MEETING OF COUNCIL

Edited Minutes of the meeting held on Wednesday 18 July 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 van Besouw
Professor J R Sneyd
Dr H M Jones
Professor J Bion
Dr E A Thornberry
Professor R P Mahajan
Dr P J Venn
Dr A Batchelor
Dr D K Whitaker
Dr D M Nolan
Dr S Patel (until 2pm)
Dr R Verma (am only)
Dr R J Marks
Dr L J Brennan
Dr J P Nolan
Dr J A Langton
Dr J R Colvin
Dr N W Penfold
Dr V R Alladi
Dr S Gulati
Dr I Wilson

Mr P Rees, RCoA Patient Liaison Group (PLG)

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

Apologies for absence: Dr R Laishley, Professor D Rowbotham, Dr T H Clutton-Brock, Dr J R Darling, Dr I Johnson, Dr M Nevin, Dr M Clancy and Dr A-M Rollin.

STRATEGY

S/2/2012 External Strategy Discussion

The President introduced Dr Vicky Osgood, Assistant Director of Postgraduate Education at the General Medical Council (GMC). Dr Osgood outlined some of the GMC's current work. The vital role of medical Royal Colleges within the quality assurance (QA) process is becoming evident as the GMC works through its QA review. This year the GMC is reviewing its quality improvement framework through interactive sessions and engagement with the Conference of Postgraduate Medical Deans (COPMeD) and others. The GMC is particularly interested in quality control and how to establish what is occurring within the workplace. Next year the GMC will review its standards, which are based on *Good Medical Practice,* the new version of which is due out before the end of 2012. A key task in 2013 will be to look at standards for medical training. The GMC is currently undertaking 12 cycles of visits across undergraduate and postgraduate educational institutions. The recently published national trainee survey had been brought "in-house" for the first time. This will enable the GMC to examine and manipulate the data more readily, thus enabling improved responsiveness to requests for reports relating to specific elements of the survey. Approximately 17 individual visits have already been carried out generally with the participation of a deanery. The GMC recognises the importance of professional expertise in the visits process. The GMC is very interested in the development of the Annual Review of Competence Progression (ARCP); there is a wish to identify best and most effective practice. The President thanked Dr

Osgood, adding that he was increasingly impressed by the scope of the work undertaken by the GMC.

Dr Brennan asked whether the GMC was content to leave to the Royal College of Anaesthetists (RCoA) the issue of successful candidates in overseas examinations being granted exemption from part of the FRCA examination. Dr Osgood explained that the GMC is happy for the RCoA to manage the process but it must be able to demonstrate that exempting examinations are fair, equitable and match the curriculum.

Professor Bion asked whether the RCoA should approach the GMC or the Medical Schools Council (MSC) if it wished to be involved in undergraduate education. Dr Osgood explained that the GMC is part of the bridge but the partner in undergraduate education is the MSC. The way in which the GMC QAs undergraduate education is different from the way in which it QAs postgraduate education. Dr Osgood explained that if the RCoA wished to review engagement with undergraduate education, it would need to work with both the GMC and MSC.

Professor Bion was keen to know if the GMC had a view on research. Dr Osgood replied that the GMC is engaged in significant amounts of research, which is usually published. In general this relates to whether curricula meet the appropriate standards. In September the GMC will publish an extensive literature review and piece of research on the Working Time Regulations. The GMC does not engage directly in educational research but in conjunction with the Academy of Medical Royal Colleges (AoMRC) will look at new forms of workplace-based assessments (WPBA) such as Supervised Learning Events (SLEs).

Professor Sneyd, raising the issue of inspections and visits, challenged the GMC to accelerate harmonisation of development for teachers and for the process of quality assurance. The GMC is in a unique position to insist on a consistent approach. In relation to manpower planning, the GMC has yet to ask doctors about which specialty they currently practise in, and whether they are full or part time. The GMC would be in a strong position to develop its database. Dr Osgood explained that the work on the recognition and approval of trainers is an example of development work for medical educators. The GMC has stated that there will be one scheme, capable of being adopted by all. There is an expectation that deaneries and medical schools will work together to ensure that everyone will have the opportunity to acquire the appropriate tools to be a trainer. GMC Council is discussing the introduction of recognition and approval of trainers from August 2013. In terms of visiting it was suggested that there may be some unnecessary duplication. This may become easier with the formation of Local Education and Training Boards (LETBs) in England. The GMC does not have a remit for workforce planning but nevertheless does hold considerable amounts of useful data. Changing the questions it puts to doctors and what is included on the Register would be complex, although the unique identifier given to students in their final year will henceforth enable the GMC to follow people through their careers. Dr Osgood explained that the GMC is proposing to have a data warehouse of people in training. The revalidation process will also provide information; it will be possible to identify what people are actually doing now rather than what their Certificate of Completion of Training (CCT) or equivalent might suggest. Dr Osgood explained that there is no "quick fix" solution; Professor Sneyd's suggestion would require a huge change in policy for the GMC. Dr Osgood added that the GMC has had internal discussions about how it might develop its databases.

