MEETING OF COUNCIL

Edited Minutes of the meeting held on Tuesday 15 March 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
Professor J F Bion
Dr E A Thornberry
Professor J P H Fee
Professor R P Mahajan
Dr P J H Venn
Dr A M Batchelor
Professor J R Sneyd
Dr S R Moonesinghe
Dr D K Whitaker
Dr D M Nolan
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 M Nevin
Dr I H Wilson
Dr J Heyworth

Mrs K Rivett, RCoA Patient Liaison Group

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

Apologies for absence: Apologies were received from Dr J D Greaves and Dr A-M Rollin.

CEREMONIAL

C/2/2011 Election to Council

(i) The President gave a verbal report of the election.
(ii) The recently elected Council member, Dr J Nolan, was formally admitted to Council.

C/3/2011 Retiring Council Member

The President presented a certificate to Professor Fee.

COUNCIL IN DISCUSSION

CID/11/2011 President's Opening Statement

(i) The President announced the deaths of Dr Rex Bennett, Dr John Bowes, Dr John Barker, Dr Libbie Hoskins and Dr Angela Hooper. Council stood in memory.
(ii) The National Institute of Academic Anaesthesia's (NIAA) Study Day coincided with Council. Council members were encouraged to drop in and speak to the trainees throughout the day. The President would be presenting the President's Prize at 1600.
(iii) The President thanked Professor Fee for his contribution to the work of the Royal College of Anaesthetists (RCoA) and in particular his work on quality assurance management. Dr Robert Darling would succeed Professor Fee as Chairman of the RCoA's Advisory Board for Northern Ireland and would be co-opted to Council.

(iv) The President reminded Council that there would be a change in committee membership. Those who had not yet had their appraisal with the President could discuss committee membership during the appraisal discussion.

(v) Mr Victor Shack would take Dr J Nolan's photograph during the lunch break.

(vi) A progress report had been released about the tackling poor diet and alcohol misuse aspects of Mr Andrew Lansley's Public Health Responsibility Deal. The Royal College of Physicians of London (RCPLond) had immediately distanced itself from the alcohol aspect of the deal which did not go as far as it would have liked. Dr D Nolan reported that six organisations have distanced themselves because the policy lacked anything specific and measurable. Additionally the drinks industry will be allowed to dictate what happens. It was noted that the Alcohol Health Alliance, of which the RCoA is a member, was not one of the six organisations. Dr Whitaker added that the key issue is the minimum price which the Government has backed away from. The President suggested that if any action was required by the RCoA it should be done through the Alcohol Health Alliance.

(vii) Dr Marks had represented the RCoA on an Academy of Medical Royal Colleges' (AoMRC) Working Party looking at a national prescription chart. This has now been circulated and is pretty much the finished product. The Working Party has devised a set of guiding principles regarding how the drug chart should be put together.

(viii) There has been correspondence from the Department of Health (DH) and the AoMRC about the quality standards being produced by the National Institute for Health and Clinical Excellence (NICE). Approximately 15 quality standards have been published and there is a lot of work to be carried out to publish the others; it will be the responsibility of Medical Royal Colleges, Associations and Specialist Societies to lead on the work and populate the comprehensive list that has been produced. A group will be put together with Dr Venn and Mr McLaughlan leading the work. The President agreed to circulate the correspondence. Professor Bion reported that a small working party is being established for intensive care medicine (ICM) which would work closely with the RCoA.

(ix) Council members were encouraged to attend the Annual General Meeting which would take place the following day. It was noted that only the President, Vice-Presidents and Chairman of the Finance Committee would be on stage and require gowns.

(x) Council members who were unsure whether or not they were attending the Anniversary Dinner should check with Miss Emma Bennett in the President's Office.

(xi) The Council Away Weekend will be held at the Macdonald Hotel Windsor. Drs Batchelor and Whitaker would organise the meeting. Agenda items should be sent to the organisers with a copy to Ms Regan.

(xii) The President updated Council on staff changes:

a. Mr Sanjay Tailor has left the IT department to move to pastures new.
b. Ms Beatrice Bonnal has joined the IT department on a temporary basis.
c. Mrs Charley Hoey has commenced a period of maternity leave.
d. Miss Sophie Lieven will cover the PA to the Chief Executive role during Mrs Hoey's absence.
e. Ms Billie Barnes has left the RCoA having been headhunted to return to a role in the Labour Party.

