MEETING OF COUNCIL

Edited Minutes of the meeting held on Wednesday 11 January 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
Dr A A Tomlinson
Dr A B H Lim
Dr R Laishley
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

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, Ms A Regan and Ms S Robinson.

Apologies for absence: Professor J R Sneyd, Dr J D Greaves, Professor D J Rowbotham, Dr S C Patel, Dr M Clancy, Dr M Nevin and Mr R Bryant.

COUNCIL IN DISCUSSION

CID/1/2012 President's Opening Statement

(i) The President announced the death of Dr Terry McMurray. Council stood in memory.

(ii) The President welcomed Ms Steph Robinson, President's Office Secretary. Ms Robinson would familiarise herself with proceedings to enable her to deputise for Ms Regan.

(iii) Congratulations were offered to those relevant to the College who had received recognition in the New Year's Honour List:
   a. Professor Dhinesh Bhugra CBE
   b. Dr Has Joshi MBE
   c. Surgeon Rear Admiral Lionel Jarvis CBE, military division
   d. Lt Col Iain Levack, Queen's Volunteer Reserves Medal
   e. Dame Julie Moore

(iv) The President hoped to attend a meeting of the Education Outcomes Framework Design Group subject to the Council meeting finishing in good time.

(v) Although exchanging communication is important, there had been discussions at previous Away Weekends regarding how Council meetings could be structured to ensure Council business was productive. The President tabled a proposal for future meetings whereby strategy meetings would be held early on in the proceedings, interdigitating with ceremonial sessions. Council in discussion and committee business would be timetabled more flexibly. The President proposed a later start time of 1000 to facilitate travel. The

President was keen to incorporate external strategy discussions with speakers from the General Medical Council (GMC), Workforce Directorate etc; this had however proved difficult to accommodate more than once a year. The President proposed use of the strategy sessions to question committee chairmen about their committees' performance against their aims and objectives as well as offering Council the opportunity to suggest further actions they would like a committee to take. It was acknowledged this would be easier for some committees than others as some are more reactive in nature. The President hoped such sessions would help to set strategic aims for the Royal College of Anaesthetists (RCoA) and facilitate writing the *Annual Report*. It was noted that Mr Storey and the Senior Management Team were working on an overall strategy for the College. Council members were asked to e-mail comments to the President. The President confirmed that the May meeting of Council would take place on the Friday of the Away Weekend.

(vi) Council Members, who had not already done so, were asked to inform Ms Robinson whether or not they would be attending the President's Dinner.

(vii) A comparison of the RCoA's membership database and census figures had shown that 96% of UK practising anaesthetists are members of the RCoA.

(viii) Improvements had been made to the Lecture Theatre; a new lectern with omni-directional microphone, a new carpet and adjustments to the sound system to eliminate feedback.

(ix) The Future Forum had published its report, which Ministers appeared to have accepted. The President offered to take comments or discuss it at a later stage to give Council more time to read it.

(x) The President had received a letter from Lord Falconer regarding the publication of the *Final Report of the Commission on Assisted Dying*; the report is available should Council wish to see it.

(xi) Lord Owen and Dr Hamish Meldrum had each invited the President to discuss the Health and Social Care Bill. In addition there would be a further meeting of representatives from the Academy of Medical Royal Colleges (AoMRC) with the Rt Hon Andy Burnham MP. The Royal College of General Practitioners (RCGP) wished to back the British Medical Association (BMA) and withdraw support for the Bill; most other Colleges however wished to remain apolitical. The RCoA's Members and Fellows had been invited to comment via the RCoA's website; this had generated very little response. The President thought that the RCoA should remain hands-off, simply saying which aspects it was concerned about and which aspects it was content with. The President sought approval from Council members that they supported this approach, particularly as he had been called to give evidence to the Health Select Committee on 24 January 2012. The President asked Council to advise him of any messages to be conveyed apart from those relating to more time and resources for training, wider National Health Service (NHS) work and the regulation of practitioners. Dr Colvin stated that there should be more flexibility to innovate in training. Dr Whitaker added that many of the proposed changes were detrimental to the specialty, e.g. the private sector had not been good at training healthcare professionals and medical training was being put at risk. The President asked Dr Whitaker to send him anaesthesia specific examples; the AoMRC's response had covered Dr Whitaker's point in more general terms. Dr J Nolan added that training of anaesthetists was being affected by the loss of ASA1 and ASA2 procedures. Dr Venn reported that Sir John Tooke had delivered a talk where he stated that he had wondered what doctors are; the boundaries between disciplines are being blown away and professional edges are blurred. In addition, the boundaries between primary and secondary care are too rigid. Dr Venn was interested to know how the boundaries for education would be defined if boundaries between professions and disciplines continued to be lowered. The President explained that this had been addressed to some degree in the Education Outcomes Framework and the Future Forum's report. The Royal College of Physicians of London (RCPLond) in particular was very worried about multi-profession training. Dr Jones stated that boundaries often exist in nomenclature but

