MEETING OF COUNCIL

Edited Minutes of the meeting held on Wednesday 12 January 2011
Council Chamber, Churchill House

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

Members attending:

Dr P Nightingale, President
Dr A A Tomlinson
Dr J-P W G van Besouw
Dr J D Greaves
Dr A B H Lim
Dr R Laishley
Professor D J Rowbotham
Professor J F Bion
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 S C Patel
Dr R Verma
Dr R J Marks
Dr L J Brennan
Dr J R Colvin
Dr M Nevin
Dr I H Wilson

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 H M Jones, Dr E A Thornberry, Dr T H Clutton-Brock and Dr J Heyworth.

COUNCIL IN DISCUSSION

CID/1/2011 President's Opening Statement

(i) The President announced the deaths of Professor Richard Bodman, Dr Kenneth Mills, Dr Harold Love, Dr David Ball, Dr John Bushman and Dr Peter Dennison. Council stood in memory.

(ii) Professor Torsten Gordh's son had written to thank the President for the condolence letter following the death of his father; Professor Gordh greatly valued his contacts with British colleagues.

(iii) An additional item would be added to the agenda; Item 2.19 Faculty of Intensive Care Medicine (FICM) Board.

(iv) Professor Sneyd had alerted the President to potential changes to the Foundation Programme. Professor John Collins has reviewed the Foundation Programme and has suggested that the General Medical Council (GMC) takes a long hard look at it in 2015. F1 may be linked directly to medical schools; this would be a way of ensuring that UK trained medical students obtain a F1 post. There is nothing for the Royal College of Anaesthetists (RCoA) to do at present other than wait and watch developments.

(v) The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) had been successful in its bid to continue with inquiries. It was noted that the Centre for Maternal and Child Enquiries (CMACE) had been unsuccessful in its bid.

(vi) Mr Mohammed Sadek and his team have been providing excellent service during the RCoA's five years in Churchill House. The President would present Mr Sadek with a pair of theatre tickets as a token of gratitude.

(vii) A demonstration coffee machine would be provided alongside the usual coffee. Council members were asked to provide feedback to Mr Storey. Council subsequently approved the machine.

Dr Whitaker joined the meeting at 0940.

(viii) It had been suggested that the number and frequency of College dinners should be reviewed. Council agreed that the Autumn Council Dinner should be cancelled; it is purely social and is relatively close to the Christmas Council Dinner.

(ix) Consideration needs to be given to the redevelopment of 34 Red Lion Square (34 RLS). There will be a two phase approach; funds are available for phase one, although it has not yet been costed. The intention is to open up the ground and lower ground floor of each building. The buildings would be linked and there would be one entrance, thus producing two large flexible areas. Consideration would be given to moving the kitchen from Churchill House to 34 RLS. Increasing the capacity of the Café to match the Lecture Theatre would also be a component of phase one. Mr Storey outlined the plans for phase two. There would be two lifts at the front of the building. Planning permission already exists to add a seventh floor flat to 34 RLS. The Eighth Floor Meeting Room in Churchill House could be demolished and planning permission applied for to build a College flat and additional meeting room on the eighth floor across both buildings. The meeting room could be used by the RCoA but also accessed from the flat to provide entertainment space for the President. This proposal would result in another two flats available for commercial letting. The President commented that the plans would improve the RCoA's image and fit in well with Dr Venn's communication strategy. Other Colleges entertain more frequently on a political level and perhaps the RCoA should do the same. Mr Storey assured Dr Batchelor that the RCoA is not at risk of spending too much money developing now when in five or ten years' time it might own more buildings in the block and choose a different option. Mr Storey explained that the size of the Lecture Theatre would not be increased; the structural engineer's initial report suggested that this could not be easily done. Dr Whitaker pointed out that the Association of Anaesthetists of Great Britain & Ireland (AAGBI) had found it more economical to undertake both phases of its development concurrently; it might be worth the RCoA waiting until it could afford to do the same. Mr Storey responded that to undertake the work in one fell swoop would be more economical but it was difficult to assess if it was worth waiting until costings were available. Mr Storey suggested that the RCoA should invest between now and 2020 in things of benefit to the College; a decrease in the number of Fellows and hence income is anticipated in 2020. Dr Brennan highlighted the importance of taking into account the needs of the Faculties. Council agreed that Mr Storey should discuss plans further with the architects.

(x) A retired anaesthetist had enquired about his eligibility to stand for election to Council. Mr Storey had responded that he was eligible but the Ordinances and Regulations state that any member of Council must retire in March following their 67th birthday. It was noted that other Colleges have elected a President who is not in current practice. There have been questions from Council members about retirement age; it was therefore important to address it and have clarity. It was suggested that it would be better to link retirement to clinical practice rather than age; using age as a cut-off could be unlawful. Dr Brennan pointed out that examiners have to retire in the academic year they cease clinical practice. Dr Lim highlighted the importance of a consistent viewpoint throughout all the RCoA's committees. Dr Tomlinson raised the issue of credibility; it is important that Council members are in clinical practice or within a year of clinical practice. The President suggested that the seniority of those who have recently retired may be beneficial; Council sets policy and strategy rather than concentrating on the minutiae of clinical practice.