CID/12/2011 UK Launch of pan-European Launch of 'Pain Proposal'

Dr Verma gave a report of the launch held on 12 January 2011 in the House of Commons. It was an exercise to bring together interested parties to increase awareness and to improve the chronic pain situation nationally. Each of the three speakers had a different approach to chronic pain and how to improve the situation; 90% of patients are unaware that chronic pain clinics exist. The financial cost of chronic pain is significant (£12billion), not just in terms of healthcare costs but also the knock-on effects. Dr Oliver Hart, a General Practitioner in Sheffield, believed that by tackling pain early and taking appropriate action the national cost could be halved. Dr Verma was struck

by how an agenda can be progressed at a national level if the right politicians are lobbied in the right way; patient groups and certain individuals had pushed this issue through politicians to national level. Dr Venn was surprised at the lack of awareness regarding chronic pain, adding that it was useful to hold such events in the House of Commons; it is a successful way of raising the profile of a particular topic. Dr Venn agreed to find out who organises such events in the House of Commons with a view to exploring hosting an event for Members of Parliament regarding anaesthesia and its contributions. The President pointed out that buy-in and a patient angle would be required. The President thanked those who had attended the launch.

CID/13/2011 Recruitment Update

Dr Marks informed Council that numbers were a little bit short. Offers are still being made but in some parts of the country round two will be needed. This seems to be part of a national issue and other specialties are worse off, particularly at ST1. The RCoA needs to consider in the long term how to recruit to anaesthesia and make it a more attractive career option. The President asked how many of the 8000 medical students produced are moving abroad; he had an indication that it is 15%. Dr Marks responded that some are being lost to general practice. Dr Marks added that trainees think they have to make a career choice early and do not appreciate that they can do one year of medicine before dropping out and doing CT1 anaesthesia. Policies for 2012 will go to the Recruitment Committee and be discussed at a workshop in May.

Acute Care Common Stem (ACCS) has proved a real problem this year with unhappiness about the process. Dr Marks explained that there are two ways a deanery can make offers; either by ranking all ACCS applicants and giving the top their first choice, the second their first choice etc or by separating them into groups according to whether they wish to do anaesthesia, acute medicine or emergency medicine (EM). Each system would obviously produce different results. Both systems had operated in different parts of the country with one deanery changing from one to another which resulted in offers having to be withdrawn. From 2012 anaesthesia and ACCS (anaesthesia) will recruit together; EM and acute medicine will either recruit independently or together as one. Although recruitment can be undertaken separately some issues such as person specifications and how the interview process will work will have to be agreed by all concerned. Professor Bion expressed concern about anything that disrupted the potential for integrated training in the management of the acutely ill patient; trainees should be firmly encouraged to enter better quality structured careers that encompass those elements required for quality care of the acutely ill patient. The RCPLond is setting up a group to look at better integration of acute care; the RCoA should engage with this process. Dr Heyworth understood and shared the concerns expressed and would be pleased to discuss options; there is an opportunity to get the process right for the specialties and trainees.

Dr Batchelor stated that two years of core anaesthetic training is not an ideal entrance to the career it is hoped those entering anaesthesia now will ultimately take up. If the concept of anaesthetists as perioperative physicians is to succeed they need to be good doctors before they become good anaesthetists. Dr Batchelor understood the difficulties of having two strands of recruitment into anaesthesia but is worried that it will be made more difficult for trainees again; the end point of a happy trainee is a happy workforce developing quality care for patients. Dr Patel stated that anecdotally there is a lot of disillusionment about having to make a career choice too early; foundation trainees ask why they do not all undertake ACCS. The President pointed out that a single programme with that flexibility becomes too expensive according to the DH. Dr Moonesinghe stated that an increasing number of trainees in both programmes seem to be taking the MRCP examination; the perception being that getting an examination, if not the experience of being a physician, has some value. Dr Moonesinghe added that this cannot add the same value as clinical experience.