the gap between the medical profession and others was as wide as it had always been. Mrs Dalton added that words matter; she had incorrectly assumed that the increasingly used term healthcare workers excluded doctors. Mrs Dalton thought it unacceptable to bundle everyone together in such a term. Dr Venn added that Sir John Tooke had suggested that most medicine could be done on the basis of protocols but doctors are good at assimilating complex situations. Dr Venn questioned whether or not the country required all the expensively trained doctors it has just to cope with infrequently arising complex situations. The President reported that in a recent talk Mr Stephen Whitehead, Chief Executive of the Association of the British Pharmaceutical Industry, had asked to be given more money to develop new drugs. The President planned to write to Mr Whitehead about keeping old drugs on the market and also nationalising drugs which do not make money.

(xii) The President had met with Sir Bruce Keogh and Dr Kathy McLean. Dr McLean is leading transition work to the National Commissioning Board. Sir Bruce wants a small group of paediatricians, anaesthetists, physicians, surgeons and obstetricians to provide help and advice about how to get clinicians involved in the national commissioning process. The President added that it was important for the specialty to be part of the group as it would allow it to try to put into commissioning things that take time for the wider NHS. Sir Bruce and Dr McLean recognised that medics needed to be released for work for the wider NHS; it is not possible however to instruct Foundation Trusts to release them for such activities.

CID/2/2012 Intercollegiate Board for Training in Pre-hospital Emergency Medicine

Council received a report of the meeting held on 14 December 2011; it was noted that Dr J Nolan had attended, not Dr David Lockey as stated on the report. The training route for non-Acute Care Common Stem (ACCS) anaesthetists who wished to undertake training in pre-hospital emergency medicine (PHEM) was discussed. This group of trainees would not have undertaken the six months of training in emergency medicine (EM) which is a prerequisite for training in PHEM; this could result in individuals going out of their way to do out of programme experience (OOPE) in EM. If they were then unsuccessful in their application for PHEM training this would be an inefficient use of time. Mr Craig Williamson is currently looking into this matter.

There was discussion about retrospective recognition of PHEM experience and use of the Certificate of Eligibility for Specialist Registration (CESR) route; there is currently no mechanism for the equivalent of a CESR for a subspecialty. Dr Thornberry reported that the AoMRC had looked at transferable competencies; if the GMC approved the document it should cover such a situation. It was noted that a mechanism existed for subspecialty recognition for entry onto the Specialist Register if the training had been undertaken, and the application made, from outside the UK. Professor Bion added that it was possible for a doctor to obtain sign-off that they had completed the required competencies; Dr Thornberry added that the latest transferable competencies document defined how to recognise who can authorise what. The President asked Dr Thornberry to send the latest draft to Dr J Nolan.

Dr van Besouw asked how the proposals for PHEM training posts had been derived as being suitable for the health service. Dr J Nolan responded that figures were the number on offer for 2012 and onwards; it is thought that 250 posts are required. It was noted that the military is the number one supplier of training posts. Dr Jones enquired whether the figures applied UK-wide. The President responded that if it was RCoA subspecialty training then the figures would be UK-wide. Dr Colvin reported that the Specialty Training Board in Scotland would discuss how to achieve some posts over the next few months. Drs Jones and Darling agreed to check what is happening in Wales and Northern Ireland respectively.

CID/3/2012 Revalidation

Council received the RCoA's response to the GMC's review of continuing professional development (CPD) consultation. Dr Brennan explained that the main concern was the general lack of quality on quantitative and qualitative aspects of CPD that a doctor should undertake in the draft guidance from the GMC. The responsibility of employers with regards to Supporting Professional Activity (SPA) time required for revalidation and CPD had also not been made explicit and would disadvantage those who found it difficult to secure SPAs. The RCoA was supportive of those aspects of the guidance placing an emphasis on team working and reflection on CPD. The President thanked Dr Brennan for a robust response. Dr Whitaker highlighted the importance of distinguishing between CPD for revalidation and CPD for excellence. The GMC is responsible for medical education from cradle to grave and should ensure there is opportunity for plenty of CPD. Dr Whitaker added that trusts need to provide resources such as office space, secretarial support etc.

