the meeting held on 8 January 2014 which were presented by the Chairman, Dr Clutton-Brock, who drew Council's attention to the following:

- *3. Financial regulations*
- *4. Election to Council*
- *5. Charity Commission*

Dr Whitaker questioned whether it would be better to list candidates for election to Council on the Ballot paper using a randomised process so that everyone is treated equally. Dr Clutton-Brock suggested that the best way to make the election truly representative is to increase the number of people who actually vote.

CB/21/2014 National Institute of Academic Anaesthesia
Council received and considered the minutes of the meetings held on 22 January 2014 which were presented by Professor Sneyd who drew Council's attention to the following:

- *NIAARC/07/2041 Research Priority Setting Exercise*

Professor Sneyd suggested that the structure of the meetings should be considered as having two meetings, the Research Council and the Board was creating a lot of redundancy in the second meeting. The President agreed that it would be beneficial to move to condensing the meetings.

CB/23/2014 Patient Liaison Group
Council was presented with a revised Terms of Reference (ToR). Mrs Dalton explained that the intention was for the new ToR to become operational on 1 August 2014 when the current Vice-Chairman demits office. Mrs Dalton drew attention to point 1.6 of the ToR and asked Council whether the point should still be included in light of the fact that the Patient Liaison Group (PLG) does not liaise with patients. Dr Marks questioned what the statement actually means as the wording is unclear. Dr Marks also asked for clarity as to what the function of the medical members on the PLG actually was. The ToR state that six medical members are required for four meetings a year and it is hard to justify this time to Trusts if the purpose is unclear. Mrs Dalton highlighted the importance of the flow of information. The Chairs of the relevant committees have been asked to clarify that PLG members are doing what is intended. Dr Fazackerley noted that for the meeting to have a quorum only three medical members are required so this does allow for some rotation or the invitation of a specific member.

Dr Selwyn questioned the numbers included in the ToR as they add up to 21 and not 22 as stated. Mrs Dalton explained that this was to allow for the group to contain 15 lay members until one retires in light of the strong recruitment candidates received. Mr McLaughlan explained that eight excellent candidates had been interviewed and of these four have been appointed. There is still one applicant from Northern Ireland to be interviewed.

The President suggested that it would be interesting to know what the Lay PLG members think point 1.6 of the ToR means.

The President noted that it would be useful for both Council and the PLG to consider what the expectation of the group is as this needs clarification.

CB/24/2014 Faculty of Intensive Care Medicine
Council received and considered the minutes of the meeting held on 16 January 2014 which were presented by the Dean, Dr Batchelor, who drew Council's attention to the following:

- *BFICM/01.14/8.4 Academy of Medical Royal Colleges*
- *BFICM/01.14.8.4 DCC-PA and SPA time in ICM*
- *BFICM/01.14/3.2 Starch-based fluid resuscitation*
- *BFICM/01.14/5.3 FFICM Examination*
- *BFICM/01.14/9.1 ICM Assessment Paperwork*

Dr Whitaker suggested that an actual figure should not be stated in terms of minimum SPA as it makes it much more difficult to argue against it as it can be taken out of context.

Dr Brennan questioned what the Medicines and Healthcare Products Regulatory Agency's (MHRA) opinion is in terms of starch-based fluid resuscitation and the EMA reversing its opinion so quickly. Dr Batchelor noted that PRAC are a European legal organisation and so enforced by European law, the MHRA cannot go against them. Dr J Nolan explained that the MHRA has not produced a final statement yet but noted that if the guidance is very strongly not to use then the PRAC decision is unlikely to influence what actually goes on in hospitals.

Dr Colvin noted that it is very difficult to justify a minimum SPA of 1.5 without an evidence base. The President highlighted that this is an ongoing debate across Colleges and that there needs to be evidence. Proper SPA time should be available for a range of activities.