Dr Tomlinson asked whether any of the 30% of F2 trainees who do not apply for core training plan to come back, assuming they have gone abroad. Dr Tomlinson suggested there might be a need to point out to the DH that what the RCoA thought would happen has happened, i.e. trainees have gone abroad. The President responded that the Centre for Workforce Intelligence (CfWI) says that 70% return after a period abroad. Mr Bryant reported that one postgraduate dean had suggested that doctors come out of foundation training, disappear into the National Health Service (NHS) and do not enter specialty training before they become trust doctors. The President reported that one of the issues arising from one of Medical Education England's (MEE) Shape of Training Workshops was the affordability of more than seven years' training. Mr Bryant had attended a similar workshop on a different day; one of the key issues was the discussion of the Cardiff Document model with a Certificate of Completion of Training (CCT) being awarded after four years' training. Dr Marks pointed out the danger of coming up with a process whereby anaesthesia crowds out EM physicians. Those who are not good enough for anaesthesia are told they have to do EM when they do not wish to; they will either leave the country or mark time and at the end of the day numbers will not have been filled. The President suggested this would make a good Away Weekend topic but as time is progressing discussions should continue in the meantime. Dr Marks agreed to talk about ACCS at the Away Weekend.

CID/14/2011 Workforce Planning

Mr Bryant had prepared an options appraisal at the request of the President, Vice-Presidents and Dr D Nolan. Workforce is being moved on by the DH and CfWI; the RCoA needs a coherent plan and strategy to avoid being swept along. The aim is to produce a policy and strategy underpinned by numbers which could be supported and defended by the RCoA when presented to the DH and CfWI. The President thanked Mr Bryant for producing the paper. The President reported that the CfWI had not produced a paper in January as planned but hoped to publish it in July; in the meantime it would issue a leadership report.

Dr Colvin stated that Council had previously discussed reaffirming the value of consultants with a CCT. In Scotland it is being viewed as an opportunity to introduce a CT3 year. This would also minimise the service gap. The President suggested including in the introduction to the policy and strategy that the RCoA would train generalists, who may have a specialist interest, but will not follow the superspecialist route which has caused problems in surgery and medicine. There is a need to look at the trainee and consultant workforce giving value for money. It is very difficult to obtain evidence but as much as possible should be collated to demonstrate that consultants do it better first time and so provide better quality care. Professor Sneyd stated that the two drivers are the perceived risk of a surplus of CCT holders and lack of money. Professor Sneyd pointed out that the starkest choice is between consultant jobs, but not as we know them, versus the mid-training waypoint. Professor Sneyd added that he was utterly opposed to the latter option; he would prefer to accept options such as reduced supporting professional activities (SPAs) than betray trainees halfway through their training. Dr Brennan suggested that the RCoA could push for a perioperative physician role; it is pragmatic in terms of the work it will do in terms of more efficiently running hospitals. Dr Nevin suggested that it is vital that the RCoA looks at ways of doing things differently and considers how anaesthesia is provided as a team, realising the unique selling point of a consultant but also recognising that Physician's Assistants (Anaesthesia) [PA(A)s] are part of that team. Dr Batchelor agreed with the use of practitioners other than doctors. The President stated that pushing for all CCT holders to go into a consultant post if they wished to and are good enough, would result in a lot of consultants but they will not be leading a team; they will be doing the work unless they have trainees and PA(A)s with them. The President added that the CfWI is keen to work with the RCoA and carry out workforce modelling. Dr Venn pointed out that another aspect is consultant retirement. The President responded that part of the CfWI's scenario is to change the career of the consultant and it is proposing that elderly consultants will be a different class of person undertaking management, teaching, training and routine lists during the