Council received the RCoA's response to the GMC's consultation on the *Licence to Practise and Revalidation Regulations 2012*. There was concern that consistency had not been recognised as a principle in shaping the development and implementation of the regulations; if they were not consistently applied some groups and individuals would be disadvantaged. With regards to withdrawing a licence to practise where a doctor has failed to co-operate with the revalidation process there was concern that there was too much subjectivity which could lead to inconsistency in decision making. The RCoA's response agreed with the concept of failure to co-operate but the regulations lacked specific criteria that make it clear when and where people would be in danger of falling foul of those rules. There is an arbitrary five year cut-off where doctors may be required to revalidate in order to re-attain a licence if they had been out of practice; in anaesthesia there are examples of doctors who felt that they required a return to work programme having been out of practice for one year. Another concern was the regulations' failure to address the issue of locum doctors who undertake short locum posts from time to time and who have caused the public much concern. The fact that such doctors would not be required to revalidate was a major shortcoming of the regulations. Several groups may be disadvantaged including staff and associate specialist (SAS) grades who may not have appropriate SPAs to meet the needs of revalidation, locums who cannot have an appraisal, carry out audits or obtain study leave, doctors working in hospitals with weak governance systems and those working in a voluntary capacity, e.g. at sporting events. The RCoA had commented that additional organisations performing the functions of a responsible officer in evaluating doctors' fitness to practise should have to meet the same governance requirements as those working elsewhere in the UK health system. Particular concern was expressed about those organisations which may charge a fee for the provision of revalidation support. The President thanked Dr Brennan for a very comprehensive and robust response. Dr van Besouw enquired about the impact of devolved health services in the interpretation of how rules might be enforced at political strategic level. Dr Tomlinson pointed out that retired doctors who undertake voluntary work on mountain rescue teams or motorsport should be demonstrating that they are doing something to keep up to date. Dr J Nolan suggested that there should be an individualised package. Dr Brennan pointed out that the bottom line was that such individuals would require a clinical licence to practise; this should not be so onerous that perfectly competent doctors are lost because of the need to revalidate. Dr van Besouw asked who would determine if someone was suitably trained for such activities, adding that the lack of a benchmark left it open to interpretation. Dr Lim reported that the RAC and Motorsports Association oversee this in motorsport. The other issue was if it was stated that doctors have to revalidate in a particular specialty; there is no particular requirement for a particular sport. Dr Batchelor added that there would be interesting things for the College to deal with in the future as retirement age increases; inevitably people's competence will decline.

CID/4/2012 Replacement FRCA Certificate

Council agreed to a request from Dr Jagat Mohan Singh Aulakh for the replacement of his FRCA Certificate.

COMMITTEE BUSINESS

CB/1/2012 Council Minutes

The minutes of the meeting held on 14 December 2011 were approved subject to the following amendments:

CID/58/2011 Faculty of Intensive Care Medicine (FICM) – 3rd paragraph, line 4 Membership of the FICM to be replaced with Fellowship of the FICM.

CID/61/2011 Review of Physicians' Assistant (Anaesthesia) Practice 2nd paragraph, line 10 'Dr Batchelor added that she would find it alarming……' to be reworded 'Dr Batchelor added that she would find it alarming if a specialist organisation opposed to PA(A)s should take a line from the document and use this as justification for stating that PA(A)s could never perform certain tasks.'

5th paragraph, final line, 'PA(A)s' to be replaced with 'practitioners such as PA(A) or ACCP's.'

Dr Whitaker asked that another paragraph be added; he had said that '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.'

The President reminded Council to feedback comments when the minutes are initially circulated.

CB/2/2012 Matters Arising

i. Review of Action Points

CID/58/2011 Faculty of Intensive Care Medicine Professor Bion reported that day time sessions have the following characteristics; duties include the care of Level 3 critically ill patients; no concurrent duties for other specialties; contracted sessions or professional activities (PAs) are reimbursed at premium rate. Dr Whitaker was dissatisfied with aspects of the definition. The President asked Dr Whitaker to review the application form on the website and discuss any concerns with Mr Daniel Waeland.

CID/62/2011 Royal College of Anaesthetists and College of Emergency Medicine Working Party on Sedation, Anaesthesia and Airway Management in the Emergency Department The President informed Council that very few changes had been reported; it was hoped the work would be completed very shortly.

CB/171/2011 Matters Arising Dr Brennan had not received the GMC notice from Professor Sneyd.

ii. CID/61/2011 Review of Physicians' Assistant (Anaesthesia) Practice

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/3/2012 Regional Advisers
There were no appointments or re-appointments this month.

