MEETING OF COUNCIL

Edited Minutes of the meeting held on Wednesday 20 July 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 H M Jones
Professor J F Bion
Dr E A Thornberry
Dr P J Venn
Dr A M Batchelor
Professor J R Sneyd
Dr S R Moonesinghe
Dr D K Whitaker
Dr D M Nolan
Dr R Verma
Dr R J Marks
Dr T H Clutton-Brock
Dr L J Brennan
Dr J R Colvin
Dr I H Wilson
Dr M Nevin

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

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

Apologies for absence: Apologies were received from Dr R Laishley, Professor D J Rowbotham, Professor Ravi Mahajan, Dr S C Patel, Dr J P Nolan, Dr J R Darling and Dr J Heyworth.

COUNCIL IN DISCUSSION

CID/33/2011 President's Opening Statement

(i) The President announced the deaths of Dr Sydney Alstadt, Dr Audrey Peeling, Dr Donald Barran and Dr Pete Mackenzie. Council stood in memory. Professor Rowbotham will pay tribute to Dr Mackenzie's contribution to pain medicine at the September Council meeting.

(ii) The President and Council welcomed Mrs Dalton, Chairman of the Patient Liaison Group (PLG), to Council.

(iii) Professor Terence Stephenson has been tasked with moving the Academy of Medical Royal Colleges' (AoMRC) Staff and Associate Specialist (SAS) Committee forward. The President thanked Professor Sneyd for his work, particularly with the British Medical Association (BMA), following the AAGBI's survey of SAS grades.

(iv) The President has been asked to chair an AoMRC short-life working party to review the problems regarding brainstem death. Professor Bion explained that in the last eight months there have been two publications containing three case reports of patients who met the criteria for brainstem death but had then initially recovered some brainstem function; however, none regained consciousness and all died soon after. There are potentially many confounding factors but this does raise the possibility that clinical diagnosis of brainstem death based on clinical tests of brainstem function could be unsound; it has been proposed that the AoMRC revisits its document on the diagnosis of death in the light of these cases. The President stated that the working party will have to look in detail at the cases and correspondence relating to them before deciding whether or not changes are required. Professor Bion agreed to circulate the publications to Council.

(v) It has been proposed recently that the AoMRC could lead on safety issues. Mr McLaughlan explained that some Colleges have been asking what will happen to patient safety at a nationwide level when the National Patient Safety Agency (NPSA) is abolished in 2012. Professor Sneyd expressed mixed feelings; he is pleased safety is not being abandoned but the proposal would remove the responsibility of the Department of Health (DH) and the state to pay for it. Professor Sneyd added that it would be wrong to convey the message that the Colleges will pick up the pieces when an important quango is abolished. Mr McLaughlan explained that there is a move to give the National Health Service (NHS) Commissioning Board a specific remit for patient safety; this is likely to be data gathering rather than looking at clinical safety. The President stated that one of the members of the AoMRC's committee could be from the DH. Professor Bion pointed out that this presents an important opportunity for professional leadership and engagement in this area. The President added that it would also offer continuity. Mrs Dalton agreed that professional leadership in this area would be important. Dr Clutton-Brock stated that it should be made clear which aspects of safety are the Colleges' responsibility. Dr van Besouw asked who would effect change. Dr Wilson thought a strong professional voice would be very useful but cautioned against involvement in something with no resource and no strength to put things in place. The President explained that the matter had been discussed at the AoMRC and clarification will be sought from Professor Dame Sally Davies. Dr Marks highlighted that a multidisciplinary approach is essential for the committee to be accepted and change implemented. The President and Mr McLaughlan will begin work on the proposal.

(vi) Her Royal Highness the Princess Royal has accepted an invitation to attend the Patient Safety Conference on 3 October 2011. Council members wishing to attend should inform Miss Odette Lester.

(vii) The President sought agenda items for the Joint Committee on Good Practice (JCGP) which meets next week.

(viii) The President updated Council on staffing matters:

a. Mrs Jennifer Tatman-Gray has left the RCoA as Mrs Katya Boyd has returned from maternity leave.
b. Mr Saul Perryman has joined the RCoA on a permanent and full-time basis as the new Examinations Administration Assistant.

CID/34/2011 Council Workload

The President reminded Council that in May 2009, when the election of President and Vice-Presidents was changed to facilitate handover in September, the committee handover date was changed from September to January. Getting Council members to take responsibility for some committees, maintaining attendance and rotating individuals to allow broad exposure to College activities is proving problematic. Dr Greaves stated that the whole nature of Council has changed during his term of office; there is less authority vested in Council members which leads to a sense of frustration which is probably greater amongst senior members. An indicator of this has been the number of people who have left recently without serving two terms. Whilst acknowledging that many had other reasons to leave, Dr Greaves pointed out that it becomes tiring discussing the same items throughout one's term on Council. Individuals leaving early results in the loss of senior medical politicians and leaves Council rather junior. Dr Greaves added that one of the striking things is how short Council meetings are now. Dr Greaves acknowledged that whilst Council meetings are run more efficiently, Council members are less involved with the business of the College; less is brought to them and more of the meeting is given to receiving Committee minutes. There has been a change in the way work is done; more is done by the Directors and Directorates, and the President and Vice-Presidents at the weekly President's Meeting. The President thanked Dr Greaves for his thought provoking comments.

The President spoke in defence of those who had left Council early citing difficulties with pensions, hospital workload and lack of promotion within the College. The President stated that it is possible to extend meetings by as long as Council wishes, although one of the reasons for shortening them was to avoid circular debate. Dr Jones suggested it may be better to change the two terms to eight and two years; individuals would have to actively resign rather than deciding after six years that they may not wish to stand for a second term.