day. Dr J Nolan asked about the availability of data regarding the performance of anaesthetists as they go into their 60s; not just clinical performance but teaching and training etc. Mr McLaughlan responded that Professor Chris Dodds had done work in this area a few years ago and it was perhaps time to revisit it. Dr Marks stated that it was all very well Colleges and the British Medical Association (BMA) saying what they would like to happen but they have to accept that the law of the market place applies especially since the establishment of foundation trusts. The other key factor is the great uncertainty that many trusts have about what their long term clinical services will be. Dr Nevin pointed out that the reason PA(A)s are in such a small percentage is that almost every trust had the opportunity to bring in or buy in extra consultants in the form of premium payment; this is no longer possible. Dr Nevin suggested that the RCoA should be looking at ways of working with and supporting rather than working against trust management. Dr Clutton-Brock reported that almost universally the reason for not recruiting more PA(A)s this year has been financial. Dr Tomlinson stated that PA(A)s will be seen as a useful substitute for trainees not for delivering anaesthetic services. However, if they were on call at night there could be a PA(A) who sees the patient and then telephones the consultant to report on what has been done so far; they would not be delivering anaesthesia but would be part of the team preparing the patient for theatre. Dr Jones stated that this is particularly relevant for ICM. Service and manpower is needed to run intensive care units (ICU) in Wales. There is the age old problem of anaesthetic trainees being used up to and beyond the demands of the curriculum. Having a PA(A) in critical care could be one way of plugging gaps and reducing trainee anaesthetists being put into the ICU to cover service. Time is an issue but this could contribute to the solution. The other solution is service reconfiguration; there are rumours of significant reconfiguration of acute services in Wales based on cost and manpower. Dr Laishley asked how the strategy or future is viewed for Staff and Associate Specialist (SAS) doctors. There is considerable evidence that SAS numbers are in decline; one of the reasons being that it is hard to recruit specialty doctors because the grade is unattractive financially and in terms of career progression. Dr Laishley suggested that the specialty doctor grade could be made more attractive with access to learning, experiential learning and by making it easier to obtain a Certificate of Eligibility to the Specialist Register (CESR); the other option would be to make it totally unattractive. The President informed Council that the CfWI has that group of the workforce in one of its scenarios including making it more attractive by getting SPAs for revalidation. Part of the proposed strategy is changing the position of the CCT in the training programme so a doctor becomes a semi-independent practitioner after four years but in a limited area. Dr Whitaker stated that any willing provider throws a spanner in the works and can affect training and research; the RCoA should strongly oppose it. Dr Patel pointed out that there had been a lot of objection to the sub-consultant role when it was previously discussed. Dr Patel asked whether there is a role for the College if that role did develop to ensure that career progression into a consultant grade is as good as it is now. The President responded that it has been emphasised to CfWI that the consultant career structure must have progression. It would be for the individual to make a case to the foundation trust that they needed to develop in a particular area. Dr D Nolan highlighted the importance of sending a very clear message to the Fellowship that the RCoA supports progression. There is also a need to be mindful of the image of anaesthesia; having worked hard for years to raise the specialty's image, if enthusiasm is lost at ground level there may be a return to the situation in the late 1970s where hardly anyone applies to join the specialty. The President added that the brightest doctors would not come into anaesthesia if it is seen purely as a service specialty; this must not be allowed to happen. Mrs Rivett informed Council that many sixth formers are being advised against a career in medicine. Dr Tomlinson noted that the Canadians had previously commented that they thought they were overproducing doctors but because of career choice and work/life balance they are still short despite thinking they would be overproducing. If trainee numbers are to be reduced it is necessary to know where they will be coming from; unless it is very clear the knock-on effect will be trainees carrying out more out of hours work which will mean less training time. Dr Jones stated that the figures produced by the

Welsh Manpower representative were based on retirement age etc; manpower should take into account the aspiration of where we want to be and delivering service for the patient. Dr Moonesinghe suggested there might be a role for parallel work looking at the impact on safety of expanding anaesthesia services; this might add weight to the work. The President asked Mr Bryant to update the paper with Dr D Nolan and Dr Tomlinson so the updated paper could be discussed at the Away Weekend. Work with CfWI should be moved forward and some modelling should be undertaken.

CEREMONIAL

C/4/2011 Fellowship ad eundem

Fellowship ad eundem of the Royal College of Anaesthetists was awarded to:
Professor Stefan Schraag
Dr Renate Wendler

COMMITTEE BUSINESS

CB/35/2011 Council Minutes

The minutes of the meeting held on 9 February 2011 were approved.

CB/36/2011 Matters Arising

(i) Review of Action Points

CID/8/2011 President's Opening Statement (iii) An update to the AoMRC's sedation document will be discussed at the next AoMRC meeting.

CB/21/2011 Matters Arising (i) Review of Action Points The President would check with Dr Greaves whether or not he had e-mailed the documentation regarding Anaesthesia, Sedation and Airway Management in the Emergency Department to Dr Heyworth.