CB/4/2012 Deputy Regional Advisers
There were no appointments or re-appointments this month.

CB/5/2012 College Tutors
Council considered making the following appointments/re-appointments (re-appointments marked with an asterisk):

North Thames Central
Dr C A Shaw (Whittington Hospital) in succession to Dr M E Dunston **Agreed**

North West
Dr N P A Greenwood (Trafford General Hospital) in succession to Dr R T Longbottom **Agreed**
*Dr G D Briggs (South Manchester University Hospitals NHS Trust) **Agreed**

Wessex
Dr A J Thompson (Jersey General Hospital) in succession to Dr C R Taylor **Agreed**

KSS
Dr G D Wearne (Queen Victoria Hospital) in succession to Dr C Patel **Agreed**

Leicester & South Trent
*Dr P M Davies (Northampton General Hospital) **Agreed**

West Midlands North
*Dr M Bieker (Birmingham Heartlands Hospital) **Agreed**
*Dr B Murali (North Staffordshire Hospital) **Agreed**

CB/6/2012 Heads of Schools
There were no appointments for Council to note.

CB/7/2012 Training Committee

(i) Medical Secretary's Update
Dr D Nolan had succeeded Dr Thornberry as Medical Secretary with effect from 1 January 2012. Dr D Nolan thanked Dr Thornberry for her hard work in the role.

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

Anglia
Dr Joanna Rachel Homer
Dr Jasmine Kaur
Dr Nicholas Michael Saunders
Dr Radha Arvind Pagedar
Dr Pallab Rudra

Dr Karim Nader Shoukrey
Dr Katherine Joanne Rowe *
Dr Agilan Chennimalai Gounder Kaliappan *
Dr Shilpa Rahul Sawant
Dr Kate Elizabeth Bush
Dr Shobhana Chhetri

London

North Central
Dr Mohammed Abdulrazaq Abdulwahab Al-Alousi
Dr Ammar Naser

St. George's
Dr Kate Ashleigh Sherrington *

Imperial
Dr Ami Kotecha
Dr Paul Inder Bhalla
Dr Jeremy Anthony Hugh Boyle
Dr Benjamin James Graham
Dr Khalil Ahmed
Dr Nick Barnett *
Dr Roger Cowdy Bloomer

Bart's & The London
Dr Shibaji Saha *
Dr Monica Naik
Dr Elaine Dorothy Maria De Silva

South East
Dr Shamim Ahmad Sarfi

East Midlands

Leicester
Dr Gary Kar-Li Lau

Mersey
Dr Catherine Mary Glennon
Dr Darshan Pathak

North West
Dr Kaushal Kishor Mishra
Dr Jan Markus Lutz
Dr Kathryn Elizabeth Sarah Dalgleish
Dr Emily Shardlow *
Dr Sofia Khan

Northern
Dr Miriam Rosa Baruch *
Dr Michael David Blundell
Dr Catherine Rafi
Dr Sean Patrick Cope
Dr Una McNelis
Dr Lewis Paul Schofield
Dr Daniel Morland
Dr Andrews David Babu
Dr Sameer Kannoth Somanath
Dr Brett Pearce
Dr Daniel Polakovic
Dr Peter Hersey *

Northern Ireland
Dr Adrian Gerard Donnelly *
Dr Barbara Elizabeth Macafee

Oxford
Dr Hanna Margareta Chin
Dr Jonathan Barry Mason

Severn/Bristol
Dr Catherina Johanna Mattheus
Dr Daniel Freshwater-Turner*
Dr Katy Konrad
Dr Stephen Tolchard

Tri-Services
Dr Matthew Timothy Davies *

Wales
Dr Richard Mark Knights
Dr Timothy James Bramma Wood
Dr Helen Louise Jewitt
Dr Eloise Sally Dawe *
Dr Karikurve Ashwina Rao
Dr Huda Al-Foudri
Dr Teresa Ann Evans *

Wessex
Dr Sharon Ann Avery
Dr Mohamed El Toukhy
Dr Heather Murray
Dr Richard Andrew Jee *
Dr Katherine McCombe
Dr Roy Amit Kukreja

Dr Dumitru Stefan Radauceanu

West Midlands
Birmingham
Dr Oliver Masters
Dr Catherine Makura
Dr Robbie Jack Kerry
Dr William Edward Rea

Scotland
East Scotland
Dr John Charles Bonner

North Scotland
Dr Anoop Kumar

West Scotland
Dr Theresa Marie McGrattan
Dr Myles John Alexander Cassidy
Dr Angela Jane Baker
Dr Michael Brett *
Dr Daniel Holmes *