Dr Jones expressed great concern in relation to the problems associated with change of emphasis in Foundation Training to Primary Care. The Welsh Deanery is looking at the split

between acute medicine and surgery, and primary care. This has the potential to disrupt Working Time Regulation (WTR) rosters and more importantly there exists a real danger that trainees will have insufficient exposure to acute care and management of the acutely ill patient. Dr Jones urged the GMC to be vigilant in relation to Deanery activity. It is crucial that the GMC looks at this centrally and gives stronger guidance. Dr Osgood agreed there was a need to look at what is happening; foundation trainees value their experience of anaesthesia and intensive care medicine (ICM), and it would be detrimental to lose this exposure.

Dr van Besouw stated that the quality of the training environment is linked to service provision. A period of major reconfiguration is imminent, and he questioned how the GMC would track the impact of this on the training environment. Dr Osgood responded that this would be through the visits process, surveys, check visits and response to concerns. Many aspects have been highlighted in terms of reconfiguration; the deaneries and not the Colleges would generally report these issues. An organisation does not need to be able to visit in order to report concerns to the GMC; the GMC will follow up concerns if it thinks there are problems. The GMC anticipates linking quality of service with quality of education.

Mr Rees enquired what role patients play in postgraduate education. Dr Osgood explained that the GMC engaged with both patient and lay representatives. GMC Council consists of 50% medical members and 50% lay members. All current committees for education have lay Council members, who are also involved when the GMC approves curricula. In addition they contribute significantly to a wide range of Task and Finish Groups. The GMC is always happy to hear from people with a view who wish to contribute.

Dr Marks remarked that WPBAs have had bad press and remain identified as a problem area in the current GMC survey. Dr Marks believed that the problems stem from the fact that they tend to micro task issues and the pass mark is too high or too low depending which way one looks at it. It is hard to fail someone without delivering them a devastating blow. Both trainees and consultants view them as a "tick-box" exercise which is produced and has to be signed every time the trainee undertakes a list. Dr Osgood stated that the work currently being undertaken in foundation training would address this. There is a discussion document currently on the GMC website in relation to WPBAs. A distinction should be made between formative and summative assessment. SLEs will be key to this; they will be the formative element and will not form part of the portfolio for foundation training, except as a quantitative measure of trainee experience. The number of passes and fails is not attached to them; they are purely for feedback. At the end of the attachment a limited number of summative assessments will be undertaken. The College of Emergency Medicine (CEM) and The Joint Royal Colleges of Physicians Training Board (JRCPTB) have applied to the GMC to run pilots.

Dr Venn asked how Dr Osgood viewed the relationship between the GMC and the healthcare industry. Dr Venn added that the GMC is probably one of the only bodies able to engender fear and apprehension in doctors and possibly also chief executives. Doctors have to practise within local constraints and there may, on occasions, be conflict between *Good Medical Practice* and the wishes of the chief executive. Dr Venn asked where the remit of the GMC starts and ends and in particular how it sees the relationship between itself, the Department of Health (DH) and Foundation Trusts. Dr Osgood responded that the first remit of the GMC is patient safety. It is the responsibility of doctors to report when such circumstances as described by Dr Venn occur. It was acknowledged that doctors are concerned about reporting matters to the GMC in case they come under personal scrutiny.

The GMC is extremely concerned that Mortality and Morbidity (M&M) meetings are disappearing and needs to know if doctors do not have appropriate opportunity to participate. If doctors are not given time to attend, this would be necessarily be viewed as a major patient safety issue and if necessary the GMC would visit the hospital concerned. The GMC can also use other regulators such as the Care Quality Commission (CQC). Dr Osgood accepted Dr Venn's invitation to formalise links between the GMC and the RCoA's Professional Standards Directorate. Dr Osgood explained that in the trainees' survey 5% identified what they considered to be patient safety issues; when investigated further it transpired that the GMC was already aware of many instances. Dr Osgood stated that the GMC needs to be informed formally about issues around attendance at M&M meetings.

Dr Verma, Chair of Equivalence, enquired as to the existence of any plans to change or improve the robustness of the process for foreign graduates wanting to go on the Specialist Register. Dr Osgood responded that the consultation on routes to the Register had just closed and that this is an important piece of work within the GMC. It will be discussed by the GMC Council following which an implementation document will be produced. One of the suggestions within the consultation is that doctors should be required to work in the UK for a period of time before applying for equivalence. The question of whether they should take an examination is currently in abeyance. In the future it may be that methods will be employed which test a doctor's knowledge of *Good Medical Practice* and how doctors practise medicine as professionals in the UK. Dr Osgood commended the RCoA's equivalence system whilst acknowledging that it is more complicated for Colleges with multiple sub-specialties.