CB/26/2011 Training Committee Dr Thornberry had discussed with Mr Chris Munsch how the surgeons are putting their case together to move from two to three year training. The reasoning is that because there are too many core trainees, one way of reducing numbers and maintaining service would be to make the programme three years. The surgeons have to make an education training need case for doing so but are confident it will be supported; it would be very difficult for anaesthesia to make a similar case.

CB/27/2011 Career Grade Committee Ms Drake reported that it was not possible to immediately pull off the data which will be tied to the membership database.

(ii) Anaesthesia for Emergency Medicine

This item will be discussed at the April meeting of Council.

CB/37/2011 Regional Advisers

Council considered making the following appointment:

East of Scotland

Dr William McClymont to the post of Regional Adviser for the East of Scotland in succession to Dr Edward Wilson **Agreed**

CB/38/2011 Deputy Regional Advisers

Council considered making the following appointment:

North West

Dr Russell Perkins to the post of Deputy Regional Adviser for the North West in succession to Dr Christopher Till **Agreed**

Northern
Dr Tim Meek to the post of Deputy Regional Adviser for the Northern region in succession to Dr Andrew Skinner **Agreed**

CB/39/2011 College Tutors
Council considered making the following appointments/re-appointments (re-appointments marked with an asterisk):
North Thames West
Dr A D M McLeod [Royal Marsden Hospital] in succession to Dr M Hacking **Agreed**

North Thames East
Dr A Shah [Homerton University Hospital] in succession to Dr L Davis **Agreed**

North West
*Dr N A Mahmoud [Royal Albert Infirmary] **Agreed**

Wessex
*Dr J C G Bell [Basingstoke and North Hampshire Hospital] **Agreed**

Leicester and South Trent
Dr N J Harvey [Glenfield Hospital] in succession to Dr T A Bedford **Agreed**

CB/40/2011 Heads of Schools
There were no appointments for Council to note.

CB/41/2011 Training Committee
(i) Medical Secretary's Update
Dr Thornberry invited Professor Bion to update Council on the ICM curriculum. Professor Bion reported that the new ICM training programme had been taken to the GMC on 1 March 2011. The programme has been approved but with four conditions and two recommendations. The conditions are:

1. Demonstrate equity between the three core programmes in terms of access to higher training from the three routes.
2. Greater clarity about outcomes from training in paediatric ICM.
3. Articulate commitment to lay and patient involvement as assessors in order to meet statutory and mandatory requirements.
4. Show how you will implement the latest equality and diversity legislation and latest government policies to protect trainees and patients.

The recommendations are:

1. Update on the examination.
2. A request to express exposure to out of hours training time in ICM as a minimum and maximum period. The Faculty had stated that about 12.5% of training time could be spent in ICM out of hours but the GMC would like a range.

With regards to transitional arrangements the document the Faculty of ICM (FICM) has received contains a conflict of meaning in the first two sentences; clarification has been requested. The new curriculum can be launched in August 2011 but becomes mandatory from August 2012, thus giving approximately 14 months to move to a single CCT programme, moving from the current joint CCT model to dual certification. The FICM will bring its proposed responses to the GMC to Council.