South East Scotland
Dr Kevin Soutar
Dr Iain James McCullagh *

Yorkshire
West Yorkshire (Leeds/Bradford)
Dr William Peat

East Yorkshire (Hull/York)
Dr Julian Alastair Hood

South Yorkshire (Sheffield)
Dr Richard Porter *
Dr Kiron Chakrabarti *
Dr Richard James Dobson *
Dr Janet Owen
Dr Stephen James Rowe

CB/8/2012 Royal College of Anaesthetists' Advisory Board for Scotland

Council received and considered the minutes of the meeting held on 29 November 2011 which were presented by the Chairman, Dr Colvin. Dr Colvin thanked Dr van Besouw and Mr Storey for attending the meeting. The Board had identified a need to strengthen information regarding retirement projections for the future in order to inform dialogue with the Scottish Government.

Ongoing engagement with the Scottish Reshaping the Medical Workforce initiative had been helpful over the summer. The initiative had now recognised that core numbers within the specialty should be managed and driven by specialty training leads. Boards have moved away from promoting the sub-consultant post-CCT expansion and there was a move away from midpoint credentialing. The Board welcomed the acknowledgement that notice must be taken of attrition rates. The primary driver for setting training numbers should be based on future requirements rather than overall establishment. There would be an excess of CCT production, probably 24 or 25 posts. It had been acknowledged that there was a need to increase the number at core training level to meet the future needs of specialty training level. 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. A solution had not been devised and the Board continues to watch the situation closely.

The Board welcomed support from the Scottish Chief Medical Officer (CMO) on supporting clinical engagement. The President hoped that there would be progress on this matter as it had not previously progressed as anticipated.

Dr Ken Stewart had agreed to lead the development of a communication strategy.

The President enquired how maintaining CT1 numbers in Scotland would link with the Centre for Workforce Intelligence's (CfWI) plan to reduce core training numbers overall. Dr Colvin responded that in the last two years Scotland had not managed to recruit a full ST3 cohort; there was powerful information that levels of attrition between CT1 and ST3 remained high. CT numbers are

based on creating a sufficient field for ST3 posts. The President pointed out that a lot of CCTs were being produced but consultant expansion was not taking place at the same rate. Dr Colvin explained the formula for modelling in Scotland; the President agreed with it but explained that it must be linked into the national picture. Dr van Besouw asked what percentage of CT1 applicants were from Scotland and how many were external; Dr Colvin agreed to find out. Dr van Besouw added that his impression was that people applied within geographical areas. Dr Jones informed Council that of the 350 graduates entering foundation training in Wales the Dean was looking to move up to 70 into community, psychiatry and primary care jobs; this would be to the detriment of anaesthesia. The President responded that there was a move to get 7.5% of foundation trainees into psychiatry; mental health trusts will not take an F1 in psychiatry without the full salary, which comes from losing two other posts. Dr Jones added that the GMC stated that foundation doctors have to be supervised by a middle grade; some hospitals do not have a middle grade in the same specialty which leads to inappropriate supervision arrangements.

CB/9/2012 Equivalence Committee

Council received and considered the minutes of the electronic meeting held on 15 December 2011 which were presented by Dr Verma. Two applications were considered; one review and one first application. Both were recommended for the Specialist Register.

CB/10/2012 Patient Liaison Group

Council received and considered the minutes of the meeting held on 13 December 2011 which were presented by the Chairman, Mrs Dalton. Mrs Dalton explained that the slight change in the meeting pattern was not intended to exclude anaesthetic members of the Patient Liaison Group (PLG). The informal meeting of lay members before the formal meeting would be used to discuss strategic issues which can be difficult to accommodate in the formal meeting.

Mr Antony Chuter, Lay Chairman of the RCGP Patient Partnership Group (PPG), had attended the meeting. A short life working party between the PPG and PLG would be convened to explore ways of promoting access to patient information on anaesthesia to the public through work with GPs.

Mrs Dalton would observe the first cycle of the FICM examinations in November 2012.

Mrs Dalton wished to record the PLG's thanks to Mr David Weatherill for his work on the website and *Audit Recipe Book*. Dr Colvin also wished to thank Mr Weatherill for his support on the *Audit Recipe Book*.

A new member of the PLG, Mr Jason Bartlett, had been appointed subject to references.

