MEETING OF COUNCIL

Edited Minutes of the meeting held on Wednesday 15th June 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 A B H Lim
Dr R Laishley
Professor D J Rowbotham
Dr H M Jones
Dr E A Thornberry
Professor R P Mahajan
Dr P J Venn
Dr A M Batchelor
Professor J R Sneyd
Dr S R Moonesinghe
Dr S C Patel
Dr R Verma
Dr R J Marks
Dr T H Clutton-Brock
Dr L J Brennan
Dr J P Nolan
Dr J R Colvin
Dr J R Darling
Dr I H Wilson

Mrs K Rivett, RCoA Patient Liaison Group
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 and Miss E Bennett

Apologies for absence: Apologies were received from Dr D Nolan, Dr J D Greaves, Professor J F Bion, Dr M Nevin, Dr D K Whitaker and Dr J Heyworth.

CEREMONIAL

C/4/2011 Election of President
Of the 23 elected members of Council four did not attend the elections due to illness and transport problems. Those who did not wish to stand for election as President were asked to make themselves known using the form circulated by the Chief Executive. Once those elected members of Council who were expected to attend were present, ballot papers were circulated. In view of the number of elected members present, 10 votes would constitute an outright majority. Dr Nightingale was elected as President for one year from September 2011.

C/5/2011 Election of Senior Vice President
Those who did not wish to stand for election as Senior Vice President were asked to make themselves known using the form circulated by the Chief Executive. Dr van Besouw was elected as Senior Vice-President for one year with effect from September 2011.

C/6/2011 Election of Second Vice President
Those who did not wish to stand for election as Vice President were asked to make themselves known using the form circulated by the Chief Executive. Professor Sneyd was elected Vice President for one year from September 2011.

COUNCIL IN DISCUSSION

CID/24/2011 President's Opening Statement

(i) The President announced the death of Dr Madhusudhana Bengalaru Honnaiah. Council stood in memory.

(ii) The President welcomed Mrs Irene Dalton to Council; Mrs Dalton will be Chair of the Patient Liaison Group (PLG) from July 2011. Mrs Dalton offered her thanks to Council.

(iii) The President gave his thanks to Mrs Rivett who will be stepping down as Vice-Chair of the PLG from August 2011.

(iv) Dr D Nolan and Mr R Bryant are attending a meeting with the Centre for Workforce Intelligence (CfWI) today.

(v) The Queen's Birthday Honours List has been announced. Two knighthoods were awarded to members of the medical profession, Professor Sir Roger Michael Boyle and Sir Harry Burns. Professor Brian Owen Williams was awarded a CBE.

(vi) The President informed Council that the new coffee machine had been installed and was available for use.

(vii) The President offered his thanks to Dr Batchelor and Dr Whitaker for organising the Away Weekend. He asked speakers and scribes to email summaries of each session to Ms Amanda Regan, with key action points and suggestions for strategy. Mr Storey and the President will be producing a strategy document for the RCoA to which these will contribute; further ideas for strategy should be emailed to the President. The document will be developed in the President's Meeting before further distribution.

(viii) The President updated Council on staff matters:

a. Mr Paul McCarthy has joined the College on a full-time temporary contract as the Deputy Financial Controller.

CID/25/2011 Workforce Planning

Mr McLaughlan presented a brief summary produced by Mr Bryant on the on-going discussions with the CfWI. There is currently only one outstanding return on the RCoA Census; once the analysis has been completed this will provide a valuable contribution to the CfWI's data on workforce requirements.

Professor Sneyd enquired as to whether the census had included individuals working in the Independent Sector, since this would give information on the paths taken by RCoA trainees; Mr McLaughlan responded that only National Health Service (NHS) staff had been asked.

Dr Colvin enquired as to the data available on the minimum number of consultants for continuity of service and consultant growth. The President responded that such an analysis would require more data than currently provided to the RCoA.

Dr Jones informed Council of discussions at the recent meeting of the RCoA Advisory Board for Wales (ABW) around the need for continuity of placements. He felt that more attention should be paid to ensuring the level of service cover that the RCoA mandates as necessary. This would include a consultant delivered service where required, and coverage of sessions (particularly within Intensive Care Units (ICU) and Obstetrics), as necessary. The President commented that whilst the CfWI state that making financial savings is outside of their remit, they do have a responsibility to look at affordability and clearly must take the costs of a consultant delivered service into account.

The President stated that the CfWI are keen for the RCoA to work with them on modelling scenarios; if Council members would like to take advantage of this they should discuss their requirements with Mr McLaughlan and Mr Bryant.

CID/26/2011 ***High Quality Women's Health Care: A Proposal for Change***

Dr Thornberry presented the document *High Quality Women's Health Care: A Proposal for Change* to Council for information. This has been a large piece of work produced by the Royal College of Obstetricians and Gynaecologists (RCOG) in a short time to great cost; its production involved a wide consultation and a large number of stakeholders, including an expert review panel of which Dr Thornberry was a member. She undertook to ensure that decisions did not impact on delivery of care and felt that her concerns were taken into account. The work was driven by the current unsustainable workforce situation and the need to guide commissioners in the newly restructured NHS. The document includes describing the current position of RCOG, hopes for future development and the actions needed to achieve this. Dr Thornberry suggested that this model could contribute to the development of the RCoA's strategy document; the President concurred with this.

Dr Thornberry explained that the document proposes a model of hub-and-spoke networks taking care into the community; the President enquired as to whether this could impact upon the RCoA's own workforce needs, particularly the increased costs of consultant cover. Dr Thornberry responded that although there would be increased costs, there is a need to see how these changes are implemented; there is unlikely to be any direct impact in the short term.

Dr van Besouw stated that he felt the document was well produced and is likely to assist with anaesthetic departments' requests for more cover, particularly as the request would be supported from outside the anaesthetic department itself.