The President asked how much responsibility Council should take for day to day matters. The Medical Secretary, regarded as a rewarding role, takes a lot of responsibility for training matters. However much of what comes into the College goes through the directorate structure; the President considers this a strength. Professor Bion expressed his satisfaction with the current arrangement adding that solutions should be brought to Council. Professor Bion stated that the College is run with considerable efficiency and he would not wish to change that. Professor Bion suggested that the College should ensure that it engaged as effectively as possible with the Fellows and trainees so that they could feed into ideas and strategy. Professor Bion felt that workload distribution for Council members should be equitable. The President stated that he is aware that some Council members appear to have a very large workload compared to others.

Dr Batchelor explained that Council is quite often distanced from the concerns the College is addressing at the time; many topics discussed at the President's Meeting do not filter through, although Dr Batchelor acknowledged that many issues require a fast response. The summaries of topics discussed at the President's Meeting are useful but Council members have not been invited to join by teleconference or videoconference recently. Dr Batchelor added that the meetings do not take place at a regular time and day which makes it difficult to plan attendance. The President responded that President's Meetings usually take place on Tuesday from 1000-1200 unless other commitments necessitate a change. The President explained that there is a standing invitation for Council to attend in person or remotely and suggested that date changes could be circulated to Council.

Mr Storey asked how the RCoA's work differed now to when it was a smaller College; there is probably a lot of work it does now but it has chosen the efficiency route to get work done without considering the loss of Council members' interest. Mr Storey asked whether the College should have more roles like that of Medical Secretary. The President pointed out that there is no doubt that the RCoA circulates in AoMRC and DH circles more than it did nine years ago.

Professor Sneyd stated that Council should make decisions rather than micromanage the College. There is increasing pressure from trusts regarding clinical time; the only way to respond to this is by not doing some work or by more efficient use of time and space, e.g. not bringing people to London unless essential, use of videoconferencing etc. The President responded that he will seriously have to look at the number of committees.

Dr Tomlinson expressed concern about the apparent inequity of work that is done. He stated that it is a great privilege to be elected to Council and whilst everyone has different interests which need to be harnessed, individuals will need to be challenged; Council members may be asked to do things they do not want to do but should take them on. It should be made clear that members should expect to chair at least one committee after two to four years on Council. There should also be a much clearer account of the time people spend on committees; not just attendance but dealing with associated tasks such as e-mails. Dr Tomlinson stated that Medical Secretary is an enjoyable role but involves a huge amount of work. Dr Tomlinson agreed with Dr Greaves' point about the inability to feel one has made a change. Dr Tomlinson explained that one of the reasons he will not be standing for a second term is that, in view of his age, he does not feel somebody senior should be making decisions that they will not have to work with.

Dr Marks pointed out that there are meetings where discussions are held and nothing happens, and those where decisions made. The RCoA needs to look at where decisions are made, who is capable of making them, and to whom must they be taken; should committee chairmen, or others in the organisation, be capable of setting College policy or should all policy decisions come through Council.

Dr Greaves explained that his comments were in no way critical of the efficient way the College is run. Dr Greaves stated that when he was elected to Council, Council members undertook College visits and Advisory Appointments Committees (AAC) were almost exclusively attended by Council and Regional Advisers; that sort of thing has gone and Council members are not respected in the regions in the way they were some years ago which is a reason why people feel that they are not really making a difference.

Dr Greaves pointed out the lack of College office space for Council members; this is very important especially for new members. The President responded that he had discussed this with Mr Storey and there are plans afoot.

Dr Thornberry suggested that many Council members do not stand for a second term because they reach retirement; should it be flagged up that people should consider standing for Council earlier in their career? Dr Brennan pointed out the difficulty in encouraging people to stand at an earlier age because of the simple problems of developing their own career. Dr Moonesinghe stated that she would not consider standing for election as a consultant member for a good few years; experience is required to sit on Council and it also would not be popular with her trust. Dr Lim cautioned against encouraging consultants to stand for Council early in their career and explained that his first four years were a very steep learning curve; he had never done anything for Council before or been a member of a committee. Young consultants would have the same problems but on a greater scale as the demands placed upon consultant members would be higher than those placed on SAS doctors. Dr Lim added that older wiser heads are required on Council. The President suggested that a consultant in their early to mid 50s standing for an eight year term would be about right.

Dr Brennan stated that there is an urgent need to look at the workload issue; work is not always equally distributed. There are increasing external pressures and there has been an increase in the work generated within the RCoA which has come from external agencies. Work needs to be streamlined more. It should be made explicit in communications to prospective Council members that Council members should expect to chair a committee within three or four years of election to Council. Dr Moonesinghe pointed out that some of the inequity of workload among Council members is because they cannot be released from their trusts for College duties. Dr Moonesinghe added that she would be against the RCoA providing financial compensation to trusts for the work Council members do. The President responded that there is duty for foundation trusts to release people for some work for the wider NHS but there are many grey areas; clarification from the Government would be useful.

The President pointed out that some committees, such as the Education Committee, need a good core of Council members on it whereas others may be more amenable to a reduction in Council members by replacing them with co-opted members from outside Council, such as RAs, College Tutors (CT) and recently retired Council members. The President will have further discussions with the Vice-Presidents and Directors before issuing the committee list.

CID/35/2011 Working with Industry – Guidelines for College Officers and Staff

Dr van Besouw explained that it would be appropriate for the RCoA to have guidance for officers and staff dealing with industry. Ms Drake explained that this is an increased area of activity for

education. The President is keen that the document and other guidelines harmonise across the RCoA, Faculties, AAGBI, Intensive Care Society (ICS) and other bodies as much as possible; this would be of great benefit to the specialty.

Dr Brennan suggested that in the section relating to personal invitations the following should be added 'any conflict of interest should be declared in Council/Committee deliberations of this topic'. Dr Brennan also requested the addition of 'use of the College logo or affiliation to the College should not be used without permission from the College'.

Dr Jones sought clarification of point ten relating to commercial support for Continuing Professional Development (CPD); does it mean that one company could pay for everything and part of the deal would be that no other company would be tolerated; how would that look? Ms Drake responded that when two companies have put equal amounts into an event and do not have competing interests it is easy.