CB/11/2012 Joint Committee on Good Practice

Council received and considered the minutes of the meeting held on 24 November 2011 which were presented by the President. The Committee had discussed the National Patient Safety Agency's (NPSA) neuraxial connectors alert. A letter had been sent to the CMO and Medical Director of the NHS.

Dr Brennan would bring the remediation report to the next meeting of Council. There would be an AoMRC Working Party to respond and Dr Rollin had expressed an interest in representing the RCoA. A meeting with the National Clinical Assessment Service (NCAS) to discuss how the RCoA may consider using assessment tools would be rescheduled. Mr McLaughlan reported that Edgecombe had offered to organise a one day reviewer e-learning event but there would inevitably be a cost involved. Consideration has been given regarding how to train those involved

in remediation; this may be a solution shared across Colleges to ensure people are trained in a similar way to a similar standard.

Changes to the function of the Committee are progressing slowly.

The President remained keen to ensure that Colleges, Associations and Societies shared common usage of words such as badging, endorsement and support. Dr Hartle continued to work on a paper addressing the matter.

Professor Pauline McAvoy would represent NCAS on the Committee following Professor Alastair Scotland's retirement.

Dr Hartle would take forward the out of hours operating as an AAGBI glossy. Dr Rollin would be a member of the Working Party.

The *Good Practice Guide* rewrite was being taking forward by Dr Thornberry and Dr Les Gemmell.

The Group of Anaesthetists in Training (GAT) had raised issues about the inconsistencies of funding for trainee study leave and the application of study leave budgets. GAT had been asked to produce a paper showing the variability between deaneries.

CB/12/12 Trainees' Committee

Council received and considered the minutes of the meeting held on 3 November 2011 which were presented by the Chairman, Dr Moonesinghe. The first edition of the *Trainee Newsletter* had been published and would be published on a three monthly basis. Since its publication positive feedback had been received although problems had been highlighted with distribution.

The Committee had discussed getting anaesthesia more involved with provision of educational material for undergraduates. Ms Drake reported that e-Learning for Health (eLfH) was allowing undergraduates, through medical schools, to access all its programmes. Dr Andrew McIndoe had produced a pathway from which undergraduates in Bristol can benefit; this could perhaps be advertised to medical schools.

The Committee had discussed co-operation with GAT on fact-finding regarding the variation in regional study leave allowances. The President asked how regional variability would be reported back. Dr Moonesinghe responded that GAT would ask each school what their study leave allowance is.

A brief job description and training package were being compiled in response to increasing calls for trainee representatives on quality visits to trusts.

Dr van Besouw stated the importance of encouraging medical schools to access e-Learning Anaesthesia (e-LA); it was a good way of encouraging people into anaesthesia. In particular the RCoA should push the basic science components of the first tranche of e-LA as they are not being taught particularly well in many schools. Professor Bion cautioned that medical schools can be tricky to work with; it was however a great opportunity which the RCoA should seize. The President added that he was keen to look after undergraduates; it would be good for the academic future of the specialty. Ms Drake had only just heard the news from eLfH; the next step would be to plan how to reach medical schools. Ms Drake added that any advice regarding who to approach and suitable mechanisms would be helpful. Dr Jones suggested that it should be formally recognised by the heads of medical schools. Dr Moonesinghe pointed out that there was potentially a lot of work to roll out e-learning in a way not deemed threatening by medical schools and suggested a

small Working Party be convened. Dr Marks stated that the question of how the RCoA recruited to and promoted the specialty was very important and queried whether medical school was the place to do it, suggesting instead that the target group should be foundation trainees; this already takes place to some extent with the career in anaesthesia day. The President disagreed stating that six weeks in anaesthesia was an excellent way for students to understand they would be taught and guided should they chose the specialty.

Professor Bion emphasised the importance of focussing on undergraduates. Dr Jones stated that it was just as important to get anaesthesia, critical care and pain medicine involved in the undergraduate curriculum; this would increase exposure to undergraduates. Dr Brennan stated that Cambridge has a perioperative medicine module in its final year; it is the best rated whereas anaesthesia used to be poorly rated seven years ago. Dr Moonesinghe suggested that she along with Dr James Dawson, Ms Drake and Dr McIndoe meet with a university representative to take this forward. The President stated that this would link with the profile of, and the future as, anaesthetists as perioperative physicians. Professor Mahajan reported that the database of curricula was five years old and would need to be started again as universities have changed the way they deliver training. Dr van Besouw pointed out the uncertainty amongst undergraduates regarding core medical training and core surgical training thus meaning they were keen to explore other options; the RCoA should make the most of this. Dr Wilson pointed out that much would depend on the specialty continuing to have a good career structure at the top end. The President stated that the point had been made to the CfWI that if the rewards of becoming a professional consultant were removed then the brightest individuals would not enter the specialty; this would filter down to sixth formers who in turn would move away from studying medicine. The President suggested that formal links with anaesthesia societies in medical schools were required. The President enquired whether there were any plans to update the document written by Professor Gary Smith, on behalf of the Intensive Care Society (ICS), for medical students undertaking placements on intensive care units. Professor Bion was unsure but stated that it was something he would be keen to develop. The President remarked that the ICS had sold the specialty well with the document and asked if there was anything similar for an anaesthesia placement, adding that one should be produced. Dr Clutton-Brock and Professor Bion agreed to take this forward.