CB/26/2014 Quality Management of Service Committee
Council received and considered the minutes of the meeting held on 8 January 2014 which were presented by the Chairman, Dr Venn, who drew Council's attention to the following:

- *QMSC/02/2014 Minutes of the last meeting and matters arising*

Dr Venn noted that there is ongoing debate within the Quality Management of Service Committee regarding engagement with the Independent Sector with not all members agreeing that ACSA should engage with the Independent Sector. This remains an ongoing discussion. Dr Venn also stated that Nuffield Health has asked whether it could be accredited as an organisation covering all their hospital sites. The Committee agreed that individual hospitals should be accredited and not organisations.

Dr Venn highlighted that Professor Sir Mike Richards and the CQC have been kept up to date on the progress of ACSA.

- *QMSC 06/2014 Review visit agenda*

- *QMCS 10/2014 Any other business*

The ACSA Reviewers conference day will take place on the 14th October 2014. Professor Sir Mike Richards will be asked to give the opening talk.

Dr Brennan noted that with regard to engagement with the Independent Sector he would hope that Council agree that the business of the College is raising standards wherever patients are managed.

Dr Whitaker strongly opposes engagement with the Independent Sector in terms of ACSA noting that the Independent Sector does not have anaesthetic departments. The College is yet to fully accredit one NHS hospital and Dr Whitaker feels that the focus should be setting up the process and making it work within the NHS.

Dr Venn highlighted that individuals held polar opposite views, it is his view that it is precisely because the Independent Sector does not have anaesthetic departments that patients are more at risk and standards need to be set. Dr Venn noted that the CQC is supportive of the College engaging with the Independent Sector.

The President highlighted that how the College engaged with the Independent Sector is a wider issue and potentially something to be discussed at the Council Away Weekend. The College has a duty to patients that they receive anaesthetic services across a level playing field.

Professor Mahajan suggested that the College may want to look at changing the name of the Professional Standards Department as the name has become obsolete.

Dr Whitaker noted that Council had already debated the involvement of the College with the Independent Sector and produced a policy statement in August 2008 requiring the NHS principle of complete equity for all Consultants employed to care for NHS patients to be maintained.

CB/27/2014 Professional Standards Committee
This item was deferred until March 2014.

CB/28/2014 CPD Working Party
Dr Marks highlighted that the Continuing Professional Development (CPD) Working Party has produced a report that will be discussed at the next CPD Board meeting. Dr Marks noted that the CPD online system is a key piece of IT fulfilling 3 roles:

- The infrastructure for CPD assessors to do their job.
- A directory of CPD approved events.
- Provides a logbook of CPD activity.

Dr Marks noted that since the CPD online system was introduced the landscape has changed, the AAGBI has introduced its own system and there is competition from Trusts who have their own systems. The College needs to ensure that it is providing the right tool and that it is being taken in the right direction. It has been suggested that the system should be a diary of SPA time, of which CPD is a requirement. Dr Marks asked Council to consider whether a group should be set up to look at the CPD online system.

Dr Langton noted that it will be important to look at the costing of any suggested changes and highlighted that the summary reports can often be linked between the CPD online system and Trusts' own systems.

The President noted that it is an evolving market and the College cannot sit back, it needs to be mindful of the future.

Mr McLaughlan noted that the AAGBI has produced a Glossy regarding SPA which includes a very helpful template for recording SPA time. Mr McLaughlan also noted that the first AAGBI event had been submitted to the College system for CPD approval.

MATTERS FOR INFORMATION

I/4/2014 Publications
Council received, for information, the list of publications received in the President's Office.

I/5/2014 Consultations
Council received, for information, the list of current consultations.