Professor Sneyd explained that the individual side of things is already covered with conflicts of interest listed on the RCoA's website, declarations of interest for speakers etc. There is scope for structure relating to industry.

Dr Clutton-Brock stated that the essential components are equal opportunity and openness.

Dr Nevin considered the document to be timely and strategically important, adding that he did not think there could ever be too much of a statement of no conflict of interest. It was noted that Dr Nevin's trust has produced a similar document.

It was agreed that Dr Wilson could share the document with the AAGBI's Directors.

Ms Drake and Dr van Besouw were asked to continue working on the document.

CID/36/2011 Engagement of a Press and Media Officer

Dr Venn reminded Council that it had previously debated the idea of having a professional to handle the RCoA's media and press relationships; it is now time to consider the appointment of someone on the payroll or the use of a specific agent with whom the RCoA has a relationship. Dr Venn listed a number of topics Council had discussed during the course of the morning upon which the RCoA could issue statements, e.g. assisted dying, future of the NPSA and safety in anaesthesia. The Communications Committee has proposed a trial period of six months of Council's preferred option.

Dr Marks asked how the RCoA could go from zero activity to getting media engagement up and running. Dr Venn suggested looking for someone part-time initially with the other part-time of their work being a College role.

Dr Thornberry explained that the Royal College of Surgeons of England's (RCSEng) press team do media training for staff in-house and when an issue arises they go through individual training with the person involved including how to deal with questions that may arise.

Dr Batchelor supported having someone to handle the media adding that whilst someone based in the College would be able to find out about its work there is a danger they may become more detached than an external person would.

Dr D Nolan informed Dr Venn that the proposal would need to come through the Finance Committee.

Professor Bion asked how the RCoA would know the proposal had worked. Dr Venn responded that it would be considered successful if people were saying 'I see the RCoA is in the media spotlight.' It could also be considered a success if the RCoA makes a difference. Dr Venn had stated a need for a strategy for the next five to ten years. Anaesthesia has changed enormously during last the 20 years; it is not known what it will be like in 20 years' time but the RCoA would wish to be in control of it. The RCoA needs a strategy which can be broadcast so others are aware of its objectives.

Dr Clutton-Brock stated that there is no difficulty in engaging with press and media but it should be a professional not a press officer who engages with them; use of a media agency would suggest that anaesthetists are not prepared to say what they think as professionals.

Dr van Besouw suggested the use of a media office to trawl the outside world to see how the organisation is perceived should be incorporated into the proposal.

Dr Greaves suggested that the question should be is the RCoA effective or not and why do we think it is not effective rather than caring what people think about the organisation. Dr Greaves cited the case of the Royal College of Nursing (RCN) which frequently makes comment with Dr Peter Carter appearing on its behalf; the RCoA should be prepared to make its professional statements for itself.

Professor Bion stated that there are risks to the strategy which he would like to see more clearly expressed. Interaction needs to be rooted in a strong focus on professionalism not on selling the College and what it is here for; its purpose is not to market an organisation.

Dr Moonesinghe pointed out that the risk of the current strategy is that many of the Fellows interpret silence as inactivity.
Mrs Dalton informed Council that she is about to initiate a debate in the PLG about how to get the message across; there are many leaflets available which do not reach patients. There is also a huge problem with people who do not have internet access. Mrs Dalton added that it is critical a message is conveyed by the College about the work it is doing in response to the National Confidential Enquiry into Patient Outcome and Death's (NCEPOD) report *An Age Old Problem.*

Mr Storey asked whether the proposal would strengthen support to the President and Vice-Presidents who currently handle the majority of media enquiries.

Professor Sneyd suggested the use of a hybrid model; hiring someone external on a retainer backed up by a member of staff with some in-house expertise. The difficult bit would be to distil key messages.

Dr Whitaker suggested that the media could also be used as a weapon in any campaign the College wished to run as well as informing the public about the work of the College.

Dr Nevin pointed out that there is an enormous difference between being reactive when something arises to being proactive about taking on elements of improving and safeguarding patient wellbeing. The RCoA does need someone beyond the Presidents and Vice-Presidents to do this; it is time consuming and a level of knowledge will be required regarding how to achieve it.

CID/37/2011 e-Portfolio for Revalidation

Mr Storey informed Council that there is pressure for the cohort of the three Royal Colleges of Physicians, the Royal College of Ophthalmologists (RCOphth), the Royal College of Paediatrics

and Child Health (RCPCH), CEM and RCoA to move forward. If the remaining £75,000 is not spent it will return to the AoMRC and the cohort may have to bid for it again. Mr Storey added that it would be wrong to do something just because the money is available but it is likely that by continuing the cohort will get an e-Portfolio which would fit the bill. The cohort has stipulated that any data entered must be secure. Everyone agrees that a mirrored server is required but the cost would have to come down. Mr Storey added that whilst it would not be the best product, a link with the physician Colleges is a strong argument for proceeding; it will encourage consistency in revalidation across the specialties. If the e-Portfolio were to take off with other Colleges and trusts taking it on board it would be good for the RCoA to have been involved. The company is selling the system as a commercial venture to trusts. If the cohort agrees heads of terms there could be an announcement made before September Council.

Dr Thornberry was concerned the e-Portfolio would not be developed in time; the perception in district general hospitals is that they need a system now, not in two or three years' time. Mr Storey responded that the system is not very well developed; he doubted that the earliest time it would be available would be in six to twelve months. Dr Thornberry stated that since the collapse of the NHS Toolkit trusts have been looking for something for over a year.

Professor Sneyd pointed out that trusts cannot afford to purchase such a system; there will be an expectation that doctors will pay for it.

Dr Moonesinghe highlighted that having something compatible with the trainee portfolio would be advantageous.

Dr Verma suggested that Council should support continuing negotiations; it is something the RCoA can do to make Fellows' lives easier in terms of documentation. The RCoA is not being proactive enough and should try to take the lead in this. Dr Tomlinson responded that in areas where the RCoA has taken the lead it has not always been to its benefit; it was taking the lead with revalidation and was seen to be setting the bar too high.