The President asked Dr Moonesinghe if trainees were expected to unsubscribe from the newsletter. Dr Moonesinghe responded that the option to unsubscribe did not exist. Dr Moonesinghe suggested that the newsletter could be circulated as a flyer in the *Bulletin*. It was noted that this would incur a cost and flyers had not previously been used. There was also the issue of time sensitivity. Dr Thornberry suggested a flyer could be used as an example of what was available and as a means of encouraging trainees to update their e-mail address to ensure they receive it.

MATTERS FOR INFORMATION

I/1/2012 Publications

Council received, for information, the list of publications received in the President's Office. Dr Rollin reported that *Advanced Conscious Sedation Techniques for Paediatric Dental Patients: a training syllabus* contained very little about quality assurance, assessment and regulation. The President asked Dr Rollin to update Council on the new Sedation in Dentistry Working Group. The intercollegiate Working Group, chaired by Professor Richard Ibbetson, would look at existing material, assess it and write standards and possibly a curriculum for the most basic techniques up to advanced techniques. The group would design a spectrum of dental sedation and the idea was to set up networks so patients can be referred on in a seamless way. The President reminded Council that Professor Sneyd was leading the work to rewrite the AoMRC's sedation document.

I/2/2012 Consultations

Council received, for information, a list of the current consultations. The President exhorted Council members to contribute to consultations. Mr McLaughlan thanked those who had commented on the GMC's consultation on the new draft of *Good Medical Practice*. The President added that the AoMRC was calling for draft comments by the beginning of February; early comments should therefore be sent to Mr McLaughlan.

Dr van Besouw asked how much feedback the RCoA received from organisations whose consultations it responds to. Mr McLaughlan responded that it varies from no acknowledgement to an expression of thanks to a request for further engagement if required. Only one organisation had made a direct approach seeking the RCoA's approval of the revised document which incorporated the RCoA's comments. The President pointed out that the RCoA does not respond to every consultation. Dr Thornberry asked what happened when the RCoA provided feedback which was subsequently ignored. The President replied that in such instances the RCoA should state it wished to take the matter further. Professor Bion suggested that whether the RCoA's views are taken into account should be part of an audit; he would like to see feedback about whether work undertaken as part of the consultation process had an impact on the final document. The President asked whether it would be reasonable to ask those who contributed to check back through the documentation. Mr McLaughlan stated that it would be possible where advice was sought by government or various fora and the end result is a document. Mr McLaughlan pointed out that documents are frequently published with a list of organisations which had been consulted without specifying which had actively contributed to the document. The President added that he would be keen for Dr Brennan to look through the documents produced as a result of the GMC consultations discussed earlier in the meeting to ascertain areas the RCoA did influence. Mr McLaughlan pointed out that this may lead to even fewer contributors to consultations. Dr Whitaker suggested that the RCoA should put the onus on the consulting organisation and include a paragraph in its responses asking to be informed of any changes which occurred as a result of the RCoA's views. Dr Marks asked how a College response was compiled when the consultation relates to a contentious matter, such as assisted dying, where there may be strong opposing views amongst those responding. Mr McLaughlan responded that on the rare occasions it happens the response is taken to the President's Meeting for final approval. Mr McLaughlan explained that there have also been consultations with responses from three different perspectives such as professional, lay and specialty, all endorsed by the RCoA. Dr Jones expressed his concern that the Welsh Government would seek opinion on maternity services in Wales but totally ignore it; the RCoA should be more proactive in contacting the CMO and Chief Executive of the NHS for each country. There should be a vociferous response if it involved patient care or safety and the RCoA thought it was being ignored. The President agreed and said consideration would have to be given regarding how to deal with it; should the documents, for example, be brought back to Council? Dr Thornberry stated that when the Welsh Government had ignored the RCoA's feedback she had contacted the Lead Midwife for Wales who had assured her by e-mail that anaesthesia and critical care in maternity had not been ignored and a sub-group had been set up to specifically deal with it. The RCoA had been proactive, had been reassured and this was the outcome of the reassurance. Dr Thornberry agreed to find out what the Royal College of Obstetricians and Gynaecologists (RCOG) was doing about the matter. Mrs Dalton stated that politicians like to consult; the trouble is that, having been consulted, people would imagine that an organisation had consented as well. Mrs Dalton recommended that this issue should come to Council as a serious debate to discuss how it could be tackled. Consultation is not negotiation. Consultation would go into a single organisation like the RCoA but the Government likes volume, i.e. individual responses. The President accepted the volume argument but stated that there was a need for a unified view. Dr Venn pointed out that there was nothing more demoralising than an avalanche of verbose, badly written consultations of which no-one takes notice to the response. The RCoA should be driving