Professor Rowbotham agreed that clinical practice is important but someone still involved in the profession in another capacity may be very useful for Council. Dr Venn expressed his unease about insisting on Council members being in clinical practice; he was unsure how important it is to give anaesthetics to be part of a policy making body and suggested that clinical practice should be defined. Dr Venn supported removing age as a cut-off as there will be a big tranche of consultants taking retirement who then return to do some sessions; clinical practice not retirement is important. Dr van Besouw emphasised the importance and advantages of Council members being actively engaged within the wider National Health Service (NHS); it is difficult to see how those who have left the NHS have access to that and can bring more to the table than lifetime experience. Dr Greaves believed that the democratic process should be trusted to elect appropriate Council members. Dr Whitaker pointed out that for the AAGBI an officer should be in clinical practice when elected; individuals begin to lose touch after being out of clinical practice for longer than two years. Dr Batchelor agreed that the democratic process should be trusted; it should be assumed that the RCoA's membership is sensible and will make sensible decisions. Dr Batchelor suggested that those over a certain age might be elected for a reduced term of office. Dr Whitaker suggested that this was another argument to reform the election process for President. Dr Nevin stated the need for a balance in Council which would allow it to drive through change for the good of patients but also a counterpoint to ensure things are not driven through which are later regretted. It was agreed that Mr Storey should draft an amendment and send it to Council for further comment.

(xi) Mr Richard Young, who had recently stepped down from the Patient Liaison Group (PLG), had written to the President expressing how much he had valued his association with the RCoA.

(xii) The Academy of Medical Sciences had published a report setting out a new pathway for the regulation and governance of health research; this would improve research in the UK. Professor Rowbotham informed Council that the National Institute for Health Research (NIHR) had said that one of the issues it would try to sort out was the bureaucracy surrounding research; it has made no inroads in that particular area. Professor Rowbotham thought that the suggestions in the Academy of Medical Sciences' report would be accepted. The National Institute of Academic Anaesthesia (NIAA) would respond formally to the report.

(xiii) The President noted that Council coincided with the New College Tutors' (CTs) meeting; if this were the case in future it would be useful for Council members to meet new CTs at the dinner held the night before Council. Mr Bryant agreed to provide the President with the dates of future meetings.

(xiv) Council had previously agreed to support an application by Dr Andrew Morley to host an exhibition at the Science Museum funded by the Wellcome Trust. Dr Morley's application had been shortlisted and further support is now required. Mrs Rivett and Dr Alan McGlennan had attended a meeting at the Science Museum where Dr Morley had put forward his proposal. Dr Steve Yentis had also attended representing the AAGBI. Mrs Rivett reported that the meeting had included a brainstorming session to put together the core components for submission to the Wellcome Trust. The general consensus had been that it would be the right sort of project to be involved in. The exhibition is planned for 2012 and there is a very tight timetable for submission of the application. Council agreed that the President should write a strong letter of support. Funding had not been requested from the RCoA or AAGBI but support from both organisations would enhance the application. Mrs Rivett pointed out that senior support would be required; this would cost in terms of time away from other activities. Dr van Besouw informed Council that the RCoA would also be required to act as media centre for enquiries arising from the exhibition. Mr McLaughlan had reminded Dr Morley that the RCoA's website and patient information should be made available to answer most of the questions which would arise. Mr McLaughlan had also

reminded Dr Morley that the Communications Section, with Dr Rollin and the PLG, can respond quickly to questions. Mrs Rivett added that the Science Museum was happy to manage questions, thus avoiding the RCoA being deluged.

(xv) Ms Leena Vara has been appointed to the permanent position of Accounts Administrator.

CID/2/2011 Simulation

Dr Greaves informed Council that although simulation is already a routine part of anaesthetic training the RCoA has no formal position on it. After the RCoA's sponsorship of the Bristol Simulator Centre it had decided not to support other developments in the UK in the same way. There are now external pressures on the RCoA to consider its position. Simulation in medicine got off the ground in anaesthesia and the public and politicians think that anaesthetists could be trained and tested on simulators in the same way as airline pilots. In addition other organisations are investing heavily in simulation at present. The new curriculum requires the RCoA to write down how it will assess each component. There is a series of outcomes which cannot be assessed appropriately and uniformly throughout the country, including human factors training. Leadership and followership are easy to teach and assess using simulation. There are a number of sensitivities around simulator centres, the majority of which are run as commercial enterprises and do not want interference which may interfere with their business programme; their vested interest in the introduction of routine simulation training should also be taken into account. Some parts of the country would require the purchase of equipment, others are well provided for. Dr Greaves pointed out that it is incumbent upon the RCoA to produce assessment systems that are fit for purpose and demonstrated to be fit for purpose. Many people are involved with simulation although there are very few genuine experts. It is suggested that the RCoA should be responsible for the central training of champions. The remainder of the discussion was postponed until Professor Sneyd's arrival at 1110.

Dr Greaves informed Council that the Working Group's suggestions are limited to the introduction of simulation into situations where it is known to be useful and where it has safety implications, e.g. introductory courses, rapid sequence induction (RSI), management of Caesarean section under general anaesthesia and human factors training. Human factors is not routinely taught to trainees in anaesthesia. Professor Sneyd was anxious that the RCoA should support simulation but pointed out that UK performance in simulation is disappointing and not world-class as stated in the report. Professor Sneyd expressed concern about dictating that certain things should be mandatory, required or compulsory; instead they should be encouraged. It is possible to teach RSI without a simulator. There will be issues if it is written into the curriculum; it will make barriers for those seeking the Certificate of Eligibility for Specialist Registration (CESR) route even harder and the only valid reason for saying 'must' is if the RCoA was convinced that it would unlock money that would not be otherwise unavailable. Professor Sneyd thought this would not happen and requested a change in the tone and language of the document. Professor Bion stated that the most powerful way to learn is in the clinical environment and he would like to see more use made of low tech mannequins with well thought out scenarios. Dr Nevin pointed out the value in a multidisciplinary approach to simulation using a spare bed space and the whole team; the RCoA needs to state the cross-specialty requirement for not only human factors but also responses to anaesthetic and intensive care. Professor Mahajan welcomed the paper; there is a need for a consistent approach and standard setting. There is very little evidence that simulation replaces the clinical environment. The paragraph regarding research opportunities should be expanded; the RCoA should seek such opportunities. Dr Venn stated that simulation at the lower level is very useful but what must underpin it is how to deal with a critical incident. Professor Fee, a great supporter of simulation, informed Council that his university has taken ownership of simulation and has invested in it greatly. Professor Fee could not envisage the postgraduate dean in Northern Ireland making use of the facilities unless there is a compulsory element or expectation that simulation will form part of training. Dr Greaves added that many universities have invested in simulation but many