Dr Jones reported that a pilot is being undertaken in Swansea based on a general practice (GP) primary care e-Portfolio; a central working group for the Welsh Government is looking at the pilot to make it more appropriate for secondary care. It should be available in the autumn and will be funded for all boards and individuals. Dr Greaves recalled the Welsh system being discussed by the Directors of CPD (DOCPD); it foundered because it was a system for Welsh GPs and the English and Scottish GPs were not keen on it.

Mr Storey hoped that in the future it would be possible for doctors to have one system after foundation training because the trainees' e-Portfolio, CPD system and revalidation e-Portfolio would all be linked.

Council agreed Mr Storey should continue with negotiations.

CID/38/2011 e-Portfolio

Dr Brennan presented the Phase 1 end report. Piloting has been completed, issues have been taken on board and it is hoped it will be rolled out nationally from August onwards. The next stage will be to complete some of the bespoke facilities within the portfolio.

COMMITTEE BUSINESS

CB/98/2011 Council Minutes

The minutes of the meeting held on 15 June 2011 were approved subject to the following amendments:

CID/24/2011 President's Opening Statement (ii)

Mrs Rivett is stepping down as Vice-Chairman of the PLG from August 2011 not July.

CID/31/2011 FICM Update for Trustees

Replace 'she has concerns over the proposal' with 'there are concerns over the proposal'.

CID/32/2011 Supervision of PA(A)s

Drs Colvin and Tomlinson to send Ms Regan rewording for the paragraph beginning 'The proposed extended PA(A) role'.

CB/89/2011 Royal College of Anaesthetists' Advisory Board for Scotland

Dr Colvin to send Ms Regan rewording for the sentence commencing 'Dr Colvin stated that he welcomed the inclusion.....'.

CB/93/2011 Professional Standards Committee

Amend 'these changes may be politically driven' to 'these changes may have been politically driven'.

CB/99/2011 Matters Arising

i. Review of Action Points

CID/24/2011 President's Statement

The Away Weekend summaries will be required to strengthen the strategy document.

CB/97/2011 Joint Informatics Committee

Dr Verma will liaise with Dr Mike Grocott regarding suggestions for the Hospital Episode Statistics (HES) database.

CB/100/2011 Regional Advisers

There were no appointments or re-appointments this month.

CB/101/2011 Deputy Regional Advisers

There were no appointments or re-appointments this month.

CB/102/2011 College Tutors

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

Northern

Dr V J Addison (Freeman Hospital) in succession to Dr M K Weaver **Agreed**

West Yorkshire

Dr P C Jackson (Leeds General Infirmary) in succession to Dr A J Pinder **Agreed**

Northern Ireland

Dr D T Lee (Ulster Hospital) has been nominated as acting Tutor for 3 months to cover for Dr R E Deyermond's sabbatical leave. **Agreed**

North Thames West
Dr A Ghori (Royal Brompton Hospital) in succession to Dr S Jaggar **Agreed**

North Thames Central
Dr A M Campbell (The Heart Hospital) in succession to Dr E M C Ashley **Agreed**

North West
Dr M S M Abdullatif (Stepping Hill Hospitals) in succession to Dr L A Hardy **Agreed**
*Dr R Bhishma (North Manchester General Hospital) **Agreed**
*Dr T J Clarke (East Lancashire NHS Trust) **Agreed**
*Dr S M Richmond (Royal Lancaster Infirmary) **Agreed**

West of Scotland
*Dr A G Macfie (Golden Jubilee Hospital) **Agreed**

Wessex
Dr M H M Jackson (Portsmouth Hospitals NHS Trust) in succession to Dr A P Mackie (Southampton University Hospital) **Agreed**

South Thames East
Dr H C Statham (Queen Mary's Hospital) in succession to Dr D J H Lee **Agreed**

Leicester and South Trent
Dr R Ferrie (Kettering General Hospital) in succession to Dr N J W Dunk **Agreed**

West Midlands North
Dr K P Krishnan (Sandwell General Hospital) in succession to Dr N P Carter **Agreed**

CB/103/2011 Heads of Schools
There were no appointments this month.

CB/104/2011 Training Committee
i) Medical Secretary's Update
Dr Thornberry gave a report from the AoMRC's Specialty Training Committee (ASTC). Medical Education England (MEE) had acknowledged that the Technology Enhanced Strategy is more of a framework than a strategy document; there is no money to drive a strategy. It recognises that there is a lot of kit out there but there is no new funding to support the development of faculty or time to teach. Concern was raised that e-learning was described as a tool for gaining knowledge and simulation was for developing skills and decision making.

A request was made for improving education material on prescribing.

There was a MEE update. The DH has released a large chunk of money for an initial ten pilot programmes exploring new ways of working. It is not certain how the pilots were chosen; it was understood there would be a tendering process but this does not appear to have taken place.

The Shape of Training is progressing slowly. A working group is exploring the conflicts between training and service, generalist versus specialist, timing of Certificate of Completion of Training (CCT), name of CCT, flexibility versus value for money, and innovation versus destabilisation. The President added that the Centre for Workforce Intelligence's (CfWI) document hardly mentions the concept of a structured consultant career.

MEE will be working with the postgraduate deans to work out where they will fit into the new system.

There is a European Consultation on the Professional Qualifications Directive. The President stated that the document contains many serious implications. The General Medical Council (GMC), BMA and AoMRC will need to respond to the DH's Professional Standards Directorate.

The broad based curriculum is making slow progress. Enhanced Acute Care Common Stem (ACCS) has been abandoned.

Public health had mapped its curriculum against others and thinks public health needs to be embedded in more curricula.

The ASTC had discussed the lack of engagement and non-attendance of trainee representatives.