Dr Jones commented that he is pleased to see the statement "skilled anaesthetic assistants and post-operative recovery staff are also required" included; he has concerns about the presence of midwifery staff in the recovery room and hopes this document will contribute to proper training for recovery staff to allow midwifery staff to keep to midwifery duties. Dr Whitaker concurred with this and stated that this would be the recommendation of the *UK National Core Competencies for Post-Anaesthetic Care*.

CID/27/2011 **Proposal to Provide Support to SAS Doctors for Equivalence Applications**

Dr Jones presented this document, prepared by Dr Ian Barker, to Council on behalf of the Equivalence Committee. It proposes the introduction of a support mechanism for Staff and Associate Specialist (SAS) grade doctors, with the provision of an advisory service to review the portfolios of SAS doctors using the equivalence route to achieve their Certificate of Completion of Training (CCT).

The proposal is to pilot the scheme at the RCoA; if successful it would be rolled out for local delivery. A maximum of eight days is proposed for the pilot but it is not clear how many doctors could be seen in this time. Despite the declaration on page two of the proposal that "this is not a CESR [Certificate of Eligibility for Specialist Registration] pre-application vetting service", Dr Jones has concerns that those using the service be clearly informed that they may still be turned down for equivalence having gone through this process. There are resource implications for the proposal, with advisor expenses and possibly Regional Adviser (RA) involvement requiring funding; Trusts would also have to find cover and funding for doctors attending. The projected cost for the eight day pilot is circa £7000.

Professor Mahajan stated that individuals who sit on the Equivalence Committee should not be seen to be guiding this process due to the conflict this would entail; he nonetheless feels that support should be provided, perhaps on a model similar to that given for examinations whereby guidance is provided locally via RAs and on the RCoA website. Dr Jones concurred with this need for separation of roles.

Mr Storey commented that the RCoA has Bernard Johnson Advisors (BJAs) for International and Less Than Full Time doctors and enquired as to whether this work could be included in the remit of the BJAs, perhaps with the development of another BJA post.

Professor Sneyd commented that as a member of the Equivalence Committee he certainly feels that the RCoA should step closer to those going through the process. He suggested a third

solution: a template could be provided and this would have to be completed for an interview with a BJA to be granted. The template could provide very specific detail on what is missing from the requirements for Equivalence; it would provide clear evidence for the candidate as well as structuring the conversation with the BJA. The President remarked that this was an excellent suggestion. Dr Clutton-Brock concurred and suggested that the document be placed online. He voiced concerns that the RCoA should not be seen to be helping people through a process only to exclude them at the end of it; furnishing support online would help separate these pieces of work.

Dr Laishley was supportive of Professor Sneyd's proposal but added that he certainly felt that face-to-face interviews would be of benefit. He further commented that the template would give doctors evidence of training needs to pass to their Trusts. Dr van Besouw added that it will provide information on where applicants should target their resources, facilitating further training in order to reach the point of equivalence; it should not been seen as a process of 'marking' in order to allow 'corrections' to be made.

The President suggested a stepped strategy: the development of the template would be followed by ascertaining the level of interest in the service and how many candidates would want interviews. Professor Sneyd stated that he is happy to contribute to the development of the template for piloting with a limited number of candidates and will discuss this with Dr Barker. Dr Jones commented that there is already a lot of guidance available, such as in the *Handbook* for SAS doctors; this process will mainly be one of collation.

CID/28/2011 Pre-Hospital Emergency Medicine

Dr J Nolan presented this document, prepared by Mr Craig Williamson, to Council. The document will be placed on the RCoA website for information. It has been developed by the Intercollegiate Board for Training in Pre-Hospital Emergency Medicine (IBTPHEM); the main focus of their work has been gaining sub-specialty recognition from the General Medical Council (GMC). They are close to achieving this but success is conditional on solving issues around the assessment process. Pre-Hospital Emergency Medicine (PHEM) is not intended to be a dual CCT; it will consist of a CCT in Anaesthesia or Emergency Medicine (EM), with a sub-specialty in PHEM. There will be a requirement for six months' experience in an EM role; this is already provided for those anaesthetists doing Acute Care Common Stem (ACCS) training.

Dr J Nolan stated that there are still unresolved issues for trainees undertaking advanced training for Dual CCTs in ICM and Anaesthesia, since he suspects that many of these individuals would be interested in PHEM. If they wished to incorporate this training into Dual CCTs, training would have to be extended beyond 8.5 years; it is not clear how this would work. Dr Thornberry stated that if trainees had done both ACCS and EM she felt it would be possible to complete in 8.5 years.

Dr van Besouw pointed out that PHEM trainees would need to be taken into account for workforce planning; he enquired as to the perceived need for this group of trainees. Dr J Nolan responded that the estimates from the IBTPHEM are circa 250 full-time equivalent consultants; assuming at least half of each consultant's time is in their parent specialty then the need is circa 500 posts. The current capacity for training is only 25 trainees a year, in four or five centres, so there is a very real gap here. There is some urgency as posts should be available from August 2012; concerns were expressed at the recent RAs meeting in Newcastle over the time available.

Dr Patel enquired as to how posts for the higher six months' training will be distributed, as they are currently applied for on an individual basis; Dr J Nolan responded that a nationalised recruitment process will be put into place.