schools of anaesthesia do not know what is available; one of the tasks would be to disseminate such information. Professor Rowbotham cautioned against upsetting people by telling them to do things which they cannot afford. Dr Wilson was of the opinion that simulation is the way forward and he would like to see the linking back into a scheme whereby people can practise simulation of events that have actually caused deaths. Dr Brennan added that a locally driven low cost simulator based course using a multidisciplinary approach is crucial. Professor Mahajan suggested using the Advanced Life Support (ALS) programme as a model for simulation; each hospital has an ALS programme which follows a central and consistent approach. The Working Group could identify centres of excellence and appropriate incidents could be selected from the critical incident reporting scheme. Dr Patel expressed concern about the cost to the individual of simulation; it must be delivered in a cost effective way for the individual who is paying for it. Professor Sneyd stated that he would like to the RCoA disseminating best practice but there is no need for it to set standards. Mrs Rivett pointed out that there are many benefits to simulation training. There is some very good work going on in the South West which should not be stifled by what is coming out of the RCoA. There does however have to be a degree of uniformity when it comes to assessment. Those coming out of medical school now are used to simulation training; the success of the programme must depend on the quality of the scenarios and the feedback.

The President asked Dr Greaves to move the work streams forward bearing in mind Council's comments.

CID/3/2011 H1N1

Professor Bion gave Council an update on H1N1. There had been approximately 837 H1N1 patients in critical care during the previous week with approximately 700 this week. The indication is that infection rates have peaked although they may raise again with the return to school. Approximately 50% of flu admissions to intensive care have H1N1. Approximately 22 patients have undergone extra corporeal membrane oxygenation (ECMO). There are five approved centres in the UK with additional approval for rescue ECMO to be provided by centres with the capacity to offer cardiac surgery if the approved centres are full. Mortality is approximately 35% for H1N1, for ECMO patients it is 10%. Dr Moonesinghe asked how centres undertaking ECMO for the first time had been quality assured and what will happen to them when ECMO is no longer required. Professor Bion informed her that they are all cardiac centres performing to a common standard, i.e. the Leicester protocol.

Best practice guidance on the management of H1N1 has been updated and is available on various websites. Leicester has also produced standards for ECMO. There is some evidence that the management of patients with H1N1 is suboptimal in a number of units. There is scope for improving reliability of practice; Dr Colvin is convening a group to address this in Scotland. Impact on service has been patchy as a result of the geographical spread of cases and hospitals' management of the crisis. Professor Bion wished to thank the various supporting services, particularly anaesthesia. The North West has been ventilating patients in theatres and recovery areas for a long time and in other areas the non heart beating donation programme is on hold. Professor Sir Bruce Keogh had brought together a group to support an approach for cancelling elective surgery to make space for emergency admissions over the winter period; the key principle is that admissions to intensive care remain the responsibility of the intensive care consultant but prioritisation of operations to be cancelled is the responsibility of the medical director working with surgeons.

It is difficult to obtain accurate data and Professor Bion would like to see real-time data made available nationally to clinicians.

Dr Colvin reported that there had been a different disease profile in Scotland; there had been lower activity generally and a lower peak in intensive care units (ICU); approximately 25% of ICU beds in Scotland are occupied by flu patients. There would be a response in Scotland to the recent publication of a UK expert report from Dr Jane Eddleston's group towards the idea of focusing on best practice; it does not suit the model of ICM provided in Scotland. Practice is being shared on the network and a strategy to ensure consistent best practice will be introduced. Three experts had been asked to put together a best practice protocol with a measurement strategy; this was produced within a week and is now at the stage of receiving feedback from regional intensive care services. The document will be modified before its introduction which will take place within one month of the original request.

The President enquired about reimbursement of the tariff particularly for ECMO patients where transfers are required; will reimbursement be on a per case basis? Professor Bion did not know but said that penalties for cancelling surgery should be rescinded. Professor Bion would take this up with Dr Jane Eddleston and Dr Bob Winter. Dr Nevin reported that in Bristol they have been told to contact the primary care trust for payment of the negotiated tariff. Professor Rowbotham stated that the crisis has come at an interesting time when the whole premise of the NHS assumes a reduction in beds. Every trust has an agenda of reducing wards but the beds are actually very necessary in the current circumstances.

Dr Nevin pointed out that it is unlikely to be the last year in which similar problems are likely to be encountered and asked what sort of planning is taking place regarding how to identify the ability to repatriate from centres offering ECMO and how we begin to plan for centralisation of ICM at a number of levels that can offer support. Professor Bion responded that repatriation is recognised as a problem and the lack of resources for ICM remains a major issue. 70% of ICUs have an occupancy rate of at least 80%. There are a variety of approaches to harmonising best practice. In the short term policy documents are being requested. In each region it is best to have one ICU which can support others in the region. Professor Mahajan's observation had been that despite morale not being at its best people had been extraordinarily cooperative and should be thanked for dealing with the situation, sometimes at personal cost; such a message from the RCoA would be welcome. Professor Bion reported that he had asked Sir Bruce Keogh to send a similar message.