I/6/2014 New Associate Fellows, Members and Associate Members
Council noted, for information, the following:

New Associate Fellows
Dr Chetana Nagaraj - North Middlesex University Hospital
Dr Zoltan Mihalik - Pilgrim Hospital, Boston
Dr David Patrick Joseph Hendron - Ulster Hospital
Dr Tacson Fernandez - Royal National Orthopaedic Hospital

New Members
Dr Augusto Horacio Mauro - European Diploma in Anaesthesia
Dr Kiran Kumar Yelamati - Primary FCARCSI

New Associate Members
Dr Michael Priestnall - Colchester General Hospital
Dr Ales Hodek - Royal Brompton and Harefield NHS Trust, Harefield Hospital
Dr Snehal Ramnath Kumbhare - Southend University Hospital NHS Foundation Trust
Dr Mohammad Imran - Royal Oldham Hospital

To receive for information, the following doctors have been put on the Voluntary Register
Dr Liana Zucco - St Georges Hospital NHS Trust
Dr Ellen Asa Maria Broberg - The Royal Victoria Infirmary, Newcastle upon Tyne NHS Trust
Dr Nigar Hashemy - Wycombe Hospital
Dr Hristina Ivonova Petkova - Queens Hospital NHS Trust, Romford
Dr Dona Samanthi Priyanga Pullaperuma - James Page University Hospital
Dr Chye Hing Siaw - Cumberland Infirmary
Dr Eleni Grani - Leicester General Hospital
Dr Kunal Targe - Barnet & Chase Farm Hospitals
Dr Rashmi Anant Bhadange - Barnet & Chase Farm Hospitals
Dr Antonio Gioia - The Royal Berkshire Foundation Trust
Dr Rashmi Anant Bhadange - Barnet & Chase Farm Hospitals NHS Trust
Dr Abigail Mackintosh - Princess Royal Hospital, Telford
Dr Chamanthi Sanjeevani Widanapathirana - Nevill Hall Hospital, Abergavenny
Dr Erika Panaro - Pilgrim Hospital
Dr Attila Jonas - Pilgrim Hospital
Dr Antonio Rubino - Papworth Hospital
Dr Nicola Anderson Bester - Frimley Park Hospital
Dr Ganeshkrishna Ravindranathan Nair - Peterborough City Hospital
Dr John Muzungu Bugo - National Hospital for Neurology and Neurosurgery
Dr Michelle Aukland - Leicester General Hospital
Dr Mona Lehra - United Lincolnshire Hospitals NHS Trust, Grantham & District Hospital

Membership Category Progression

Associate Fellow
Dr Stephen Richard Humble - Charing Cross Hospital

Members
Dr Alvina Lone - RCSI Final
Dr Deepak Malik - RCSI Final
Dr Vishal Premprakash Handa - RCSI Final
Dr Kavitha Sadan - Primary of the RCoA
Dr Anil Kumar Bhalla - Primary of the RCoA

Associate Members
Dr Muhlis Baris Pekicten - Hospital unknown
Dr Yenika Nilanthi Kumari Mahappu Kankanamalage - Grantham Hospital

I/7/2014 Academy of Medical Royal Colleges
Council received, for information, a summary of the Council meeting held on 29 January 2014.

PCS/2/2014 PRESIDENT'S CLOSING STATEMENT
1. Council members, who had not already done so, were asked to reply to the invitation to the Anniversary Dinner as soon as possible.

MOTIONS TO COUNCIL

M/5/2014 Council Minutes
Resolved: That the minutes of the meeting held on 8 January 2014 be approved subject to minor amendments.

M/6/2014 College Tutors
Resolved: That the following appointments and re-appointments be approved (re-appointments marked with an asterisk):
North Thames Central
Dr R E Bartlett (Acting Tutor, St Mary's Hospital)

North West
*Dr N A Mahmoud (Royal Albert Edward Infirmary)

South East of Scotland
Dr J D Antrobus (Borders General Hospital)

South West Peninsula
Dr R A Price (Royal Devon & Exeter NHS Foundation Trust)
Dr M Khakhar (Taunton & Somerset NHS Foundation Trust)

South Thames East
Dr P Kelly (St Thomas' Hospital) in succession to Dr I Ahad

Wales
*Dr V Madhavan (Wrexham Maelor Hospital)

West Midlands South
Dr A N Kelly (University Hospitals Coventry and Warwick)

CEREMONIAL

C/1/2014 Retiring Council Members

The President presented a certificate to:
Dr Hywel Jones
Dr Sumit Gulati