Dr Colvin enquired as to the GMC's mindset in relation to flexibility in the delivery of curricula. Dr Osgood explained that flexibility means different things to different people. There is flexibility for an individual to do what they need to do but also flexibility for service to have the right skills at the right time and to adapt to service changes and developments. The GMC has been trying to increase flexibility within the constraints of UK and European law; it is possible to identify alternative options in some areas. For example with dual Certificates of Completion of Training (CCTs) the GMC has agreed that trainees can start sequentially; this is an innovation. Transferable competences are the way forward. Dr Osgood had been impressed by the way some academic leads have been viewing out of programme experience: academic experience is central to a trainee's development and there should always be a degree of flexibility around management and educational opportunities. Flexibility however may imply increased cost. Dr Osgood suggested that the profession was not very good at saying how many people it needed to produce each year, focussing instead on estimating, usually inaccurately, how many trainees should enter programmes year on year. It does not matter then how long people take in training. Finance can be manipulated more easily if there is no restriction on the number entering training rather than fixing on the number which need to be produced each year. Dr Osgood added that it is not good for people to be in training for overly lengthy periods. The President pointed out that there is wide appreciation that there needs to be greater flexibility for academic trainees.

Professor Sneyd suggested that it would be good to see an article entitled 'Keeping Hospitals Safe' in the next GMC magazine saying that the GMC would like to hear about difficulties in attending M&M meetings, poor provision of safety equipment etc. Dr Osgood responded that a paper was being written although this would not be in the next magazine. The paper details the work the GMC has done in response to concerns. Dr Osgood pointed out that the GMC can only be as good as the information it receives and her challenge to the RCoA would be to report such matters to the GMC as soon as possible.

The President thanked Dr Osgood for a very spirited discussion.

COUNCIL IN DISCUSSION

CID/19/2012 President's Opening Statement

(i) The President announced the deaths of Dr Cyril Scurr, DrAlexander Kilpatrick, Dr Andrew Richardson, Dr Bryony Wells and Dr Pradeep Natarajan. The President also announced the death of Dr Denis Edwards a former president of the Intensive Care Society (ICS). Council stood in memory.

(ii) The President welcomed back Dr Patel from his fellowship in Canada.

(iii) The President would write to Dr Vicky Osgood after her very useful presentation to Council. It was noted that many of the questions asked had featured in the College's consultation process. Council used to receive all consultations but because of the lack of feedback they were now sent to particular committees or individuals. The President's Meeting would discuss whether or not to resume sending all consultations to Council members with particular individuals/committees being tasked to respond.

(iv) Mr Storey would shortly be asking Council members whether they would be continuing on Council; this would enable the correct number of seats to be advertised for the 2013 election.

(v) Dr Andy Wolf has been elected as President of the Association of Paediatric Anaesthetists (APA) from 2015.

(vi) Dr Mark Bellamy has been elected President of the ICS.

(vii) Professor Bion informed Council that the two earthquakes in Italy had destroyed one factory and damaged the second of the three plants supplying disposable equipment for Baxter dialysis machines used in intensive care; Baxter supplies 50% of intensive care capacity. It is possible that two of the three other suppliers of dialysis machines may be able to fill the gap. A meeting would take place on 20 July following which a position statement would be widely circulated throughout the UK via the ICS and Faculty of Intensive Care Medicine (FICM); it is anticipated that it will propose that alternative suppliers would provide additional equipment particularly for larger units who would then supply smaller units reliant on Baxter kit. Machines, disposables and training have to be provided by 29 August 2012. There are two unknown factors; potential incidents during the forthcoming London Olympics and another earthquake in Italy destroying the third factory. Dr Whitaker suggested that cardiopulmonary bypass equipment would also be affected; Professor Bion agreed to check and to copy the statement to Drs Jones and Colvin.

(viii) Council members agreed they would prefer to continue receiving papers by e-mail rather than accessing them via Dropbox.

(ix) The President had attended the Shape of Training Review. The papers will be publicly available on the GMC's website; the President would circulate items of interest to Council. Discussion had centred on the age groups with whom the future of medical careers should be discussed i.e. in medical schools or sixth forms and whether consideration should be given to service elements to be provided by trainees of the future. The President agreed to circulate the minutes when available and explained that he would be seeking feedback on the papers and e-mail discussions. Although he is part of the review by way of a personal invitation, the President would be keen to ensure he was conveying the views of the RCoA.

(x) The President had attended the Health Education England (HEE) Transition Advisory Board meeting which discussed workforce planning and how LETBs in England will feed

workforce requirements to the Centre for Workforce Intelligence (CfWI) and HEE. The President would circulate the relevant papers.

(xi) The President had attended a meeting of the Future Hospital Commission where implications for workforce were discussed at length. The vision being articulated through a number of work streams initiated by the Royal College of Physicians of London (RCPLond] will inevitably drive rationalisation of services into larger hospitals. The other issue is a drive to generalism from specialism and a move towards the Harvard Model where patients have a named doctor, who is a generalist, and who takes day-to-day care decisions after admission. The President agreed to circulate the papers to Council.

(xii) The President noted that the Shape of Training Review and Future Hospital Commission have websites for input. Council members were asked to submit a copy to the President if they made any comments via the websites.

(xiii) Committee Chairmen have now been finalised. Individual committee members will be finalised soon.

(xiv) There is a need to think strategically about the construct of Council. There have been discussions at the President's Meeting about how representatives on Council would be sought in the future if the workforce is constructed differently across the UK. The RCoA has also encompassed Staff and Associate Specialist (SAS) grades and perhaps the time has come to disband the SAS Committee and roll out SAS doctors into other committees. The Trainee Committee may also have to review its structure.