Dr Thornberry gave a report of the transferable competencies meeting which was attended by the author of the report of the latest cohort study. Dr Thornberry considered the most useful summaries to be those showing what people wanted to be when they were in the equivalent of the first year of core training (CT) and what they eventually ended up doing. Anaesthesia poached from emergency medicine (EM), medical specialties and general practice. If someone in ACCS (anaesthesia) changes to EM in the programme, that is recognised for CCT. If they are in ACCS (EM) and want to be an anaesthetist and apply for CT2 anaesthesia they have to go back to CT1 or they will not get a CCT; alternatively if they redo all the assessments in CT1 they could be fast-tracked. There are attempts to get the GMC to acknowledge such anomalies at the start. Dr Batchelor stated that this would be relevant for those in intensive care medicine (ICM). Those who do ACCS will have done the CT3 year; there is a wish for this to be counted for ST3. Dr Vicky Osgood had suggested that all of the ACCS posts are designated and recognised for training in anaesthesia, ICM and acute medicine up front even if they are labelled to be something else. Dr Marks noted the inclusion of radiology and obstetrics in the desirable list of the ST3 anaesthesia person specification and asked how experience in those areas should be weighted against experience in other areas. Dr Thornberry responded that they were discussed as being part of the enhanced ACCS which has been abandoned.

The big issue regarding the Medical Training Initiative (MTI) is the Tier 5 consultation; Dr Kate Wark has submitted the RCoA's response to the AoMRC. The feeling is that the DH is listening to the whole issue of MTI doctors only being able to come for a year but there is not much confidence the profession will get the response it wants. Dr Thornberry suggested targeting a press release about the MTI around the consultation's closing date. The President suggested the RCoA could ask its Fellows and Council members to lobby their Members of Parliament perhaps using a template produced by the RCoA.

CB/105/2011 Anaesthesia Related Professionals Committee

Council received and considered the minutes of the meeting held on 14 June 2011 which were presented by the Chairman, Dr Batchelor.

The Health Professions Council's (HPC) decision not to regulate Physicians' Assistants (Anaesthesia) [PA(A)] would have a knock-on effect; if they do not have a regulator they will not be able to become independent prescribers.

There will probably be 10 new PA(A) trainees commencing this year.

There is considerable interest in Advanced Critical Care Practitioner (ACCP) training.

The AAGBI's survey and visits to departments with PA(A)s has started. Dr Wilson added that it is hoped a draft report will be available for the October meeting of Council.

Clinical leads for critical care are meeting and producing a unified curriculum across multiple providers.

The PA(A) clinical lead is arranging a meeting of all leads in October after the PA(A) examination. The PA(A) clinical lead is keen to take forward emergence from anaesthesia; this will be considered at the meeting.

CB/106/2011 Examinations Committee
Council received and approved the list of Fellows by Examination June 2011.

Council agreed that the under-mentioned doctors be awarded the Macintosh Prize for performing at the highest levels of distinction in all sections of the Final examination at their first attempt at the June 2011 sitting of the Final FRCA SOEs:

Dr Rajiv Malhotra – University Hospital Aintree
Dr Jessica Alice Longbottom – Wythenshawe Hospital

CB/107/2011 Audit and Internal Affairs Committee
Council received and considered the minutes of the meeting held on 15 June 2011 which were presented by Dr Thornberry. The Committee had discussed the Financial Regulations; there is a list of small changes to be incorporated.

A summary of the contribution made by the RCoA to the National Institute of Academic Anaesthesia (NIAA) will be produced on an annual basis.

The Committee reviewed and agreed the audit plan.
The *Removal of College Office Holders* document currently excludes members of Council; *College Regulations* cover the removal of Council Members. The recent review of documents had revealed that the mechanism in the first document is fair, just and probably rigorous enough to withstand challenge whereas the mechanism in the second document is not. The Committee was asked to review and consider a single document covering all.

The Chairman had agreed to seek the views of Council on the election process for the President and Vice-Presidents outside the committee.

CB/108/2011 Royal College of Anaesthetists' Advisory Board for Scotland
Council received and considered the minutes of the meeting held on 1 June 2011 which were presented by the Chairman, Dr Colvin. The Board explicitly opposes NHS Scotland Employers' proposals for mid-point credentialing.

The consultations from the Reshaping the Medical Workforce Board had been sent to the Board for comment. The Board supports the Scottish Academy's position on proposals to improve delivery of training that take into account affordability and service constraints.

The Board welcomed the Scottish Government Health Directorates' (SGHD) Workforce Directorate's recognition that attrition is a key part of trainee number modelling. The Board wishes to press for an increased CT1 intake in 2012 to ensure an adequate recruitment field for future ST3 intake.

The Board and the Scottish Academy have endorsed the Royal College of Physicians of Edinburgh's (RCPE) Charter for Medical Training.

The Honorary Secretary agreed to write to NHS Medical Education Scotland's (NES) Medical Director to convey the Board's view that continued Scottish trainee access to RCoA e-learning material is essential.

The Board supported the Scottish Academy's proposals for engagement with Scottish Government (SG) workforce and training initiatives. Dr Colvin sought the opinion of Council on the proposed strategy which was circulated as Paper 2. Clarity is required regarding what each group is doing. There is a duty to point out the risks of some potential solutions. The President stated that there should be a UK-wide solution to workforce. Dr van Besouw noted that it was striking that the assumption is that it is an internal market; there is some evidence nationally to support that consultants are appointed from without and from the European Economic Area (EEA). Dr Colvin replied that the Government Workforce Group is saying that essentially there is two way traffic but there is no overall trend in emigration or immigration with Australasia and other parts of the European Union (EU) but it is not clear that these assumptions are valid. The Scottish Board has suggested that this assumption carries significant risk. Professor Sneyd suggested that it demonstrates the complete folly of sub-UK manpower planning; it is a waste of time and the RCoA should say as much. Others noted that workforce planning on a devolved or Regional basis is vital but it is essential that it is not done in isolation.