Professor Sneyd stated that many roles currently include the tasks included in PHEM; he challenged the value of this sub-specialty given that the range of positions into which trainees are likely to go is so diverse that he would question whether a single training process could encapsulate it. Dr J Nolan responded that it is important that training is standardised across the UK. The President added that it will also provide national assessment, which is currently lacking. Dr

Batchelor further commented that there is much less option these days for trainees to pick up skills they want without the support of a curriculum.
Mrs Rivett enquired as to whether trainees from General Medicine would be able to swap into this training and how it would be ensured that they were capable of undertaking all these roles. Dr J Nolan responded that currently only Anaesthesia or EM trainees will be eligible and although this could alter in the future, trainees would only be accepted if they held all these competencies.
Dr Patel commented that unless trainees decide on this route very early in ST4 then they will be excluded from many of these jobs, which will likely be ring-fenced for this sub-specialty. Dr J Nolan replied that although it is not yet certain that these jobs will be ring-fenced, this could be a problem. Dr van Besouw enquired as to whether posts would be ring-fenced for Defence Medical Services trainees, as they have the most to gain and to offer in training terms; Dr J Nolan responded that he is unaware that discussions have taken place on this yet.
Dr Lim enquired as to whether this might affect individuals who put in time out of hours volunteering at events to provide this form of care, and whether there would be a requirement for these competencies in all such situations. Dr J Nolan responded that it will be some time until this could become a problem. Dr Batchelor added that many of those roles are remunerated and so it is worth being aware of future changes.
The President stated that currently members of the Association of Anaesthetists of Great Britain and Ireland (AAGBI) or the Intensive Care Society (ICS) are insured during transfers; he enquired as to whether PHEM doctors would be required to join one of these organisations to get indemnity for PHEM jobs. Dr J Nolan responded that this has not been discussed by IBTPHEM and he would raise the issue there.

CID/29/2011 Replacement FRCA Certificate
Council agreed to a request from Dr Bernard John McClement for the replacement of his FRCA certificate.

CID/30/2011 Specialist Societies – Withdrawal of Charging for CPD
Dr Tomlinson presented to Council a letter that will be sent to Specialist Societies regarding charging for Continuing Professional Development (CPD) approval. It had become clear that the small administration fee charged for CPD approval had been badly received. Following discussions at Finance Committee it was agreed that the charges be dropped. GMC proposals suggest that CPD providers may soon be able to provide their own approval; there is a general wish within the College to ensure the specialty is not divided by the quality assurance of CPD, since this will make it very difficult for appraisers to assess the value of individual CPD. The RCoA therefore intends to adopt a process whereby approved CPD providers will be offered use of the RCoA Revalidation Logo on promotional materials as a 'Kite Mark' of approval. The President clarified that commercial companies will still be charged for CPD approval.
Dr Clutton-Brock stated that he strongly supports the proposals; he stated however that he feels that CPD is an aspect of revalidation rather than a separate issue and so would rather the 'Kite Mark' was referred to as the RCoA CPD Logo. Dr Tomlinson concurred, since there is otherwise a danger that if doctors have achieved all the CPD required for revalidation their Trusts would not approve any further CPD.

CID/31/2011 FICM Update for Trustees
Dr Batchelor presented this item in Professor Bion's absence. She noted the suggestion that an ICM CCT should be available in 2012; there are concerns over the proposal and the request has been made to the GMC that the Joint CCT be retained for another year. Discussions are ongoing.
Dr Brennan enquired as to the statement on the enclosure that a single CCT programme would be piloted in August 2011 and asked whether these posts had been advertised as he understood that there were still issues over the curriculum; Dr Batchelor responded that she believes this to be

a typographical error since the August 2011 curriculum has been delayed by a year in agreement with the GMC.
Dr Batchelor informed Council that the consultant workforce survey had achieved 60% returns; a second phase is planned in order to pick up information for more detailed modelling once data has been analysed.
Dr Batchelor informed Council that work on the Quality Improvement Forum is moving forward.
Dr Batchelor informed Council that applications for Fellowship continue to be received; Mr Storey added that the 700th application had recently been received.

Dr Clutton-Brock enquired as to the work on the Acute Respiratory Failure National Strategy and whether dates had been set for commissioning for Extracorporeal Membrane Oxygenation (ECMO) Centres, as time is getting short for the process to be completed. Dr Batchelor responded that an email was received in August 2010 asking for volunteers to undertake the work but nothing further has been received. She added that this is Department of Health work rather than FICM work, although they are contributing to the process.

CID/32/2011 Supervision of PA(A)s
Dr Batchelor informed Council that a query had been received from a hospital regarding the supervision of Physicians' Assistants (Anaesthesia) [PA(A)s]. The hospital has no out-of-hours surgery, no Accident & Emergency Department, and takes acute medical admissions from 8am to 5pm. Consultant physicians are present in the evening to deal with issues from the day's intake and the medically-led High Dependency Unit (it was reported that there was no ICU). On-call anaesthetic cover is by special arrangement and reported to be expensive and so the hospital has enquired as to whether the PA(A)s already in post could undertake the required tasks, primarily airway support during cardiac arrest. This was discussed at the meeting of the Anaesthesia Related Professionals Committee (ARPC) on 14th June. Council accepted the Committee's recommendation that such a development could not be supported without a proper support structure in place, as per the RCoA guidelines on supervision of PA(A)s.

CEREMONIAL

C/7/2011 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 Mohamed Abdullatif	Stepping Hill Hospital, Stockport
Dr Lawrence Azavedo	Royal Preston Hospital
Dr John Donnelly	Queen Margaret Hospital, Dunfermline
Dr Lucinda Hardy	Stepping Hill Hospital, Stockport
Dr Sian Jaggar	Royal Brompton Hospital, London
Dr Andrew Klein	Papworth Hospital, Cambridge
Dr Arun Krishnamurthy	Princess Alexander Hospital, Harlow
Dr Nicholas Morgan-Hughes	Northern General Hospital, Sheffield
Dr Shankaranarayana Nagaraja	University Hospital Aintree, Liverpool
Dr Alexander Ng	Royal Wolverhampton Hospital

C/8/2011 Fellowship ad eundem
Fellowship ad eundem of the Royal College of Anaesthetists was awarded to Dr Andrzej Krol.