(xv) The President updated Council on staff changes:

a. Dr Mike Galsworthy has taken up his post as Health Services Research Centre (HSRC) Researcher.
b. Ms Natalie Bell has been appointed as permanent, full-time PA to Director (Education & Research).
c. Ms Hollie Brennan has been appointed as the permanent, full-time Anaesthesia Review Teams (ART) and Patient Liaison (PLG) Co-ordinator.
d. Mr Chris Kennedy has been appointed as the permanent, full-time Revalidation and Continuing Professional Development (CPD) Administrator.
e. Ms Judi Hickman has joined the College as a Specialty Training Co-ordinator on a full-time and permanent basis.
f. Ms Anamika Trivedi has joined the College as Communications Officer on a full-time and permanent basis.
g. Ms Elena Fabbrani has joined the College as PA to Director (Professional Standards) on a full-time and permanent basis.

CID/20/2012 National Audit Project 4

Ms Drake presented Dr Tim Cook's proposal for a way forward in increasing dissemination and implementation of the findings and recommendations of the 4th National Audit Project (NAP4).

It was agreed that Dr Whitaker should act as liaison to report back to Council if required.

Dr Thornberry noted the need for a drive to educate more senior members of departments of anaesthesia in relation to new techniques such as fibre-optic intubation.

Dr Brennan cautioned that if the RCoA promotes a lead for this area it could be legitimately criticised if other groups asked it to promote leads for other areas of anaesthetic practice.

Council agreed the following proposals which would also be submitted to the Difficult Airway Society's (DAS) Council:

1. A 'strong recommendation' from the College for each hospital to appoint a departmental airway lead although there are a few reservations about having a named person. It was noted that many departments already have an airway lead. Ms Drake pointed out that there was a recommendation in NAP4 that there should be a lead; this was endorsed by the RCoA.
2. That the College supports a national survey of institutional responses to NAP4.
3. That the College supports a national 'sprint-audit' to explore the impact of NAP4.

CEREMONIAL

C/5/2012 Admission to the Board of Examiners

The following Fellows were admitted as examiners to the Primary Fellowship Examination of the Royal College of Anaesthetists:

Dr Jo Budd	Worcestershire Royal Hospital
Dr Dharshini Radhakrishnan	Whipps Cross University Hospital, London
Dr Asius Rayen	City Hospital, Birmingham
Dr Emily Simpson	Southend University Hospital
Dr Carl Stevenson	Hereford Hospital NHS Trust
Dr Christopher Taylor	National Hospital for N&N, London
Dr Mritunjay Varma	Royal Victoria Infirmary, Newcastle
Dr Simon Vaughan	Blackpool Foundation Hospital NHS Trust

COMMITTEE BUSINESS

CB/90/2012 Council Minutes

The minutes of the meeting held on 20 June 2012 were approved.

CB/91/2012 Matters Arising

i. Review of Action Points

CID/15/2012 The RCoA had been unable to send a guest speaker to the Keele Course. The President stated that there had been a suggestion that a similar course might be brought in-house. Ms Drake responded that there was an overlap with the RCoA's leadership and management courses and suggested that perhaps Dr Charlie Ralston should go to Keele. Ms Drake thought that the RCoA should definitely remain engaged with Keele. Ms Drake agreed to feed back to the President on a dinner where Dr Jonathan Fielden had spoken.

CID/17/2012 The CfWI was appreciative of the comments which the President had fed back verbally; this would be followed up a written synopsis of specific areas by the President. Professor Bion reported that although anaesthesia and intensive care medicine (ICM) are no longer priority areas the FICM has organised a workshop on 9 November to which the CfWI has been invited. The workshop will be used to sketch scenarios to enable the specialty to produce its own workforce plans to present to CfWI. Mr Bryant had met Professor Moira Livingston the week before. Priorities have changed and the CfWI has been given responsibility to look at the entire healthcare workforce. CfWI is now looking at radiology and general surgery. The RCoA will continue positive engagement with the CfWI and there will be a monthly two-way update. The CfWI had agreed to flag up with Mr Bryant any key pieces of work, papers on its website etc; Mr Bryant would keep Council updated.

Dr Batchelor reported that a critical care practitioner who wrote a paper a few years ago considering the costs of having other grades doing medical jobs was trying to locate it.

CID/18/2012 Professor Sneyd would chair the Nominations Committee and would lead the work on Fellowship ad eundem.

CB/73/2012 The GMC Postgraduate Board has not yet met; the President would raise the issue of the Specialist Register and Cardiothoracic Anaesthesia listing at the next meeting.

CB/80/2012 The President had not received a paper from Dr Laishley for discussion at the President's Meeting.

PCS/6/2012 Ms Drake thanked those who had volunteered to chair sessions at the Current Concepts Symposium. The list of chairmen would be reviewed at the next President's Meeting.

All other actions were complete.

CB/92/2012 Regional Advisers
There were no appointments or re-appointments for Council to consider.