Dr Colvin explained that the idea of three year delivery of training is that it does not deliver an extra waypoint; if done in the way it is outlined in the Scottish context then it provides much opportunity to allow flexible and innovative delivery of training. Dr Batchelor stated that three year core training is a good idea if it is used to gain more skills to become a good doctor. The President pointed out that in England an educational case would have to be made for three year core training. Dr Marks stated that some trainees require three years, partly because some will do ACCS or will do some medicine first; regardless of the target set some people will always take longer. Professor Sneyd could not agree to everyone doing three years of core training; it should be possible to do two years and go into ST3. Dr Jones reported that it is up and running in Wales; many of the CT3 posts include ICM or acute medicine as part of that and there is a move to create added value rather than just repeating anaesthesia. Such posts also bring added value in the educational field, e.g. an educational fellow in surgery post has been created whereby two sessions per week are dedicated to teaching; this is a pilot Wales is keen to roll out to many specialties. Employers are happy that they can recruit trainees in their third year who have some experience, which has to be better for patients. Dr van Besouw stated that justification would have to be given in competency terms why an extension of training should be afforded, though this initiative is about delivery of the current curriculum more flexibly rather than changing the curriculum per se. Professor Bion supported Dr Jones' view; from the ICM perspective that additional year brings a lot of added value to anaesthesia. It is fundamentally important that the core training programmes get themselves recognised as suitable for training in ICM so that time can be recognised when people go into ST training. If the competencies required at CT level can be incorporated into ST level the length to training may not be as long as envisaged if there was a CT3 year.

CB/109/2011 Royal College of Anaesthetists' Advisory Board for Wales

Council received and considered the minutes of the Board's joint meeting with the National Specialty Advisory Group (NSAG) held on 1 March 2011 which were presented by the Chairman of the Board, Dr Jones. Dr Jones reported that there are moves to amalgamate the Board and NSAG which is the National Specialty Advisory Group for the Welsh Government. The current Chief Medical Officer (CMO) and Medical Director want to revamp it and have a common pathway

for specialist advice. The second iteration of the proposed constitution is with Mr Storey at the moment. Independent meetings will be held this autumn but it is hoped there will be a joint meeting in the New Year where the proposed amalgamation will be proposed and voted on. There will be an election for the Chairman of the new group. This will strengthen the ability to deliver local and College based advice, support and influence towards the Health Minister, CMO and Medical Director NHS Wales. A final draft of the proposal will be presented to Council. The Chairman will be co-opted to Council. Intensive care and where it fits into this is being debated. Some of the intensivists in Wales want a separate NSAG. The view from the Medical Director is that at this stage there would be a multidisciplinary subgroup looking at ICM.

Dr Jones had attended a meeting chaired by the CMO about the maternity review. The document is very much focussed towards nursing and midwifery; perhaps the RCoA needs to go into lobbying and press mode about its concerns.

CB/111/2011 Revalidation Development Committee

Council received and considered the minutes of the meeting held on 20 June 2011 which were presented by the Chairman, Dr Tomlinson.

Dr Tomlinson had circulated a paper *Guidance on Supporting Information for Revalidation for Doctors in Anaesthesia, Critical Care and Pain Medicine*. This is a fast-moving area and another version had been drafted since the paper was circulated to Council. Dr Tomlinson stated that the latest version removes much of the repetition in the version presented to Council. Dr Tomlinson explained that the challenge is to make guidance as generic as possible. The core elements of supporting information that doctors will be required to provide, listed in bold on page 2, match the GMC's document on supporting information. It is hoped that the specialty specific guidance will be generic across the RCoA, FICM and Faculty of Pain Medicine. As far as page 12 of the document will be generic for every doctor across all Colleges and Faculties; this will be followed by a short specialty specific section at the end. The intention is to publish the document on the website by the end of July or early August to enable Members and Fellows to review and comment upon it. Dr Tomlinson is keen for as much feedback as possible and invited comments from Council.

The President asked if the FICM would be producing its own specialty guidance or whether it would be wrapped up in surgery, EM, anaesthesia and medicine. Dr Tomlinson intended to discuss the matter with Professor Tim Evans as Faculty lead for revalidation. Professor Bion stated that the FICM wished the guidance to be as generic as possible, but the specialty-specific elements should clearly be defined by the Faculty and could then be disseminated via the Trustee Colleges.

Dr Moonesinghe informed Council that the Working Group on Colleague and Patient Feedback recommends that anaesthetists consider using the anaesthesia specific elements of the NHS Survey. With regards to patient feedback on communication skills the Working Group recommends that anaesthetists with outpatient responsibilities use one of the 360 degree feedback tools. It is not possible to make recommendations for anaesthetists with solely perioperative responsibilities at present as there is insufficient guidance. The Working Group therefore recommends that the HSRC, in conjunction with patient representatives, addresses this unmet need. Examples of such work may include:

1. Development and validation of a patient questionnaire focussing on communication skills in short consultations.
2. Development and validation of a patient questionnaire focussing on perceptions of the quality and delivery of information provided during the consent process.

3. Wider consultation (e.g. through a survey) with the profession aimed at identifying how individual anaesthetists or departments may have overcome some of the perceived barriers to the implementation of patient feedback tools.

Dr Tomlinson reported that Dr Brennan and Ms Drake are updating the matrix to move away from the current empty box appearance. A list of specialist interest areas of practice and links to Specialist Society and Faculty websites will be included. Dr Brennan explained that where there is no link there is no Specialist Society or specialist advice available.

The publication of the DH's remediation report has been delayed although there is ongoing discussion between the DH Working Group and the National Clinical Assessment Service (NCAS) regarding how remediation will work. The Revalidation Development Committee will consider further the possibility of developing a remediation recipe book with anonymised real examples of problematic concerns and details of remediation and educational programmes. Dr Tomlinson would discuss with Dr Nevin whether or not he would be prepared to lead on developing the recipe book.

CB/112/2011 Patient Liaison Group

Council received and considered the minutes of the meeting held on 14 June 2011 which were presented by the Chairman, Mrs Dalton. Mrs Dalton was pleased that Mrs Kate Rivett would continue to work on both the Enhanced Recovery Pathway and *An Age Old Problem* after she retires as Vice-Chairman.