C/9/2011 Signing of Fellowship Book
Dr Aileen Adams CBE attended in order to sign the Fellowship book.

COMMITTEE BUSINESS

CB/81/2011 Council Minutes

The minutes of the meeting held on 20th May 2011 were approved, subject to the following amendments:

CB/78/2011 'Ms Sue Saddle' should read 'Mrs Sue Saville.'

PCS/5/2011 'UCL Clinical Effectiveness Unit' should read 'RCS Clinical Effectiveness Unit'

CB/82/2011 Matters Arising

i. Review of Action Points

CID/21/2011 President's Opening Statement Some comments have been received regarding the Quality Indicators; more would be appreciated.

CB/67/2011 Possible Development to 34 and 35 Red Lion Square No comments have been received; comments will still be welcomed.

CB/73/2011 Examinations Committee This work is in progress; Mr Bryant to report to the July meeting of Council.

CB/74/2011 Finance Committee This has been noted; the agreed budget will be circulated to Council when minutes are circulated to Finance Committee.

CB/78/2011 Revalidation Development Committee This work has moved on; Mr Don Liu and Dr Tomlinson are currently amalgamating core supporting information from all Colleges to create a cross-specialty document.

CB/79/2011 Recruitment Committee Further discussion was held at the Away Weekend; Dr Marks' document will be discussed during this meeting of Council following which the President will take it to the MPB T&F group.

PCS/5/2011 President's Closing Statement To be discussed at this meeting of Council.

All other actions had been completed.

CB/83/2011 Regional Advisers

Council considered making the following re-appointment:

Anglia

Dr Simon Fletcher, Regional Adviser for Anglia **Agreed**

CB/84/2011 Deputy Regional Advisers

Council considered making the following re-appointment:

South Thames East

Dr Joy Curran, Deputy Regional Adviser for South Thames East **Agreed**

CB/85/2011 College Tutors

Council considered making the following appointments:

West Yorkshire

Dr S B Walwyn [Dewsbury District Hospital] in succession to Dr C L Hildyard **Agreed**

North West

Dr N J Pickstock [Lancashire Teaching Hospitals NHS Trust] in succession to Dr K J Kidner **Agreed**

South West Peninsula

Dr A R A Ruston [Derriford Hospital] in succession to Dr T C E Gale **Agreed**

South Thames East

Dr I Ahmed [Guy's Hospital] in succession to Dr J B Watkiss **Agreed**

Sheffield and North Trent
Dr S Sanghera [Northern General Hospital] in succession to Dr A R Dennis **Agreed**
Dr E M Wilson-Smith [Sheffield Children's Hospital] in succession to Dr C M Wilson **Agreed**
Dr C E Smith [Rotherham General Hospital] in succession to Dr J R Clark **Agreed**

Wessex
To receive a request for an extra tutor at Southampton University Hospital **Agreed**

CB/85/2011 Heads of Schools
Council noted the following appointment:
Barts and the London School
Dr E McAteer in succession to Dr K Wark

CB/86/2011 Training Committee
i) Training Committee
Council received and considered the minutes of the meeting held on 1st June 2011 which were presented by the Chairman, Dr Thornberry.
The Committee followed up on a request received from the Faculty of Pain Medicine (FPM) to include a sentence encouraging trainees to undertake pain rounds during higher training.
A number of subtle changes have been made to the curriculum in response to previous suggestions.
Changes to the structure of Committee membership, as discussed at the April meeting of Council, will be implemented from September.
The Committee discussed including training in patient safety, in response to comments received from the Advisory Board for Scotland (ABS); Dr Thornberry is to discuss requirements with Dr Colvin.
Reports were received from the ABS and ABW regarding the three-year training programme; a working party will be convened to utilise these reports as evidence for the benefits of introducing three-year training in England.
The Committee discussed the benefits of Mr Bryant and Mr Williamson attending local Specialty Training Committees as a source of information for the Training Department.

ii) Certificate of Completion of Training Recommendations
Council noted recommendations made to the GMC for approval, that CCTs be awarded to those listed below, who have satisfactorily completed the full period of higher specialist training in anaesthesia. Those doctors whose names have been marked with an asterisk have been recommended for Dual CCTs in Anaesthesia and Intensive Care Medicine.

London
South East
Dr Kumarvel Veerappan
Dr Raja Sekhar Reddy Byreddy
Dr Rebecca Helen Mines
Dr Krishna Rajesh Srinivas

North Central
Dr Anthony Keith Parsons *
Dr Jason Ayite Cronje
Dr Kwok Mun Woo

Bart's
Dr Tabitha Anne Tanqueray
Dr Tarannum Rampal

Imperial
Dr Tasneem Katawala

St George's
Dr Sumita Saxena

East Midlands
Leicester
Dr Alison Jayne Brewer
Dr Thomas Edward Cowlam

Nottingham
Dr Ruth Mary Longfellow
Dr Lucy Andrew
Dr Melanie Jane Davies
Dr Kathryn Rose Corrie
Dr Tony Derrick O'Leary
Dr Daniel John Robertson Harvey *

North West
Dr Rosalind Beth Morley
Dr Abigail Jones
Dr Tom Henry Lupton
Dr Iain Dunn
Dr Claire Elizabeth Moore
Dr Jaya Thakur Nariani
Dr Sailesh Kumar Mishra

Northern Ireland
Dr Monica Chogle
Dr John Michael McLoughlin
Dr Siobhan Anne Cavanagh