CB/93/2012 Deputy Regional Advisers
Council considered making the following appointment:
Mersey
Dr P M Mullen as Deputy Regional Adviser for Mersey in succession to Dr N M Robin **Agreed**

South East Scotland
Dr J A Wilson as Deputy Regional Adviser for South East Scotland in succession to Dr K G Stewart **Agreed**

CB/94/2012 College Tutors
Council considered making the following appointments/re-appointments (re-appointments marked with an asterisk):
Anglia
*Dr S G H Rao (Queen Elizabeth Hospital, Kings Lynn) **Agreed**
*Dr A A Klein (Papworth Hospital) **Agreed**

West Yorkshire
Dr B S Ghoorun (Calderdale and Huddersfield NHSFT) in succession to Dr M R Beadle **Agreed**
Extra in Huddersfield

North Thames West
To receive a request from Dr Michelle Hayes the Regional Adviser for North Thames West for an extension to Dr M A Stevens (Hillingdon Hospital) term of office. **Agreed**

North Thames Central
*Dr M Sivarajaratnam (North Middlesex Hospital) **Agreed**

North Thames East
Dr E K Reid (Broomfield Hospital) in succession to Dr H Jones **Agreed**

Mersey
Dr K E J Palmer (Liverpool Heart & Chest Hospital) in succession to Dr O Al-Rawi **Agreed**

Dr A M Troy (Countess of Chester Hospital) in succession to Dr P M Mullen **Agreed**
*Dr M Diwan (Royal Liverpool University Hospital) **Agreed**

North West
Dr A W Monks (Blackpool Victoria Hospital) in succession to Dr S T A Vaughan **Agreed**
Dr S Sharma (Lancashire Teaching Hospitals NHS Trust) in succession to Dr F Sloss **Agreed**

West of Scotland
Dr L A McGarrity (Crosshouse Hospital) in succession to Dr C H Whymark (December 2012) **Agreed**

KSS
Dr M G Way (Royal Surrey County Hospital) in succession to Dr V Nataraj **Agreed**

Wales
Dr S H Burnell (Ysbyty Gwynedd) in succession to Dr J D Walker **Agreed**

CB/95/2012 Heads of Schools
There were no appointments to note.

CB/96/2012 Training Committee
(i) Medical Secretary's Update
Dr D Nolan reported that there are continued pressures on the curriculum. There would be a meeting with the President of the Society for Obesity and Bariatric Anaesthesia in August to look at some of the issues the Society has raised and what it perceives to be key aspects of training which are not currently being addressed.

Dr D Nolan had attended the National Stakeholders' Forum on the President's behalf following the release of the White Paper *Caring for our Future*. LETBs will be responsible for local workforce planning.

There had been a very successful and collaborative meeting with Regional Advisers (RAs) from the London Deaneries and some representatives from East Anglia. The frequently asked questions as expected were in relation to intensive care and problems with a completely electronic ARCP process which makes the proceedings very slow. Dr Thornberry asked if feedback had been received from South East Scotland which had been using a completely paperless ARCP process. Dr Brennan responded that the feedback had been that it was used successfully. Dr Thornberry suggested issuing an invitation to write an article for the *Bulletin*.

(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 (ICM).

Anglia
Dr Ashwani Gupta
Dr Rachel Morris
Dr Ram Adapa
Dr Jonathon Francis
Dr Anjalee Brahmbhatt
Dr Ashish Shetty
Dr Owain Evans
Dr Srinivas Jakkula
Dr Awanee Kumar

North Central
Dr Omaima Glesa

Bart's and The London
Dr Edward Breeze
Dr Nadir Sharawi

Mersey
Dr Neil Sahgal

North West
Dr Judith Young
Dr Alice Arch
Dr Nitin Arora
Dr Vimmi Oshan
Dr Sarah Wood
Dr Wendy Aubrey *
Dr Kailash Bhatia

Severn/Bristol
Dr Sara-Catrin Cook *
Dr Andrew Georgiou *
Dr Robert Jackson *
Dr Thomas Martin

Tri-Services
Dr Timothy Hooper *

Wessex
Dr Andrew Leitch *

Wales
Dr Alexandra Ford

Scotland
East Scotland
Dr Sharon Hilton-Christie *

South East Scotland
Dr Binu Arthur
Dr Nicola Alexander

West Scotland
Dr Brenda Daly
Dr Julia Robertson
Dr Nithin Roy
Dr Richard Appleton *
Dr Philip Lucie
Dr Shebeen Hamza

Yorkshire
West Yorkshire (Leeds/Bradford)
Dr Meyyappan Nachiappan
Dr Bobby Daniel
Dr Matthew Devall
Dr Sarah Marsh *
Dr Sumit Gulati

East Yorkshire (Hull/York)
Dr Christopher Smith
Dr Mariappan Sivakumar
Dr Rohit Garkoti
Dr Rajeev Jha *
Dr Uthappa Belliappa

South Yorkshire (Sheffield)
Dr Prashanth Sadhahalli

Dr Allen Pinto
Dr Juliette Fraser
Dr Jabulani Moyo

CB/97/2012 CCT in Anaesthetics Assessment Guidance

Dr D Nolan sought Council's comments on the *CCT in Anaesthetics Assessment Guidance*. Dr Venn pointed out that looking through the curriculum one cannot find ENT in any of the headings. Dr Venn sought clarification on what the curriculum says about training in head and neck surgery. Dr D Nolan reported that it is not explicit and was worth reinforcing which she agreed to do. Mr Rees welcomed the paper but suggested that in the second section after 'explain' that 'and communicates effectively the options and risks' be added. Mr Bryant pointed out that this would need to be changed in the curriculum.