The PLG wished to support Dr Verma's online pre-operative assessment tool with the caveat that it did not replace personal contact with the anaesthetist.

The PLG has contributed to the National Institute for Health and Clinical Excellence (NICE) patient experience consultation.

CB/113/2011 Safe Anaesthesia Liaison Group

Council received and considered the minutes of the meeting held on 4 April 2011 which were presented by Mr McLaughlan. Contents of the Safe Anaesthesia Liaison Group's (SALG) newsletter and a summary of incidents are on the website at the moment and there will be follow up articles in *Anaesthesia News* and the *Bulletin*. The distribution list for the newsletter will be expanded. The NPSA has said that the summary of incidents submitted to the National Reporting and Learning Service (NRLS) will continue until the end of 2012. There has always been the problem that incidents in Scotland were not taken into consideration in England; it is hoped this can be joined up through SALG.

Membership of the Data Analysis Group will be finalised by July and the first meeting will be held in October 2011.

With regards to IV paracetamol in smaller adults and children, manufacturers have changed the labelling. Both the NPSA and MHRA are involved in continued discussions to ensure it is correct. Dr Whitaker requested that manufacturers be asked if IV paracetamol could be put into plastic bags for infusion rather than glass bottles.

An NPSA alert would be issued regarding the use of single ampoules for more than one patient.

Dr Duncan McPherson continues to work on production of specials. There are also links into NICE. There is particular concern about the wide variation in the production of specials.

SALG is tapping into the Risk Managers' Network in Wales. Dr Heather Hosie is going to see how that could be better formed in Scotland. There is no network in England.

There is increasing interest in the Safety Conference with the attendance of the Princess Royal.

With regards to rapid infusion of potassium chloride, the general issue of pump malfunction is being looked at.

Dr Clutton-Brock stated that when incidents are reported to the Medicines and Healthcare Products Regulatory Agency (MHRA) it is of the view that the AAGBI is the group that deals with device safety; where SALG sits is not always obvious to outside bodies. Mr McLaughlan responded that SALG was established to look at serious untoward incidents and critical incidents reported through the NPSA. Membership included the RCoA, AAGBI and NPSA to look at those incidents and what can be done about them. Mr McLaughlan acknowledged that there is overlap with other safety organisations now, not least of all the AAGBI's Safety Committee, adding that there may be potential confusion outside of anaesthesia regarding who deals with what and why. It was agreed this should be debated by the JCGP. Dr Lim stated that the AAGBI's Safety Committee and SALG carry out two different functions; the Safety Committee primarily works with manufacturers and the MHRA on a more proactive basis.

CB/114/2011 Faculty of Intensive Care Medicine

Council received and considered the minutes of the Board meeting held on 8 July 2011 which were presented by the Dean, Professor Bion. Professor Bion reported that the Faculty has 826 Fellows to date and will hold its first Faculty Day on 6 February 2012.

The last diet of the Diploma in ICM will take place in June 2012; the new Faculty Examination will be launched after that.

The Faculty believes that consultants will be very much more in the frontline in future. The workforce survey shows that approximately 25% of intensive care units (ICU) are still operating a day and day about form of consultant input. Smaller units appear to be covering out of hours work with consultants who do not have daytime sessions in ICM.

Mrs Annette Richardson, an ICU Nurse, has been asked to work with the Faculty by joining its Training Committee. Professor Bion asked Council if Mrs Richardson could join the Anaesthesia Related Professionals Committee (ARPC) as the FICM's representative to form a link between PA(A)s and ACCPs. Council agreed to the request. Dr Greaves asked why an ACCP had not been invited as the representative; he was concerned not with the individual appointed but the fact that it would convey the message that ACCPs are extended role nurses. Dr Batchelor explained that there is already an ACCP on the ARCP; Mrs Richardson would be there representing the FICM as someone who is involved with training ACCPs.

Two trainee surveys have been conducted, the first being of Foundation and Core trainees which had received more than 750 responses; the majority of responders expressed significant or definite interest in intensive care as a career with the preference being for dual CCT training. The second survey had been of intensive care trainees in London.

The Faculty workforce census had achieve a response rate of more than 75% and will be used to inform the production of material from the CfWI.

Professor Bion reported on a meeting with the GMC, DH and the Conference of Postgraduate Medical Deans of the United Kingdom (COPMeD). The new CCT programme in ICM will be

launched on 1 August 2012; the recruitment process will start this autumn and there will be a great deal of work involved to get everything in place. As far as transition from the current to the new programme is concerned the Faculty proposed that it can continue to take applications for the joint programme up to and including 31 July 2013; partly to maintain the output of specialists and also because it does not wish to disenfranchise trainees already in an ST programme. The GMC is likely to accept this proposal and a response was anticipated by the end of the following week. There will be a national process for recruitment and appointment with a lead deanery. Mr Bryant pointed out that one of the keys to the process is the identification of West Midlands as the lead deanery; whether the tight timelines can be achieved will be down to the deanery. A regional appointment process will be maintained for the Joint CCT programme. There was broad acceptance at the meeting that ICM needs double the number of training posts it currently has; these will probably be obtained by the transfer of posts from other specialties which are surplus to requirement and by changing trust doctor posts to training posts with approval. Dr Nevin urged caution about trust posts; many view trust doctors as short-term positions. Dr Greaves asked if the posts coming from other specialties and trust doctor posts will be predominantly single CCT posts. Professor Bion responded that it is not possible to provide a complete answer although a variety of possibilities have been modelled. The proposal to double training posts is predicated on 10% single CCT split and maintaining the current production of specialists within the new programme.

CB/115/2011 Trainees' Committee

Council received and considered the minutes of the meeting held on 11 June 2011which were presented by the Co-Chairman, Dr Moonesinghe. Council agreed to the Committee's request to provide financial support for travel/accommodation for members of the Trainees' Committee attending (on request) University Anaesthesia Societies to promote the profession.