Dr Batchelor explained that the FICM had struggled with the equity bit beforehand and had discussed it with the Lead Dean, Dr Fiona Moss; ideas on how to achieve this would be welcome. Dr Batchelor stated that the FICM would not wish to see an advertisement for six ICM CCT posts, four of which must go to anaesthetists and two to physicians or any variant of that. The FICM had tried to make core training for ICM three years but had been firmly told that it was two years. Dr Moss and the Regional Advisers (RAs) in ICM see this as an issue. The only solution Dr Batchelor could see is that period of training needs to be supernumerary so that posts can be provided that are appropriate to people; it is a relatively small but very real problem for which an answer must be found. One solution is transferable competencies; if someone does ACCS (anaesthesia) they are ready to leap to ST4 as long as competencies for core training can be accepted as competencies for specialist training. It had been specifically pointed out to the GMC Panel that the FICM wished to put people into single CCT training from August 2012 but three years of transition would be required for those currently in specialist training posts who would still want access to ICM training. This would also mean service would be delivered by producing a continuous stream of trained intensivists. Dr Thornberry stated that she is unhappy with the transitional arrangements. Professor Bion said that the transition process refers to appointment into a programme and does not mean those within a programme have to change to something new; this would need to be clarified with the GMC. Professor Mahajan asked what was meant by equity of access. Professor Bion interpreted it as meaning that individuals applying for specialist training in ICM should not be disenfranchised because they lacked certain competencies. The solution to this lies in ST3 and ST4 when individualised training would ensure that all trainees had the same competencies before entering ST5. The other interpretation is that there must be equal access for anaesthesia, medicine, EM, surgery etc and therefore posts will have to be hypothecated. Dr van Besouw asked what would guide intelligence regarding the number of single CCT National Training Numbers (NTNs) that will be available; where will they come from and which specialties. Professor Bion replied that there would be a meeting of the Conference of Postgraduate Medical Deans (COPMeD) in a couple of month's time at which this issue would be discussed with the FICM. If the Government wants hospitals to have quality ICUs it will have to pay to train quality intensivists. Mrs Rivett sought clarification about the comment for greater lay involvement in assessment; would this be satisfied by lay involvement in the Annual Review of Competence Progression (ARCP) process? Professor Bion thought that this was one of the answers, but that the GMC may have additional expectations. The GMC had been informed that the training programme had considerable lay involvement in the construction of the competencies, and that there were research activities in progress (for example the use of family satisfaction surveys and multisource feedback) to evaluate the utility of bringing the 'external eye' of families and patients to the process of quality of care. Representation at the ARCP process is not a problem; that already happens. Professor Bion stated that he would regard the use of family satisfaction surveys and multisource feedback as an area for research development and that is being done.

The President stated that he was keen to ensure that anything done about out of hours work links to the Training Committee. The President was also very keen that in the case of those anaesthetists who do not choose go do down the dual or single CCT route the FICM recognises any further training they might do.

Dr Thornberry had circulated the minutes of the Academy Specialty Training Committee (STC) meeting held on 18 January 211 for information.

Dr Thornberry had also circulated a paper on workplace based assessment. The paper had been prepared by a small Working Party established by the GMC following a workshop.

Dr Thornberry gave a report of the Academy STC meeting held on 3 March 2011. There had been a lot of presentations from MEE. MEE is looking at the balance between service and trainees and what their role is and what the role of the consultant is. MEE also claims to be looking at how to have a consultant service without making life intolerable for consultants. There had been an update on CfWI; the phase 2 publication was not fit for purpose so was not published in January as planned. Surveys by MEE had identified that there is a huge number of resources but they are not being particularly well used.

There had been an update on the Medical Programme Board; MEE was in the middle of two workshops looking at the shape of training in the future.

A draft Academy STC response to the white paper was presented with a request to provide feedback as soon as possible. The key points were that someone must maintain the deanery function; there must be some separation of commissioning and providing at skills network level.

The STC had been given an update on the Medical Training Initiative (MTI). The visa will be changed to one year because this makes an individual a temporary worker not an immigrant. Whilst there is sympathy for the effect it will have on training overseas doctors the decision will not be reversed because it would create a loophole open to challenge from other areas. There is evidence that it takes nine months for international medical graduates to settle in and contribute to a department.

The GMC's Approval of Trainers Task and Finish Group report should be ready to go out for consultation at the end of the year. Its purpose is to create an approval framework for all trainers.

There will be no change to national training surveys this year.

The GMC has no plan to introduce credentialing but is looking at areas that have no CCT or specialty training programme. They are looking at how a 'specialist' in such areas would revalidate and in particular how a non-CCT holder might prove expertise in these areas and what standards they would need to be at to be considered a specialist in these areas. Less than full-time training had been revisited. The GMC is concerned about unintended consequences if it restricts it and claims wider consultation is required.

CB/42/2011 Finance Committee

Council received and considered the minutes of the meeting held on 8 February 2011 which were presented by the Chairman, Dr D Nolan. The Committee had previously agreed in principle to quarter fund the Intercollegiate Board for Training in Pre Hospital Emergency Medicine; estimated annual costs were £10,000. A business case now identified the 2011 costs to be £11,400; the Committee agreed to ask to be invoiced for this amount.

The Committee agreed to fund the upgrade of the motor mechanism for the rear lift. A stainless steel handrail system and the replacement of two windows in the 6th Floor toilets were also agreed.