CB/98/2012 Royal College of Anaesthetists' Advisory Board for Scotland

Council received and considered the minutes of the meeting held on 1 June 2012 which were presented by the Chairman, Dr Colvin. The agreement that NHS Education for Scotland (NES) will run a second ST3 recruitment round for February 2013 was supported by the Board.

There was a failure to recruit to all ST3 posts because the pool of applicants was not sufficiently large.

The Board agreed to pursue with NES the need to offer dual training in ICM and Anaesthesia in Scotland as part of the transition plan to new ICM training. Professor Bion enquired if Scotland was moving towards anaesthesia and ICM at one sitting. Professor Bion added that the argument is that because there are no non-anaesthesia linked ICM consultant posts in Scotland there cannot be appointments to a primary ICM training programme. Dr Colvin responded that there is a view that there should be some standalone posts in ICM. Professor Bion explained that the FICM does not see hypothecated posts as being the way forward; hypothecating posts can be problematic and is not recommended by the FICM.

A sub-committee has been convened to manage a range of quality and safety initiatives in Scotland including input into the Government's Health Quality Strategy, development of critical incident reporting and Clinical Quality Indicators in Scotland.

15 ST Posts have been disestablished in the West of Scotland. The threat that these posts would be replaced with ill-defined post-CCT 'fellowship' posts seems to have receded. Instead there has been significant consultant expansion.

The President reported that he had looked at the surgeons' system of approving Fellowship posts and suggested that the RCoA should possibly take the same path. Professor Sneyd was not sure that the College should be specifying the content of post-CCT fellowships; there is significant risk associated with this proposal. Dr Colvin added that there could be other risks if the RCoA were outside the process. Mr Bryant reported that the potential for modular credentialing post-CCT and for out of programme experience (OOPE) is on the agenda for the Training Committee. The Training Committee envisages setting up a working party to look at standardising training syllabuses for specialist societies and specialist interest areas post-CCT so they may be formalised. Dr Marks cautioned against this, adding that lessons should be learnt from paediatric anaesthesia. The RCoA's currently expressed view is that once clinicians have a CCT, they are then considered fully trained. There is a danger that every specialist society will demand additional specific training for anaesthetists wishing to

work in their specialty areas. Professor Sneyd added that the RCoA should remain distant. The President stated that a serious implication of the Shape of Training Review may be that the CCT will be awarded at the end of ST4 and that the holders will then sub-specialise. The President agreed the RCoA should have a prepared response to that proposal. Dr D Nolan would be taking a paper to the Training Committee. Dr D Nolan shared others' reservations stating that this is not an attempt to say once a trainee has their CCT they have to subsequently train in a sub-specialty for two years. Dr Patel highlighted the need to ensure that this does not become a cheaper way of not giving trainees consultant posts. Dr Jones thought it would be remiss of the RCoA not to consider how training will look in the future, and the question of the QA of post-CCT training, possibly taking over this role from the deaneries. Professor Bion agreed with this approach stating that Colleges generally have a very important role in lifelong learning. The RCoA should be creating a framework in which there are a number of providers and opportunities which are pre-accredited. Dr Colvin reported that NES is looking at the content of these potential posts with a view to approval if appropriate. The specialty could be part of it or not but his personal sense was that involvement would enable the RCoA to influence these matters. Professor Sneyd was not keen on curricula or examinations being written for the posts. Dr Brennan pointed out that for the benefit of trainees or post-CCT doctors if they are going to be involved in one of these posts they need to know that it meets educational standards. If a post has a kite mark that the College has been involved with, it may give confidence to an employer. The President had suggested to Dr D Nolan that this be linked into the Medical Training Initiative (MTI) work. Dr Gulati reported that many trainees are facing limited options because of the current employment situation. Dr Thornberry stated that the RCoA should support appropriate mentoring for newly appointed consultants and that this should be part of a Departmental Accreditation system. Dr van Besouw stated that the CCT is determined by the curriculum and the GMC. Everything else falls into the category of CPD, which is tailored to the requirement of the individual and the employer. It would be difficult for the RCoA to mandate what is appropriate in that setting.

A report will be prepared on the direct clinical care (DCC)/supporting professional activity (SPA) split in recent consultant appointments.

Dr Eddie Wilson has been appointed Chair of the NES Specialty Board.

Dr Colvin thanked the President for his support and encouragement during the last three years.

CB/99/2012 Examinations Committee

Council received and approved the list of Fellows by Examination June 2012.

Council agreed that the under-mentioned doctor be awarded the Macintosh Prize for performing at the highest level of distinction in all sections of the Final examination at his first attempt at the June 2012 sitting of the Final FRCA.

Dr Benjamin Nicholas Harris –University of London - MB BS 2006 –
University Hospital Southampton

CB/100/2012 Equivalence Committee

Council received and considered the minutes of the meeting held on 21 June 2012 which were presented by Dr D Nolan as Dr Verma had by this time left the meeting. Two first applications had been considered but not approved for recommendation to the GMC for inclusion on the Specialist Register.