Oxford
Dr Kevin David Johnston

Severn / Bristol
Dr Kieron Derek Rooney *
Dr Adrian Upex
Dr James Matthew Peyton

South West Peninsula
Dr Andrew Murray McEwan

Tri-Services
Dr Timothy Charles Nicholson Roberts *

Wessex
Dr Matthew Edward Cross
Dr Tamsin Louise Gregory

West Midlands
Stoke
Dr Ratnayake Mudiyanselage Athula Wimal Ratnayake

Warwickshire
Dr Matthew John Gray

Wales
Dr Alan Martin Slater
Dr Stefan Achmed Martellock
Dr Louise Jennet Allman
Dr Christine Range

Scotland
South East Scotland
Dr Gary Andrew Morrison
Dr Benjamin Michael John Slater *
Dr Abdul Muthaleef Shaikh Dawood *
Dr Audrey Shu-Yin Jeffrey

North Scotland
Dr Garry Wilson Reilly *

West Scotland
Dr Susanne Agnes Farrell
Dr Helen Jane Duffty
Dr Kevin Richard Fitzpatrick

Yorkshire
West Yorkshire
Dr William Wynn Jones
Dr Claire Elizabeth Schofield

South Yorkshire (Sheffield)
Dr Michael Sean Scanlan

iii) Medical Secretary's Update
Dr Thornberry had nothing further to report.

Dr Marks' paper on three year core training was discussed at this point.
Dr Marks informed Council that his fundamental recommendation is of the need to convene a working party to look at this issue. The arguments for a move towards three-year core training have been raised repeatedly; the recommendation of broader based training was included in the RCoA response to Sir John Tooke's *Final Report of the Independent Inquiry into Modernising Medical Careers*. There are likely to be logistical problems, including the likely response of the GMC, as well as issues around how twice-yearly recruitment at CT1 will be carried out. Training has

in the past been of variable length and Dr Marks proposed that this would be necessary for three-year core training to work; questions must be asked around whether the third year would be compulsory. There are educational arguments around extending the length of training including counteracting the influence of the European Working Time Directive, which means that trainees get less experience and undertake fewer unsupervised cases. Dr Marks stated that three year core training would have to be fitted into the totality of seven years' training and suggested models including "3 + 4", "3 + 4 + service" and "3 + 5." He emphasised that there are clearly implications of this change both for funding and for workforce requirements, and the management of the transition would have to be carefully handled. He stressed the value of the Scottish and Welsh models as these have been successfully piloted and would provide a useful precedent to propose a model for implementation in England.
Council agreed that a short life working party be convened to look at this issue.

CB/88/2011 Communications Committee
Council received and considered the minutes of the meeting held on 19th May 2011 which were presented by the Chairman, Dr Venn.

Dr Venn informed Council that the *Bulletin* is now full until January 2012; there is a long waiting time for articles to be published although attempts are made to prioritise important articles. The President offered his congratulations on the production of a professional looking magazine; Dr Venn offered his thanks to the Communications team for their work.
The Committee considered alternative forms of communication, including the high number of followers the RCoA Twitter feed already has. The use of Facebook was again discussed; Dr Patel is to liaise with a trainee who has approached the RCoA to discuss establishing a Facebook forum for trainees. The Committee is keen that this runs parallel to the RCoA rather than directly from within; the Committee has previously agreed that Facebook is not an ideal method of communication since it allows for two-way discussion and therefore requires a high level of engagement.
Discussions were again held regarding the engagement of a Press and Media Officer; the Committee is keen on this suggestion. Dr Venn and Mrs Mandie Kelly visited the Royal College of General Practitioners (RCGP) to discuss how they have successfully raised their profile; these recommendations would generally require the establishing of such an Officer for implementation. Dr Venn is to develop a paper to bring to the July meeting of Council on this subject. Professor Sneyd informed Council that at the recent meeting of the European Society of Anaesthesiology a professional science writer had been employed to produce press releases from abstracts at the meeting; this has given these abstracts a massive boost in internet returns to searches. The President informed Council that he has previously discussed with Mr Storey the blog produced by trainees at the Annual General Meeting of the ICS; it was generally agreed to be useful and could be something for the RCoA to look into.
The Committee discussed the forthcoming exhibition at the Science Museum; it will be working with Dr Andrew Morley and the AAGBI on its development. The Wellcome Trust, who are funding the exhibition, have been clear in stating that the exhibition should focus on the science of anaesthesia rather than anaesthetists.

Dr Marks informed Council that an alignment meeting had been held with the website developers to discuss the RCoA's requirements for the new website and how these can be achieved. It is hoped that the website could go live in October 2011. The main concern is with the length of time required for content migration.

CB/89/2011 Royal College of Anaesthetists' Advisory Board for Scotland
Dr Colvin gave a verbal report of the meeting held on 1st June 2011.

The ABS is currently interacting with the Scottish government on reshaping the workforce and examining initiatives proposed by NHS Education for Scotland. Objections have been noted on mid-point credentialing and dialogues are ongoing around current workforce numbers and future projected need, to ensure gaps in service are managed. The ABS is, via the Academy of Medical Royal Colleges and Faculties in Scotland (AoMRCS), involved in the development of Quality and Standards for career progression. Contributions to annual recruitment continue on the basis of specialty training.
The ABS is working to link RCoA and AoMRCS work on revalidation.
Dr Colvin informed Council that the ABS is also contributing to government developments of patient safety including Critical Incident Reporting.
Dr Colvin stated that he welcomed the arrangements for Scottish representation on the FICM Board and Training Committee which have recently been agreed.

Dr Tomlinson stated that he felt discussions at the meeting around workforce had been very interesting; the issue had been raised that if care is not taken over the structuring of the workforce then anaesthesia is at risk of becoming an unpopular specialty, as has happened with EM, due to the need to be resident on call. As training numbers fall consideration must be given to delivery of service; countries such as India, which have traditionally provided extra doctors, will not necessarily continue to do so. There is increasing difficulty in attracting high quality candidates.