CID/4/2011 The Royal College of Anaesthetists and College of Emergency Medicine Working Party on Anaesthesia, Sedation and Airway Management in the Emergency Department

Dr Greaves explained that Part 2 of the Working Party's draft report and recommendations is about the administration of sedation in emergency departments (ED) by emergency physicians. It is controversial in that what they actually do is give general anaesthesia (GA). Dr Greaves sought Council's advice explaining that the guidelines for starvation prior to removing the capacity to cough have been developed in 150 years of anaesthesia practice; the guidelines should not be modified without the authority of a properly constructed research investigation. A lot of fundamental things are under attack in all situations where deep sedation is used. In the document sedation has been divided into two types; that where it is possible to talk to the patient and that where it is not. A whole host of facilities, skills and knowledge is required to step beyond that point. It has been raised whether or not the 2001 Academy of Medical Royal Colleges' (AoMRC) paper on sedation should be revisited. One of the problems arises as a result of emergency medicine's perception that problems arise with junior anaesthetic trainees sent to the ED in terms of their contribution to the team and management of the patient. As a consequence emergency medicine physicians believe it is better to carry out sedation themselves. In future all doctors in emergency medicine will have at least six months' experience of anaesthesia. It has been suggested that the RCoA, in conjunction with the College of Emergency Medicine (CEM),

draws up a curriculum format for teaching people further along in their Certificate of Completion of Training (CCT) training to conduct RSI which they will then carry out in their consultant career. Professor Mahajan reported that National Audit Project (NAP) 4 covered EDs; a significant number of airway incidents occurred in the ED and also in ICU where patients were under the care of junior doctors who may or may not have been trained in anaesthesia. It was noted that NAP 4 looked at patients undergoing GA; those undergoing sedation were not reported. Professor Sneyd declared an interest (the European Society of Anaesthesiology published guidance on propofol and gastroenterology in December 2010). Europe and the USA are struggling with this; although the evidence is pretty straightforward, politics and evidence become irrevocably mired. Professor Sneyd added that they are so intertwined that whatever the RCoA promulgates there will be those who take offence on the basis of their feelings rather than on the basis of evidence. Dr Brennan suggested that the various work streams on sedation should be brought together with an overarching statement about sedation; it is about safety in patient selection and the RCoA should look at it globally and look to provide a consensus statement, possibly with the AAGBI. The President pointed out that permission would have to be sought from the AoMRC to review its 2001 document. Dr Rollin stated that although the RCoA is part of each work stream they are being driven by the specialists and the College is at risk of signing up to things it should not be associated with; one of the ways of managing this would be to revisit the 2001 document. The President explained that there is a balance between patient care and risk. Unless an anaesthetic service can be provided in the ED every minute of the day there will be those who push the boundaries; it is a case of when does the RCoA say it is too risky and it cannot condone it. The President added that the issues could be thrashed out more formally through the AoMRC. Mrs Rivett stated that if there is a document from the RCoA it would be a huge benefit to reveal it. Mrs Rivett enquired why this had suddenly become a problem and whether or not it is in the patients' best interests. The President responded that it is in their best interests but it has to be balanced with risk. Dr Batchelor suggested that the specialty needs to think about its own attitude to the fasting rules; something is not necessarily right just because it has been done that way for a very long time. Dr Greaves pointed out that the RCoA is being asked to endorse practices that it does not endorse in anaesthesia which will have a massive impact on the specialty. Dr Wilson recognised the difficulties of what has been described having been approached, as Medical Director, by emergency medicine doctors who had used propofol in 200 cases and were seeking his approval; much of it was good clinical practice although some of what they had to say was difficult to hear. Dr Greaves was confident that in most EDs a pragmatic approach is taken; what will potentially develop is the wide belief that the most appropriate person is the emergency physician when in fact an anaesthetist is available. Dr Whitaker suggested that sedation and airway management be separated as putting them in the same document is causing problems. Council agreed that there should be two separate documents as suggested by Dr Greaves to Professor Jonathan Benger. Dr Marks suggested that an element of compromise is required; the RCoA should look at the supervision and training of those who will carry out sedation and possibly suggest that there is a process whereby people who are going to undertake sedation have to be approved by their own registrar or consultant before doing it unsupervised. Mrs Rivett stated that there needs to be a defined standard; the RCoA needs to issue a position statement which is clear and precise. Dr Tomlinson reported that the Australian and New Zealand College of Anaesthetists (ANZCA) has produced some quite clear guidelines on sedation which could be used as a starting point. Dr Tomlinson stated that the AoMRC's guidelines are incredibly sensible and there is not much that could be changed ten years after they were written. Dr Rollin agreed that the basis is there and there is now a curriculum. It would be difficult for the RCoA to say people can be trained to a lesser extent; this would devalue its standard. There is a need to have an anaesthetic view of sedation. The President asked Dr Greaves to continue his good work. The draft document (marked confidential for College discussion only) would be circulated to enable Council to e-mail comments to Dr Greaves. Council was asked not to circulate the document further. ANZCA's

paper should be looked at and Council should consider asking the AoMRC whether in view of the new curriculum the guidance should be updated.