The Committee had discussed how to increase trainee attendance at the RCoA's CPD conferences. It was suggested that one way of increasing attendance would be to make courses more interactive; workshop/practical courses have a greater appeal to trainees.

The Committee had discussed a strategy for improving lines of communication between the Trainees' Committee and trainee members and Fellows. An e-mail address has been created which will provide a means of contact.

There has been some dissatisfaction reported to the Committee about the quality of the guidance interviews after repeated failure of the FRCA Examination. Dr Patel had discussed this informally with Dr Brennan; the matter will be discussed at the September meeting of the Examinations Committee.

The Committee had considered a joint publication with the Group of Anaesthetists in Training (GAT) to explain the differences between the work and roles of trainees within the RCoA and the AAGBI. Dr Moonesinghe was asked to e-mail details of any financial implications to Mr Storey or Dr D Nolan.

MATTERS FOR INFORMATION

I/25/2011 Publications

The list of publications received in the President's Office was drawn to Council's attention.

I/26/2011 Consultations

Council received, for information, a list of the current consultations. The President thanked those who contribute to contributions and encouraged Council members to respond to those within their areas of interest.

I/27/2011 New Associate Fellows, Members & Associate Members

Council noted the following:

New Associate Fellows – July 2011

Dr Susan Atkinson - Royal Hospitals Belfast HSCT
Dr Richard Michael Bateman - Bristol Royal Infirmary

New Members– June 2011

Dr Bhamini Ramaswamy - Primary FFA, RCSI
Dr Ammar Keiralla - Oxford Radcliffe Hospitals NHS Trust
Dr Subha Brata Bagchi - Primary FCARCSI
Dr Robert Austin Stafford - Primary FRCA

New Member – July 2011

Dr Thosa Jayasekara Gunawardena Johnson - Primary, FRCA

New Affiliate – Physicians' Assistant – July 2011

Miss Adele Louise Chinyimba - Queen Elizabeth Hospital, Birmingham

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

Dr Tapas Kumar Mandal - Chase Farm Hospital, Edgware
Dr Kunal Ashok Joshi - Chase Farm Hospital, Edgware
Dr Nidhi Gautam - Watford General Hospital

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

Dr Nidhi Gautam - Watford General Hospital
Dr Rohit Mittal - Freemans Hospital, Newcastle-upon-Tyne
Dr Sarvesh Parlhad Zope - Birmingham Heartlands Hospital
Dr Ashwini Umakant Keshkamat - Birmingham Heartlands Hospital
Dr Ida-Fong Ukor - William Harvey Hospital, Ashford, Kent
Dr Helga Elisabeth Rohwer - Salisbury District Hospital
Dr Faraz Shafiq - Scarborough Hospital

PRESIDENT'S CLOSING STATEMENT

PCS/7/2011 President's Closing Statement

(i) The President again sought agenda items for the JCGP.
(ii) The President had discussed the Press Officer proposal with Mr Storey and Mr McLaughlan. There were issues requiring discussion before the proposal is taken forward.

MOTIONS TO COUNCIL

M/31/2011 Council Minutes
Resolved: The minutes of the meeting held on 15 June 2011 were approved subject to the following amendments:
CID/24/2011 President's Opening Statement (ii)
Mrs Rivett is stepping down as Vice-Chairman of the PLG from August 2011 not July.

CID/31/2011 FICM Update for Trustees
Replace 'she has concerns over the proposal' with 'there are concerns over the proposal'.

CID/32/2011 Supervision of PA(A)s
Drs Colvin and Tomlinson to send Ms Regan rewording for the paragraph beginning 'The proposed extended PA(A) role'.

CB/89/2011 Royal College of Anaesthetists' Advisory Board for Scotland
Dr Colvin to send Ms Regan rewording for the sentence commencing 'Dr Colvin stated that he welcomed the inclusion.....'.

CB/93/2011 Professional Standards Committee
Amend 'these changes may be politically driven' to 'these changes may have been politically driven'.

M/32/2011 College Tutors
Resolved: That the following appointments and re-appointment be approved:
(re-appointments marked with an asterisk):

Northern
Dr V J Addison (Freeman Hospital) in succession to Dr M K Weaver

West Yorkshire
Dr P C Jackson (Leeds General Infirmary) in succession to Dr A J Pinder

Northern Ireland
Dr D T Lee (Ulster Hospital) has been nominated as acting Tutor for 3 months to cover for Dr R E Deyermond's sabbatical leave.

North Thames West
Dr A Ghori (Royal Brompton Hospital) in succession to Dr S Jaggar

North Thames Central
Dr A M Campbell (The Heart Hospital) in succession to Dr E M C Ashley

North West
Dr M S M Abdullatif (Stepping Hill Hospitals) in succession to Dr L A Hardy
*Dr R Bhishma (North Manchester General Hospital)
*Dr T J Clarke (East Lancashire NHS Trust)
*Dr S M Richmond (Royal Lancaster Infirmary)

West of Scotland
*Dr A G Macfie (Golden Jubilee Hospital)

Wessex
Dr M H M Jackson (Portsmouth Hospitals NHS Trust) in succession to Dr A P Mackie (Southampton University Hospital)

South Thames East
Dr H C Statham (Queen Mary's Hospital) in succession to Dr D J H Lee

Leicester and South Trent
Dr R Ferrie (Kettering General Hospital) in succession to Dr N J W Dunk

West Midlands North
Dr K P Krishnan (Sandwell General Hospital) in succession to Dr N P Carter

M/33/2011 Examinations Committee
Resolved: That the under-mentioned doctors be awarded the Macintosh Prize for performing at the highest levels of distinction in all sections of the Final examination at their first attempt at the June 2011 sitting of the Final FRCA SOEs:

Dr Rajiv Malhotra – University Hospital Aintree
Dr Jessica Alice Longbottom – Wythenshawe Hospital