CB/101/2012 Education Committee

Council received and considered the minutes of the meeting held on 19 June 2012 which were presented by Ms Drake. Speakers' biographies have been added to the Events pages of the College website.

Mr Don Liu had submitted a proposal for a course for anaesthetists as appraisers. The Committee felt that generic training should be delivered by trusts but there was enthusiasm for development of specialty specific training.

Work continues to build on the Events App.

Ms Drake thanked those who had volunteered to chair sessions at the Current Concepts Symposium.

Lessons had been learnt from this year's Annual Congress. An organising committee has been set up to plan the 2013 Congress.

A new event, "Making the Most of ST5-7", would be held in March 2013.

The Committee is seeking to be more strategic in its outlook and plans to set up sub-groups to support the development of e-Learning Anaesthesia (e-LA) and simulation.

CB/102/2012 Patient Liaison Group

Council received and considered the minutes of the meeting held on 19 June 2012 which were presented by the Vice-Chairman, Mr Rees. The PLG was saddened that the short life working party with the Royal College of General Practitioners (RCGP) on patient information would be disbanded as there had been no reciprocal interest.

The PLG was very interested in, and supportive of, the RCoA's intention to embark on departmental accreditation.

The PLG has issued a very clear statement in relation to multi-source feedback for revalidation. The PLG is fully supportive of the initiatives being undertaken.

The PLG was very encouraged by the development of the RCoA's website.

Mr Rees expressed the PLG's thanks to the President and Council for supporting the strengthening of the PLG; three new members have been appointed subject to satisfactory [references. The President expressed Council's appreciation of the PLG's work on behalf of the specialty.

Mr McLaughlan reported the release of two documents relating to the Enhanced Recovery Pathway explaining that they had come about with great effort from the PLG. Mr Rees was appreciative of Mrs Kate Rivet's efforts in seeing the work through to fruition.

CB/103/2012 Audit and Internal Affairs Committee

Council received and considered the minutes of the meeting held on 20 June 2012 which were presented by the Chairman, Professor Mahajan. Professor Mahajan had received no comments regarding the election process. The Committee had looked at the process and considered it to have worked well but noted there was not actually a ballot because all three candidates had been elected unopposed. Council agreed that a simulated election should be run later in the year.

The Committee had agreed the Terms of Reference of the Advisory Committee on Clinical Excellence Awards (ACCEA) Scrutiny Panel.

The Committee had discussed the AoMRC's proposed guidelines for preventing leaking of information. Professor Mahajan would speak to the RCoA's Media Adviser to come up with a generic outline for Council and all College officers.

CB/104/2012 Finance Committee

Council received and considered the minutes of the meeting held on 2 May 2012 which were presented by the Chairman, Dr Jones. The draft budgets were attached for Council's information; the full document is available from Mr Storey upon request. The Committee had approved the draft budgets.

Endowed funds of £1.1 million were invested in Newton's Charity Fund on 3 April 2012.

The Committee had agreed to appoint Temple Lifts as the contractor to provide the replacement rear lift.

The Committee had agreed media contractual arrangements; it would proceed with Mr Si Scott for a period of six months. Mr McLaughlan informed Council that the arrangement was working very well with Mr Scott continuing to engage with the RCoA throughout a period of annual leave. Additionally Mr Scott had very quickly become attuned to the specific requirements of the RCoA. The President suggested that Mr McLaughlan talked to Mr Tom Grinyer.

The College's financial position for the first nine months of the year is £268,000 better than budget. The forecast surplus is for £950,000 at year end.

The Committee considered creating a budget to support educational activity for developing world projects.

The Committee had agreed, in between meetings, to purchase four SimMen from Laerdal.

Mr Storey reported that a cheque to the value of $77,000 is on its way in respect of the Eric Green legacy; the outstanding 40% could take a significant amount of time to arrive.

Mr Storey reported that he had attended a meeting where the three surgical Colleges had petitioned the GMC for funding of CCT work; the other Colleges had opposed this believing it to be core business. The GMC had responded that it would not fund the work.

CB/105/2012 Trainee Committee

Council received and considered the minutes of the meeting held on 19 April 2012 which were presented by the Chairman, Dr Patel. The Committee had agreed to develop a proposal for BJA donations to developing nations.

Trainee representation for hospital visits will initially come from the Trainee Committee.

An e-newsletter *Gas* has been well received.

The Committee continues to liaise with the Society for Education in Anaesthesia (SEA [UK]) and the Group of Anaesthetists in Training (GAT).

CB/106/2012 Anaesthesia Related Professionals Committee

Council received and considered the minutes of the meeting held on 19 June 2012 which were presented by the Chairman, Dr Batchelor. The Committee had agreed to produce an updated toolkit on 'How to grow your own Physician's Assistant (Anaesthesia) [PA(A)]'.

The PA(A) clinical leads are still very keen to produce a proposal on competencies relating to management of emergence from anaesthesia that would embed into the basic curriculum rather than being a locally agreed add-on.

The Advanced Critical Care Practitioner (ACCP) leads are producing a full curriculum for training ACCPs based on the FICM's medical curriculum. It is hoped this will be finished by the autumn when it will be brought to Council and the FICM Board for discussion.