CID/5/2011 Guidance for the Use of Propofol Sedation for Adults undergoing Endoscopic Retrograde Cholangiopancreatography

Dr Tomlinson presented the latest draft of the guidance. The guidelines aim to cover UK practice for the use of propofol for sedation in adult patients and have been changed so they are less prescriptive in telling people how to give drugs; this appears to have been well received. There is however no mention of the delivery of oxygen over the period. Dr Whitaker has suggested that a statement be added that oxygen should be administered throughout the procedure, commencing before the procedure is started. Dr Tomlinson asked Council to approve the guidance with the addition of a statement about oxygen and tightening up on the advantages of capnography. Dr van Besouw pointed out that one of the issues the RCoA will have is providing access to this for its trainees within the current curriculum; it would have to ensure that trainees attend these sessions. Dr Tomlinson responded that at the sedation meeting it was clearly identified that it is all very well for the RCoA to have a sedation curriculum but the delivery of it would be difficult as not many places provide sedation services within their own hospitals. Dr Whitaker pointed out that page seven of the AoMRCs' guidelines included a point about the presence of dedicated trained assistance; this should be added to the guidelines presented today. Dr Tomlinson replied that anaesthetists felt this was not necessary because it is consultant delivered. Council was asked to e-mail comments to Dr Tomlinson following which the document would be put on the RCoA's and British Society of Gastroenterology's websites for consultation.

CID/6/2011 Current CT1 Process

Dr Marks informed Council that CT1 short listing is more or less finished; feedback has been that it has worked and that the move to electronic short listing had been satisfactory. The first round of standard interviews is about to commence. ST3 recruitment will start soon and is going to plan.

The quality of candidates has been good for anaesthesia and Acute Care Common Stem (ACCS).

The Group of Anaesthetists in Training has sent a letter of support which will be published on the RCoA's website.

The move to national recruitment will continue next year.

It had been proposed that all offers for posts would be made through a central system at NHS Education for Scotland (NES); this had been withdrawn at the last minute because of worries about not all Deanery algorithms being ready to implement. Work is going on to ensure this is in place for next year.
A request has been received from the Department of Health (DH) to look at efficiency savings; it is happy to continue funding national recruitment but wants money to be saved. Consideration is being given to giving every applicant a guaranteed interview thus saving money on short listing. The National Recruitment Working Party is looking at this but does not need to decide until May. Consideration is also being given to combining anaesthesia recruitment with ACCS recruitment.

Council agreed that the National Recruitment Working Party should become the Recruitment Committee.

CID/7/2011 Clinical Directors

Dr Nevin reminded Council of the objectives he had been set following his co-option to Council:

1. To work with Council to ensure the views of Clinical Directors (CDs) are being heard and understood;
2. To develop a network of CDs which would provide both an information and support mechanism for CDs;
3. To help design, organise and deliver a programme of regular meetings to bring together CDs with leading figures in the RCoA and other leaders in the healthcare community.

Initial discussions with a group of CDs highlighted a desire to develop and utilise a network along with an appetite to help develop the agenda to be discussed. CDs are feeling increasingly isolated, caught between increasing tensions between teaching/training the workforce on one hand and efficiency savings and service delivery on the other. CDs felt almost universally that it is the right time to develop a mechanism which can deliver support as well as guidance. However many CDs had also commented that such a network had been promised previously but had not delivered. It became evident that the RCoA did not have an up-to-date database of CDs; this is being rectified with the help of the President's Office and CTs; Dr Nevin wished to thank Ms Regan and Miss Emma Bennett for their assistance. The aim is to have a fully functioning network by the time of the Joint CDs' meeting.

A dedicated e-mail address has been established at the RCoA and a letter had been sent to those on the database outlining what the RCoA could provide and asking CDs what they require. Confirmation is awaited regarding developments regarding the secure area of the website; Dr Nevin thanked Mr McLaughlan and Mr Williams for their work so far in this area. A live discussion board would be welcomed by many. Dr Nevin is keen to progress with podcasts and Web-ex.

The Joint RCoA/AAGBI meeting for CDs has been planned for 7 March 2010. Dr Nevin thanked the President and Dr Wilson for their advice regarding the meeting and Ms Natalie Lowrie for helping with the organisation. Feedback from previous meetings indicated a wish for more open debate; the afternoon of the meeting will be devoted to a question time session with an expert panel.

Dr Nevin reported that the current position is such that the launch of the national CDs network for Anaesthesia, Critical Care and Pain Management could be acknowledged and formally announced on the RCoA's website. Dr Wilson stated that he was keen that the network was regarded as a Joint RCoA/AAGBI network.

Dr Nevin thanked those who had helped so far and encouraged Council and the RCoA to engage with the future development of the network to produce the highest levels of training and personal development for anaesthetists and also to ensure, through sensible trust management decisions, the best possible outcome for patients.

The President thanked Dr Nevin for his work and comprehensive report and urged as many Council members as possible to attend the meeting on 7 March.

COMMITTEE BUSINESS

CB/1/2011 Council Minutes

The minutes of the meeting held on 8 December 2010 were approved.

CB/2/2011 Matters Arising

(i) Review of Action Points

CID/58/2010 Professional Bodies Quality Leads Meeting Discussions are ongoing.

CB/3/2011 Regional Advisers
There were no appointments or re-appointments for Council to consider.