the opinions; if asked for its opinion it should release a press statement too. Dr Venn asked what progress was being made towards appointing a press officer; this would be core to the RCoA's strategy over the next few years. The President responded that he would not wish to flood the market with press statements but having a position statement on a number of issues was the way he would wish to go forward. Mr McLaughlan reported that the matter had been discussed by the Communications Committee; the RCoA is considering three or four people it could retain for this function. Dr van Besouw pointed out that every piece of information in the assisted dying report was credited to those who raised it. Dr Jones stated that on certain issues there were very few professionals who would argue against what the RCoA was supporting and there may be a time when politicians start to listen. If the RCoA felt so strongly about an issue that patient safety and standards were being ignored then it may be worth issuing a press statement although it should be selective.

I/3/2012 New Associate Fellows, Members & Associate Members

Council noted, for information, the following:

Associate Fellows – November 2011

Dr Ralph Zumpe – St George's Hospital, Tooting.

Associate Members – December 2011

Dr Rajagopal Jeganathan – Southampton General Hospital
Dr Haidar Al-Tahan – Medway NHS Foundation Trust

To receive for information, the following doctors have been put on the Voluntary Register– November 2011

Dr Magdalena Cerna – Derby Hospital
Dr Mugurel Catalin Dumbrava – Lincoln County Hospital
Dr Kate Wilkinson – Royal Blackburn Hospital

I/4/2012 Tenth Anniversary of the Health Informatics Unit

Council received, for information, Dr Verma's report of the meeting held on 15 September 2011.

I/5/2012 National Leadership Academy Reference Group

Council received, for information, a summary of a meeting attended by Dr Nevin on 14 December 2011.

PRESIDENT'S CLOSING STATEMENT

PCS/1/2012 President's Closing Statement

(i) Noting the early finish, the President hoped that it could be attributed to the fact it was January. The President added that although Council members needed to know what was going on in every area of the College, Council does set strategy for committees and streams of work. Any areas Council members wished to see developed could be discussed as a strategy or discussion item. The new system would enable direct access to heads of committees to develop strategy on Council's behalf.

MOTIONS TO COUNCIL

M/1/2012 Council Minutes
Resolved: That the minutes of the meeting held on 14 December 2011 be approved with the following amendments:

CID/58/2011 Faculty of Intensive Care Medicine (FICM) – 3rd paragraph, line 4 Membership of the FICM to be replaced with Fellowship of the FICM.

CID/61/2011 Review of Physicians' Assistant (Anaesthesia) Practice 2nd paragraph, line 10 'Dr Batchelor added that she would find it alarming……' to be reworded 'Dr Batchelor added that she would find it alarming if a specialist organisation opposed to PA(A)s should take a line from the document and use this as justification for stating that PA(A)s could never perform certain tasks.'

5th paragraph, final line, 'PA(A)s' to be replaced with 'practitioners such as PA(A) or ACCP's.'

Addition of the paragraph 'Dr Whitaker stated that 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.'

M/2/2012 College Tutors
Resolved: That the following appointments be approved:
North Thames Central
Dr C A Shaw (Whittington Hospital) in succession to Dr M E Dunston

North West
Dr N P A Greenwood (Trafford General Hospital) in succession to Dr R T Longbottom
*Dr G D Briggs (South Manchester University Hospitals NHS Trust)

Wessex
Dr A J Thompson (Jersey General Hospital) in succession to Dr C R Taylor

KSS
Dr G D Wearne (Queen Victoria Hospital) in succession to Dr C Patel

Leicester & South Trent
*Dr P M Davies (Northampton General Hospital)

West Midlands North
*Dr M Bieker (Birmingham Heartlands Hospital)
*Dr B Murali (North Staffordshire Hospital)