CB/90/2011 Examinations Committee
Council agreed to extend the term of examinership of Dr Jane Pateman (Final Examiner) by one year to July 2012.

Council agreed that the under-mentioned doctor be awarded the Nuffield Prize for performing at the highest level of distinction in all sections of the Primary examination at her first attempt at the May 2011 sitting of the Primary FRCA:

Dr Randa Ridgeway – Bradford Royal Infirmary

CB/91/2011 Equivalence Committee
Council received and considered the minutes of the meeting held on 18th May 2011 which were presented by Professor Mahajan.

One application was considered and was found not to be suitable for recommendation to the GMC for equivalence, based on domains 1b and 2a lacking evidence of planning, conducting and presenting audit. It was otherwise considered to be a reasonable application, although it could have been better completed, and the candidate was encouraged to reapply.

CB/92/2011 Enhanced Recovery Programme Intercollegiate Guideline Group
Council received and considered the minutes of the meeting held on 3rd May 2011 which were presented by Mrs Rivett.

The group has been convened in order to prepare guidelines for patients who find themselves in an Enhanced Recovery Programme (ERP). Lay representatives were present from the RCGP and Royal College of Surgeons (RCS); in addition Dr Venn and Dr Mary Selby of the RCGP attended as clinical representatives. A clinical representative from the RCS has been invited.
It was felt to be a positive meeting and the group endeavoured to produce a reasonable timescale for completion of the work.
Dr Selby outlined her concerns regarding her lack of up-to-date information on anaesthesia; this was felt to be a general problem and it was felt that some form of e-Learning could be produced to rectify this. Dr Venn has discussed this issue with Ms Drake.

Mrs Rivett informed Council that when the concept of enhanced recovery was first discussed at the RCoA in early 2010, Professor Monty Mythen outlined a very clear and confident clinical pathway that adamantly started with the GP. However, at the meeting of the ERP Intercollegiate Guideline Group, the RCGP representatives stated that many patients would not be aware that they were on an ERP until they were already in secondary care. This suggests that the pathway is not being properly implemented, and patients are therefore not being given proper control of their care; they may also be being discharged early. It is unclear how this can be communicated to patients but it is crucial that this happens as otherwise Trusts may be left able to cherry-pick aspects of care.

Dr Moonesinghe stated that she felt the convening of the group was a positive step. She expressed concerns around the suggestion that patients are being discharged early but stated that this may be due to a lack of understanding of the purpose of the ERP: it is intended to reduce post-operative complications and therefore allow patients to be ready for discharge earlier. If patients are being discharged earlier than they should be then this is a failing, but she expressed uncertainty that this is taking place. Dr Moonesinghe further suggested that, from the comments above General Practitioners may not have the necessary anaesthetic information, the group could be better served looking at pathways for all surgical procedures and not exclusively for ERP. Although many elements of ERP are very technically specific, the required follow-up applies to all surgery. Mrs Rivett responded that this issue had been discussed at the meeting and it was felt that enhanced recovery is not a new concept but is rather based on improving implementation of existent practice. The President added that the ERP pathway is concerned with establishing a coherent whole to help ensure best outcome and fewer complications for patients. Dr Venn stated that ERP was intended to break down the artificial barrier between primary and secondary care, but questioned why this work was not being carried out for the benefit of all, and not just ERP, patients. He further commented that such work could form an integral part of the RCoA strategy document: the production of such work, which would form an accepted core for UK healthcare, could be based around the integral role of anaesthesia and would certainly have a positive impact on the RCoA's media profile.

CB/93/2011 Professional Standards Committee

Council received and considered the minutes of the meeting held on 26th May 2011 which were presented by the Chairman, Dr Venn.

Dr Venn informed Council that the departmental accreditation programme is moving forwards. Recent work has involved assembling the stakeholders for the programme; now that the Care Quality Commission (CQC) is involved the last major delay has been passed and work can proceed. Twenty Clinical Directors were approached for voluntary subscription to the scheme; only one response was received. Departments would be asked to register an interest but would not be initially expected to be up to scratch. A preliminary meeting would be held where the requirements for accreditation could be established and when the department was ready the accreditation visit would be carried out.

Professor Sneyd commented that a list had previously been put together of departments who were wiling to be involved in piloting the scheme, including his own department, which has not been approached. Dr Venn stated that he was unaware that such a list existed; the President stated that he and Dr Rollin had a copy and it would be forwarded to Dr Venn.

Mrs Rivett enquired as to whether the accreditation review teams would include lay representatives and Dr Venn commented that although these decisions are some way ahead he was confident that they would do so. Ultimately the hope is for this scheme to replace the work currently carried out by the CQC and so lay representation would be compulsory.

The organ donation taskforce has now been wound up but work will continue within the Committee. The Committee intends to liaise with the FICM to produce a list of necessary work.

The Committee received the new *Guidelines for the Provision of Anaesthetic Services*; these had previously been signed off but further changes have been made and the Committee will need to reapprove them before sending them to the National Institute for Health and Clinical Excellence (NICE) for accreditation.
The Committee has undertaken a number of new pieces of work including the development of guidelines on paediatric anaesthetic airways and the revision of guidelines on local anaesthetic for intraocular surgery. Both will need to be reconsidered by the Committee.
The Academy of Medical Royal Colleges (AoMRC) are working towards the production of intercollegiate sedation guidelines but the Committee felt that there is room for the RCoA guidelines to be revised. Discussions were held on establishing a sub-group to examine this topic.