CB/4/2011 Deputy Regional Advisers
Council considered making the following appointment:
Dr K A Eggers, Deputy Regional Adviser for Wales, in succession to Dr E Wright **Agreed**

CB/5/2011 College Tutors
Council considered making the following appointments/re-appointments (re-appointments marked with an asterisk):

Anglia
*Dr J J Brown [The Ipswich Hospital] Agreed
*Dr A K Gregg [Peterborough & Stamford Hospital] Agreed

East Yorkshire
*Dr P S Smith [York District Hospital] Agreed
*Dr S W U Husaini [Diana, Princess of Wales Hospital] Agreed

West Yorkshire
*Dr M R Beadle [Calderdale Royal Hospital] Agreed
*Dr J D Dodman [Pinderfields General Hospital] Agreed
*Dr A L Lansbury [Leeds General Infirmary] Agreed

Northern Ireland
Dr R O Laird [Altnagelvin Area Hospital] in succession to Dr P Stewart Agreed

North Thames Central
*Dr M V Chapman [University College Hospital] Agreed
*Dr R Sharma [Royal National Orthopaedic Hospital] Agreed
*Dr J Jovaisa [King George's Hospital] Agreed

North Thames West
Council is asked to consider a request from Dr Peter Brodrick, RA for North Thames West, to extend Dr S I Jaggar's [Royal Brompton Hospital] term of office for 7 months. Dr Jaggar is Lead Tutor until June 2011. **Agreed**
Dr J M Lowe [St Mary's Hospital] in succession to Dr S-M Lim Agreed

Severn
Dr R M Craven [Bristol Royal Infirmary] in succession to Dr M A Taylor Agreed

South Thames East
Council is asked to consider a request from Dr Claire Shannon, RA for South Thames East, to extend Dr D J H Lee's [Queen Mary's Hospital, Sidcup] term of office for a third term. **Agreed**

Nottingham and Mid Trent
Dr J R Mole [University Hospital, Nottingham] in succession to Dr I K Moppett Agreed
Dr C B Gornall [University Hospital, Nottingham] Agreed

West Midlands South
Dr L J Tasker [University Hospital, Birmingham] in succession to Dr M G Knowles Agreed

CB/6/2011 Heads of Schools
There were no appointments for Council to note.

CB/7/2011 Training Committee
(i) Medical Secretary's Update
Professor Mahajan had nothing to report in Dr Thornberry's absence.

CB/8/2011 Education Committee
Council received the minutes of the meeting held on 24 November 2010. The Chairman, Professor Kumar, had given a report of the meeting to the December meeting of Council.

CB/9/2011 Royal College of Anaesthetists' Advisory Board for Scotland
Council received and considered the minutes of the meeting held on 2 December 2010 which were presented by the Chairman, Dr Colvin. The annual meeting with the Scottish Chief Medical Officer (CMO) had been postponed until 10 January 2011 because of weather and travel problems.

With regards to trainee recruitment there is a good feel for CT1, ACCS and anaesthesia recruits. The Board is comfortable with the workforce figures. The Scottish Health Department's National Workforce Reshaping Board is currently focused on setting training numbers. In 2011 it will turn its attention to defining the shape and nature of the future medical workforce, governance of transition arrangements and how to sustain and promote training. The CMO is supportive of a programme of work that is developing relating to supporting the consultant grade. The Board had agreed that it should provide specialty input to the Scottish Academy's work on career progression for consultants.

With regards to revalidation the Board is keen to promote the concept of consistent application of the principles although the delivery may be different.

The Board recognises the value of Scottish patient safety and quality improvement work and is developing initiatives to contribute to the delivery of the Government's Scottish Patient Safety Programme and the Quality Strategy. There are still a number of number-based targets but there is an increased emphasis on the safety aspect. Mr McLaughlan reported that there are strenuous moves to join up the e-form with the systems currently available in Scotland. The 2% reduction in annual mortality rate is encouraging and the current systems are working. There may be an opportunity to share that learning through the Safe Anaesthesia Liaison Group (SALG) with the co-option of a Scottish member and to take it into account when it is time to consider how the system should operate post-National Patient Safety Agency (NPSA).

There is a cross-specialty push to at least get reinstatement of the local awards system in Scotland.

The meeting with the CMO had been very positive. The President had raised the issues of trusts giving doctors time away from the hospital for College activities and will write to the CMO before the meeting of the four CMOs.

Dr Laishley noted that the three year core training programme fits in well with the Staff and Associate Specialists (SAS) development document. It was further noted that the SAS representative on the Scottish Board had picked up on the lack of appraisal for SAS doctors. Dr Laishley added that this is a national problem. The career document for specialty SAS doctors advocated a named educational supervisor for each SAS doctor; this would be a mechanism to improve appraisal for SAS doctors. This will be discussed by the CDs' Forum.

CB/10/2011 Examinations Committee
Council approved that the Fellowship be awarded to those who were successful at the December 2010 Final Examination.

CB/11/2011 Equivalence Committee
Council received and considered the minutes of the meeting held on 9 December 2010 which were presented by Dr Laishley. This had been the first meeting based on the new 2010 curriculum. The Committee had considered four applications, two of which were recommended for inclusion on the specialist register.

CB/12/2011 Royal College of Anaesthetists' Advisory Board for Northern Ireland
Professor Fee gave a verbal report of the meeting held on 12 November 2010. The Board had discussed training standards for those who assist anaesthetists. A survey has been completed on the assistance provided for anaesthetists in theatre, recovery and elsewhere. Preliminary analysis indicates that training for this group does not meet UK standards. The analysis will be completed before being reported at the February meeting of Council.

There had been 56 applications for three posts. There are in fact eight posts and the number may increase to ten.