The Committee agreed to organise a clinical lead for PA(A)s meeting and also one for ACCPs.

The Association of PA(A)s has agreed that all PA(A)s should acquire 25 CPD points per year and wondered if it would be possible to have access to the RCoA's CPD system at a reduced rate. Mr McLaughlan explained that PA (A) s who are already affiliate members of the College would have access to the CPD system.

The PA(A) course will run in Birmingham this year.

The Association of PA(A)s would like as much support as possible to get people onto the Managed Voluntary Register; work will be undertaken with Dr Nevin to publish information through the Clinical Directors' network.

The Committee had welcomed the Association of Anaesthetists of Great Britain and Ireland's (AAGBI) report on PA(A)s which gave a very balanced view. The AAGBI has not received any negative feedback. Dr Whitaker stated that other sources of negative feedback had been received.

An examination will be produced for ACCPs. It is hoped that this will give them a route into FICM membership.

A census of ACCPs suggests that at least 35 are currently in post although the number may be closer to 50.

Mr McLaughlan explained that he had been invited to a perioperative care collaborative meeting the following day. Dr Hartle would raise at the meeting qualifications for anaesthetic assistants. Mr McLaughlan further explained that there is not currently a committee looking at operating department practitioner (ODP) and anaesthetic nurse qualifications. Council agreed that the Anaesthesia Related Professionals Committee (ARPC) would seem the logical forum.

MATTERS FOR INFORMATION

I/23/2012 Publications

Council received, for information, the list of publications received in the President's Office.

I/24/2012 Consultations

Council received, for information, a list of the current consultations. The President noted that the first two had been circulated to the Joint Committee on Good Practice (JCGP) but may be of interest to others; even reading one chapter and sending in comments would be helpful.

I/25/2012 New Associate Fellows, Members & Associate Members

Council noted, for information, the following:

Associate Fellow – June 2012

Dr Oghogho Nosakhare Jude Oronsaye – Barts Health NHS Trust

Member – June 2012

Dr James Lloyd Garwood – FRCA Primary

Associate Members – June 2012

Dr Dora Eszter Pappne Dr Paal – Perth Royal Infirmary
Dr Tariq Rasheed Chaudhari – Hinchingbrooke Hospital, Huntingdon

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

Dr Sean Thiaga Nadaraja – University College Hospital, London
Dr Ivett Blaskovics – Princess Royal Hospital, Telford
Dr Syed Sameer Ahmed – Freeman Hospital, Newcastle-upon-Tyne

PRESIDENT'S CLOSING STATEMENT

PCS/7/2012 President's Closing Statement

(i) Dr Wilson would be unable to attend the September meeting of Council thus meaning this would be his last as AAGBI President. The President thanked Dr Wilson for his attendance and support given to the College. Dr Wilson thanked Council for its friendship adding that he considered Council to be a committed and reassuring group.

(ii) The President had chaired his last meeting of Council and thanked members for their support.

MOTIONS TO COUNCIL

M/26/2012 Council Minutes

Resolved: That the minutes of the meeting held on 20 June 2012 be approved.

M/27/2012 Deputy Regional Adviser

Resolved: That the following appointments be approved:
Dr P M Mullen, Deputy Regional Adviser for Mersey
Dr J A Wilson as Deputy Regional Adviser for South East Scotland

M/28/2012 College Tutors

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

Anglia

*Dr S G H Rao (Queen Elizabeth Hospital, Kings Lynn)
*Dr A A Klein (Papworth Hospital)

West Yorkshire
Dr B S Ghoorun (Calderdale and Huddersfield NHSFT) in succession to Dr M R Beadle
Extra in Huddersfield

North Thames West
To receive a request from Dr Michelle Hayes the Regional Adviser for North Thames West for an extension to Dr M A Stevens (Hillingdon Hospital) term of office

North Thames Central
*Dr M Sivarajaratnam (North Middlesex Hospital)

North Thames East
Dr E K Reid (Broomfield Hospital) in succession to Dr H Jones

Mersey
Dr K E J Palmer (Liverpool Heart & Chest Hospital) in succession to Dr O Al-Rawi
Dr A M Troy (Countess of Chester Hospital) in succession to Dr P M Mullen
*Dr M Diwan (Royal Liverpool University Hospital)

North West
Dr A W Monks (Blackpool Victoria Hospital) in succession to Dr S T A Vaughan
Dr S Sharma (Lancashire Teaching Hospitals NHS Trust) in succession to Dr F Sloss

West of Scotland
Dr L A McGarrity (Crosshouse Hospital) in succession to Dr C H Whymark (December 2012)

KSS
Dr M G Way (Royal Surrey County Hospital) in succession to Dr V Nataraj

Wales
Dr S H Burnell (Ysbyty Gwynedd) in succession to Dr J D Walker

M/29/2012 Examinations Committee
Resolved: That the under-mentioned doctor be awarded the Macintosh Prize for performing at the highest level of distinction in all sections of the Final examination at his first attempt at the June 2012 sitting of the Final FRCA.

Dr Benjamin Nicholas Harris –University of London - MB BS 2006 –
University Hospital Southampton