Dr Wilson referred to the discussion in the minutes regarding neuraxial connectors; he informed Council that discussions were recently held at the AAGBI on this subject. In 2001 the NHS decided that new connectors should be designed to prevent administration of incorrect drugs intrathecally. However, there are concerns over the fact that up to seven new connectors are coming onto the market without proper testing; what tests have been carried out have shown there to be problems, including leaking. In Wales the intention is to carry out testing and choose one single connector for national use; however in England the National Patient Safety Agency (NPSA) is pushing forward with introducing all the new connectors for testing across all hospitals. Given that the original problem that led to these changes has largely been solved through changes in procedures and drug storage, there appears to be little justification for the use of such an unsafe testing procedure, particularly as it is likely to cause difficulties with procurement. The Clinical Reference Group, of which Dr Tim Cook is a member, is meeting on 5th July and so this is the time for clinicians to express concerns over the proposals. The AAGBI have produced a risk assessment document on this, which Dr Wilson has shared with the President.
Dr Clutton-Brock commented that he is in favour of adopting a single international non-interchanging connector; designs have been produced. He concurred with Dr Wilson's criticisms of the plans for testing multiple new connectors and stated his concerns that the NPSA may not fully understand the issue.
Dr J Nolan enquired as to why the NPSA appeared to be pushing so hard for this process to begin and Dr Clutton-Brock responded that it may be a result of the NPSA's previous involvement with the standards process, which was seen as very slow moving; these changes may have been politically driven by the Chief Medical Officer.
Professor Mahajan stated that the risks involved in this are huge; unless clinicians are able to make informed decisions based on testing then the adoption of the new connectors should not be mandated.
Mrs Rivett stated that the PLG supported the AAGBI's work towards ensuring that the new connectors were properly tested.
Council was in favour of supporting the AAGBI stance on this issue. The President will circulate the AAGBI document.

Council also received and considered the draft Terms of Reference for the Short Life Working Group to Draft a Response to the NCEPOD Report *An Age Old Problem* (hereafter referred to as NCEPOD WG).
Dr Venn informed Council that the NCEPOD WG has been established as a multidisciplinary group of representatives and the work is moving forward. The group have thus far examined the conclusions of the report to establish where responsibility for managing such patients lies; it seems that almost all the conclusions drawn could sit within the remit of anaesthesia but the problem may be that patients are not seen by anaesthetists until late in the course of treatment. Whilst a pathway could be established with recommendations from anaesthesia there is a need for a method to identify such patients and ensure that they are seen by anaesthetists earlier. The next

stage of work will be to produce guidelines for managing the admissions process for such patients. The work is expected to go on into autumn 2011.

CB/94/2011 Quality Management of Training Committee

This item was not discussed due to Dr D Nolan's absence.

CB/95/2011 Board of the Faculty of Intensive Care Medicine

Council received and considered the minutes of the meeting held on 10th May 2011 which were presented by Dr Batchelor in Professor Bion's absence.

Dr Batchelor informed Council that the President of the Scottish ICS has been co-opted to the FICM Board. The Lead RA from Scotland has been co-opted to the FICM Training & Assessment Committee.

The first Annual Meeting of the FICM will be held on 6th February 2012 at the Royal College of Physicians of London.

The single CCT in ICM has been approved by the GMC with some conditions. Working groups have been established to create guidance for dual programmes; the estimated length of dual CCTs in ICM and anaesthesia is 8.5 years; this includes some double-counting of training.

There are concerns over whether enough posts will be available for the number of trainees currently being turned out. A group has been convened to look at the issue. Professor Bion recently met with the Conference of Postgraduate Medical Deans to discuss this and feedback is awaited.

There is currently no e-Portfolio for ICM; several thoughts were discussed on how this can be progressed including whether or not it should be an add-on to the anaesthesia e-Portfolio.

Dr Batchelor informed Council that membership categories are currently in development. The President added that he met with Mr Storey and Mr Daniel Waeland on 14th June to discuss the problems with establishing these categories. Dr Patrick Nee is heading the Advisory Group on this work and the President suggested that Mr Storey could usefully contribute to this. The President will liaise with Professor Bion on this.

The workforce census has now had over 60% responses; this is positive although a lot of follow-up work will be required. This data will be used to inform discussions with the CfWI on the number of National Training Numbers (NTNs) that will need to be created for ICM. There is a great deal of pressure for this work to be completed, as if training is to start as of August 2012 then NTNs should have been created by July 2011 in order that Deans can take them into account in September when planning for 2012.

Dr van Besouw questioned the suggestion that Trusts will be open to Trust-funded ICM posts being absorbed into GMC and Deanery approved posts given that this will mean opening them up to national appointments. Dr Batchelor responded that whilst she recognised the potential for problems, it is worth noting that some units may be happy for such moves as posts are currently often held by overseas Fellows who may require more support than UK doctors.

Professor Sneyd commented on the statement in the minutes regarding National Audit Project 4 (NAP4) as he felt it was unclear regarding EtCO2 monitoring. The RCoA has written to all Chief Executives of Trusts recommending implementation of the recommendations of NAP4 but the FICM appears to be adopting a different position. The President stated that there would be value in establishing if the FICM is differing from the recommendations of NAP4, the ICS and the AAGBI. Dr Batchelor responded that the FICM Board were not unanimously agreed that capnography should be constant for all patients. During the discussion it was felt that this would be profitably discussed by the FICM Professional Standards Committee but it was suggested that this had been pre-empted by NAP4 and AAGBI recommendations; at present the FICM is not directly recommending this practice. The President will seek clarification of the position from the FICM.

CB/96/2011 Board of the Faculty of Pain Medicine

Council received and considered the minutes of the meeting held on 5th May 2011 which were presented by the Chairman, Professor Rowbotham.

The Board discussed NICE Quality Standards; on 10th June FPM representatives visited NICE to discuss the adoption of Pain (Acute and Chronic) Quality Standards. The meeting was felt to be positive and NICE are to take the work forward. The President will raise this topic in his meeting with Sir Michael Rawlins on 5th July.