The trainee representative had drawn the Board's attention to low pass rates in the Primary examinations of the RCoA and the College of Anaesthetists of Ireland. Various explanations were offered including the downgrading of basic sciences, poor oversight of the courses which are being run and trainees having difficulty getting to courses. It was agreed that Professor Fee, Dr Clive Stanley and the Director of the Belfast Trust will meet the postgraduate dean to discuss this. It is hoped that the postgraduate dean will take a sympathetic view and CDs will try to find protected time for the course director to have oversight of courses. Ms Drake was asked to obtain data showing the uptake of e-learning to support training for the Primary examination. Dr Nevin pointed out that at the last sitting of the Final examination it was felt that candidates were being encouraged to take it as soon as possible and lack of experience might account for the low pass rate; Professor Fee stated that this factor was not identified during the Board's discussions.

Dr Ken Lowry had updated the Board regarding the information to be submitted to the GMC regarding the Irish Fellowship and the CCT.

CB/14/2011 Patient Liaison Group
Council received and considered the minutes of the meeting held on 7 December 2010 which were presented by the Vice-Chairman, Mrs Rivett. Following advertisement for further PLG members, 28 applications have been received for short listing. It is hoped that four members will be recruited and will be in post by the March meeting of the PLG.

The PLG still has concerns about the enhanced recovery programme and recognises that the RCoA continues dialogue with Professor Monty Mythen. The suggestion has been made that the PLG should be involved with intercollegiate guidelines.
Mrs Rivett has written to the four CMOs regarding NCEPOD's report *An Age Old Problem*. Mrs Rivett stated that she would be interested to hear what progress the RCoA is making following the discussion at the last Council meeting. The President responded that it is on the list of things to move forward.

CB/15/2011 Royal College of Anaesthetists' Advisory Board for Wales
Council agreed that the constitution of the Board should be amended to include the addition of the Chair of the Paediatric Anaesthetists in Wales Group.

CB/16/2011 Revalidation Development Committee
Council received and considered the minutes of the meeting held on 15 December 2010 which were presented by the Chairman, Dr Tomlinson. The Committee had welcomed Mr David Hepworth, the new PLG representative, and Dr Allan Cole of the NHS Revalidation Support Team (RST).

A small Working Group will be formed examining the potential role of Regional Advisers (RAs) in revalidation. A RA representative will be sought for the Revalidation Development Committee.

Lead appraiser training will be put on hold pending the development of the updated RST guidance on medical appraisal.

It was agreed that the RCoA should establish recommendations for a minimum dataset for career grade doctors in anaesthesia, intensive care and pain medicine. A small Working Group will be convened.

The Committee had received a summary of the GMC reports following the consultation on revalidation.

The GMC is considering how the Royal Colleges can be involved in quality assuring revalidation. There is a group looking at the quality assurance of GMC revalidation decisions and another considering the wider quality assurance issues in revalidation.

Dr Cole has presented early thoughts on the RST's current views about medical appraisal taking into account feedback gained so far from the pilot sites. Dr Cole had stressed the importance of having a working and practical appraisal system applicable to all GMC licensed doctors in place by the end of 2012. The updated guidance will conform to the GMC's request for a more streamlined process. An AoMRC Group is developing guidance on requirements for core supporting information which complements the RST work on appraisal.

The Committee has suggested that the Professional Standards Department develops guidance on the induction, mentoring and clinical supervision of non-UK based anaesthetists working in the UK.

The Working Group on Colleague and Patient Multi-Source Feedback Questionnaires, chaired by Dr Moonesinghe, has met for the first time. Significant questions have been raised about the validity of patient questionnaires for anaesthesia.

The Committee had received a progress report on revalidation projects and activities. Dr Mike Grocott is leading on developing outcomes and performance data/quality indicators. With regards to funding there is very little capacity within the existing revalidation budget for introducing any new activity or project without a formal submission to the Finance Committee for additional funds.

Professor Sneyd emphasised the importance of making clear in Level 3 of the Continuing Professional Development (CPD) Matrix that Specialist Societies provide appropriate material rather than specifying what activity must be done; there are a couple of references that could be misunderstood.

CB/17/2011 Faculty of Pain Medicine

Council received and considered the minutes of the meeting held on 2 December 2010 which were presented by the Dean, Professor Rowbotham.

The Board has agreed a protocol is required for when members are invited to pharmaceutically led meetings.

The concept of a FPM Gold Medal was approved; the regulations will mirror those of the RCoA.

The FPM is looking at the feasibility of a national register for spinal implants.

The guideline *Good Practice in the Management of Continuous Epidural Analgesia in the Hospital Setting* has been published.

The final version of the guideline on the use of epidurals for chronic pain has not yet been published: the possibility of it being endorsed by the rheumatologists is being explored.

The examination has been formally announced. The first examination will be in September 2012 and any trainee commencing advanced pain training in February 2011 will be required to take the examination as well as the local competency assessments.

Dr Joan Hester had attended her last meeting of the Board and was thanked for her enormous input into the establishment of the FPM.

CB/18/2011 Intercollegiate Board for Training in Intensive Care Medicine

Council received the minutes of the meeting held on 26 November 2010.

CB/19/2011 Faculty of Intensive Care Medicine

Professor Bion gave a verbal report of the first Board meeting held on 22 November 2010. The induction process had gone well and Professor Bion wished to thank the President for his support and kind words.

The main task is the delivery of the primary specialty programme to the GMC by the end of January which will need to be congruent with possible dual certification in due course.