The previously unresolved issue around the creation of a Pain Research Network was discussed. It had been felt that the British Pain Society (BPS) were not keen on the concept but it was established that this was an incorrect judgement and so the work will be taken forward, with BPS support.

CB/97/2011 Joint Informatics Committee

Council received and considered the minutes of the meeting held on 19th May 2011 which were presented by the Chairman, Dr Verma.

Dr Verma informed Council of a review underway of the Hospital Episodes Statistics (HES) database, which contains information collected nationally by the NHS Information Centre. The quality of data is generally regarded as poor, and HES includes very little anaesthetic data; despite this, important decisions are based on this data. Dr Andy Spencer is heading the review, which aims to improve the quality of the data gathered, and Dr Verma requested that quality indicators be suggested to cover elements of anaesthetic practice that could usefully be included on the HES database. The President asked Dr Verma to liaise with Dr Mike Grocott and the Health Services Research Centre to establish a list of proposals which can then be brought to Council.

Dr Verma also stated that there was a survey which Dr Spencer has requested be publicised. Dr Patel enquired as to the RCoA position on publicising surveys as he receives many requests to do so. Ms Drake responded that currently surveys will only be promoted if related to a specific RCoA committee but this is currently under review. The President commented that surveys may be noted but not necessarily endorsed by the RCoA.

Dr Verma drew Council's attention to the letter received from the Society for Computing and Technology in Anaesthesia on the provision of free online data backup. He also enquired as to the procedures for the storage of RCoA data. Mr Storey responded that data is backed up on on-site servers; twice a week data is taken for storage off-site. The College of Emergency Medicine will be taking up new premises at the end of 2011 and discussions regarding reciprocal storage arrangements in their new premises are ongoing.

MATTERS FOR INFORMATION

I/21/2011 Publications

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

I/22/2011 Consultations

Council received, for information, a list of the current consultations.

I/23/2011 New Associate Fellows, Members & Associate Members

Council noted the following:

New Associate Fellows - May 2011

Dr Prasanna Nirmala Tilakaratna – Broomfield Hospital, Chelmsford
Dr Andras Safranko - The Cheshire & Merseyside NHS Treatment Centre
Dr Ann Carmel Gallagher - Ulster Hospital, Dundonald

Affiliate – Physicians' Assistant – May 2011

Miss Samantha McColl - Queen Elizabeth Hospital Birmingham

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

Dr Rahul Gosavi – Royal Glamorgan Hospital
Dr Saba Mohammed Mahmood Al Sulttan – Royal Free Hospital, Hampstead
Dr Bindiya Hari- Watford General Hospital
Dr Dehiwala Liyanage Saman Priyankara Seneviratne - West Sussex Hospitals, Worthing
Dr Chetana Chandan - Colchester General Hospital
Dr Pranay Kumar Varaganti - Epsom & St Helier NHS University Hospitals
Dr Thomas Michael Walsh - St Peters' Hospital, Chertsey
Dr Charles Knight Rumboll - Scarborough General Hospital

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

Dr Agata Kapuscinska – Epsom & St Helier NHS Trust
Dr Cecilia Maria Mihaila – Imperial NHS Trust, Hammersmith
Dr Rajiv Ghose – St John's Hospital, Livingston

I/24/2011 Academy of Medical Royal Colleges

Council received, for information, a summary of the meeting held on 19th May 2011.

PRESIDENT'S CLOSING STATEMENT

PCS/6/2011 President's Closing Statement

The President informed Council that he is working on the allocation of committees and hopes that this will be finalised within the next week.

The President informed Council that Professor Sneyd will lead on the rewriting of the AoMRC Sedation guidelines.

MOTIONS TO COUNCIL

M/25/2011 Minutes

Resolved: That the minutes of the meeting held on 20th May 2011 be approved subject to the following amendments:
CB/78/2011 'Ms Sue Saddle' should read 'Mrs Sue Saville.'
PCS/5/2011 'UCL Clinical Effectiveness Unit' should read 'RCS Clinical Effectiveness Unit'

M/26/2011 Regional Advisers
Resolved: That the following re-appointment be approved:
Anglia
Dr Simon Fletcher, Regional Adviser for Anglia

M/27/2011 Deputy Regional Advisers
Resolved: That the following re-appointment be approved:
South Thames East
Dr Joy Curran, Deputy Regional Adviser for South Thames East

M/28/2011 College Tutors
Resolved: That the following appointments be approved:
West Yorkshire
Dr S B Walwyn [Dewsbury District Hospital] in succession to Dr C L Hildyard

North West
Dr N J Pickstock [Lancashire Teaching Hospitals NHS Trust] in succession to Dr K J Kidner

South West Peninsula
Dr A R A Ruston [Derriford Hospital] in succession to Dr T C E Gale

South Thames East
Dr I Ahmed [Guy's Hospital] in succession to Dr J B Watkiss

Sheffield and North Trent
Dr S Sanghera [Northern General Hospital] in succession to Dr A R Dennis
Dr E M Wilson-Smith [Sheffield Children's Hospital] in succession to Dr C M Wilson
Dr C E Smith [Rotherham General Hospital] in succession to Dr J R Clark

Wessex
An extra tutor at Southampton University Hospital

M/30/2011 Examinations Committee
Resolved: to extend the term of examinership by one year for Dr Jane Pateman (Final Examiner) to July 2012.
Resolved: that the under-mentioned doctor be awarded the Nuffield Prize for performing at the highest level of distinction in all sections of the Primary examination at her first attempt at the May 2011 sitting of the Primary FRCA.
Dr Randa Ridgway – Bradford Royal Infirmary.