The examination will be in two parts. Part 1 will be the Part 1 examination of the other specialties. Part 2 would be in specialist training year 6 and will be multiple-choice questions (MCQ) with structured viva/objective structured clinical examinations (OSCEs). A MCQ-based Part 1 examination will be developed for those trainees in the ICM primary specialty programme.

The Faculty will continue to try to make headway on an e-portfolio.

Dr Alasdair Short is responsible for workforce planning and will be working with Dr Nolan together with Dr Alison Pittard as Lead RA. It is hoped that following the RAs' meeting on 24 January there will be more data on the size of the current workforce.

Dr Tim Evans will lead on revalidation.

The Faculty has proposed the establishment of a quality improvement forum for groups with an interest in improving the quality of care and to act as an advisory body to the Faculty on achieving that. It is hoped it will also provide a home for critical care networks and the stakeholder forum.

Dr Batchelor informed Council that the curriculum went out for consultation in December. Mrs Patricia le Rolland at the GMC did not understand the specialist skills year and the description will have to be strengthened. There has been feedback from various sources about how dual certification will be done. The Faculty has tried to produce an ICM programme which can do two jobs, i.e. produce an ICM specialist and produce an ICM specialist who has trained in another specialty. The Faculty wished to allow wide access so has said that pretty much any core training programme is acceptable for entrants to ST3 in ICM. Programme Directors are saying this will cause problems because the ST3/4 year will need to be different for different trainees and it will be difficult managing posts.

Professor Bion informed Council that Dr David Watson has been promoted to a Chair of Intensive Care Education in The William Harvey Research Institute within Barts and The London School of Medicine and Dentistry at Queen Mary University of London.

MATTERS FOR INFORMATION

I/1/2011 Publications

The list of publications received in the President's Office was drawn to Council's attention. The President noted that the article *Strategy for a Campaign* in *Patient Voice* could come in useful.

I/2/2011 Consultations

Council received, for information, a list of the current consultations. The President thanked Mr McLaughlan for his work on consultations. Council members were urged to respond as early as possible to consultations as there if often a very tight deadline especially for those responses which will inform the AoMRC's response.

I/3/2011 New Associate Fellows, Members & Associate Members

Council noted the following:

New Associate Fellows - December 2010

Dr Manav Jagdish Bhavsar-Altnagelvin Area Hospital, Londonderry
Dr Jeffrey Ryan Brown –Craigavon Area Hospital
Dr Sushil Kumar–East Lancashire NHS Trust

New Members – December 2010

Dr Yvonne Anne Carola Starske-Primary FRCA
Dr Subramanyam Mudali Salvakam – Primary FCARCSI

To receive for information, the following doctors have been put on the Voluntary Register– December 2010

Dr Guillernio Cristian Martinez Munoz- Papworth NHS Foundation Trust Hospital
Dr Nathalie Frayssinet- Southmead Hospital
Dr Daniel Themba White-Dorset County Hospital
Dr Riyan Sukumar Shetty-St Georges Hospital, London
Dr Janaka Mangala Abeynarayana-Aberdeen Royal Infirmary
Dr Baddegama Hewage Akalanka Mahima Jayawardena-St Richards Hospital
Dr Shanmugappriya Vijayarajan-Calderdale & Huddersfield NHS Foundation Trust
Dr Paula Maria Simoes Costa Caldinhas-Naidenov-Northwick Park Hospital, Harrow
Dr James Edward O'Carroll-Dorset County Hospital
Dr Josip Stosic-Norfolk & Norwich University Hospital
Dr Vihara Henadirage Erangika Gunasekera Dassanayake

PCS/1/2011 President's Closing Statement

(i) The President reminded Council that CMACE has not been awarded the contract for confidential enquiries. The RCoA would need to keep a voice.

(ii) The President looked forward to receiving a report of the launch pan-European Pain Proposal which was being attended by some members of Council.

(iii) Professor Sneyd urged Council to respond to the consultation *Liberating the NHS: developing the healthcare workforce*. The document suggests things which are fundamentally contrary to core values and must be the subject of robust responses from Colleges, individuals and medical schools.

MOTIONS TO COUNCIL

M/1/2011 Minutes

Resolved: The minutes of the meeting held on 8 December 2010 were approved.

M/2/2011 Deputy Regional Adviser

Resolved: That the following appointment be approved:
Dr K A Eggers, Deputy Regional Adviser for Wales

M/3/2011 College Tutors

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

Anglia
*Dr J J Brown [The Ipswich Hospital]
*Dr A K Gregg [Peterborough & Stamford Hospital]

East Yorkshire
*Dr P S Smith [York District Hospital]
*Dr S W U Husaini [Diana, Princess of Wales Hospital]

West Yorkshire
*Dr M R Beadle [Calderdale Royal Hospital]
*Dr J D Dodman [Pinderfields General Hospital]
*Dr A L Lansbury [Leeds General Infirmary]

Northern Ireland
Dr R O Laird [Altnagelvin Area Hospital]

North Thames Central
*Dr M V Chapman [University College Hospital]
*Dr R Sharma [Royal National Orthopaedic Hospital]
*Dr J Jovaisa [King George's Hospital]

North Thames West
Dr S I Jaggar's [Royal Brompton Hospital] term of office extended to July 2011
Dr J M Lowe [St Mary's Hospital]

Severn
Dr R M Craven [Bristol Royal Infirmary]

South Thames East
Dr D J H Lee's [Queen Mary's Hospital, Sidcup] term of office for a third term

Nottingham and Mid Trent
Dr J R Mole [University Hospital, Nottingham]
Dr C B Gornall [University Hospital, Nottingham]

West Midlands South
Dr L J Tasker [University Hospital, Birmingham]