The Committee had received a demonstration of the Echo 360 system and had agreed to purchase an annual licence for that type of technology. Ms Drake informed Council that she is looking at Mediasite which is a similar system.

The Committee agreed to provide a £25,000 budget as requested by the Examinations Committee.

Month six of 2010/2011 showed a favourable variance compared to budget.

The Committee had discussed funding for e-Learning Anaesthesia (e-LA). Mr Storey informed Council that e-Integrity had since met. The e-Learning for Health budget is secure for 2011/2012; the platform and existing content will be maintained but there will only be a small amount of development. Arrangements for 2013 have not yet been finalised.

With regards to a researcher for the Health Services Research Centre (HSRC), it was agreed to request the cost from University College London.

The Committee agreed to progress the offer from Mr John Thompson Rowling to provide a £50,000 endowment fund to allow an annual oration in the memory of his father, Dr Samuel Thomas Rowling. The first eponymous lecture will probably be given at the Autumn Recent Advances meeting.

CB/43/2011 Revalidation Development Committee

Council received and considered the minutes of the meeting held on 1 February 2011 which were presented by the Chairman, Dr Tomlinson. Following discussion at the RAs' Meeting the RAs' Revalidation Group will be formed. Dr Jones would be the Council member chairing the Group. The AoMRC is very keen to ensure that groups of senior professional advisers are working from the same terms of reference. Dr Jones explained that part of the RAs' Meeting had been split into different spheres of interest one of which was targeted towards revalidation and the involvement of RAs. The fundamental question was would the RAs take on this role or should it be someone else. Feedback overwhelmingly suggested that it should be within the RAs' influence but if it was not the RAs themselves it should be an ex or Deputy RA. A discussion had followed about what the RAs' role would be. One of the overwhelming messages was that they should not be part of the revalidation process other than in an advisory capacity to the Responsible Officer. There was debate about whether RAs would be involved with selecting lead appraisers and appraisers; the general feeling was that they could be asked for advice but choosing appraisers was the employers' domain. There is uncertainty about the workload although experience from the Leicester pilot suggested it was not that great. Volunteers are being sought to join the Working Group. Dr Tomlinson thanked Dr Jones for undertaking this work. Dr Jones stated that many of the lead appraisers are lead clinicians or Clinical Directors (CDs); there is a need to debate if there is a conflict of interest. For example, if the lead appraiser is not a CD or clinical manager how is it possible to transfer information a CD would have about an individual on the basis of their practice whilst maintaining confidentiality. Dr Nevin stated that job planning is the role of the CD and it should be identified that although complementary, it should be conducted separately. Dr Thornberry described the system in her trust whereby there is a CD's report that has to go into an individual's appraisal portfolio. Dr Jones pointed out the sensitive area of transferring information from a CD to the appraiser or lead appraiser where there is a problem with illness, alcohol, bullying etc.

A response to the House of Commons Health Committee Inquiry Report on the Revalidation of Doctors has been posted onto the website.

Dr Moonesinghe had attended a meeting of the Patient Liaison Group (PLG) to obtain its view on how to approach patient feedback in revalidation. The PLG is currently considering this and will respond to Dr Moonesinghe. The Multisource Feedback Group is progressing well; Dr Tomlinson expressed his gratitude to Dr Moonesinghe for undertaking this difficult piece of work.

The RCoA has been participating in an AoRMC/GMC Working Group to identify the core supporting information that doctors will need to produce or collect for revalidation. Dr Tomlinson, Mr Don Liu, the RCPLond and the Royal College of General Practitioners (RCGP) have been working closely with the GMC. The GMC has produced a document, due for publication next month, which gives a clear indication of what is expected for revalidation. The Academy has been working with the GMC on this. Three columns have been populated which are core to every doctor in every specialty. The fourth column is specialty specific. The RCoA's, RCP's and RCGP's specialty specific elements and requirements will be used as the guidance for other Colleges to complete their core supporting information. Council and the Revalidation Development Committee will be sent a draft of the fourth column.

The AoMRC has money available for lead appraiser training. The RCoA will submit a bid and modify the programme Professor Chris Dodds had originally put together.

Many Fellows want a minimum data-set for their logbook/record of clinical activity. Any Council member wishing to lead the work to develop a minimum data-set should let Dr Tomlinson know.

Dr Tomlinson reported that Dr Venn is leading the e-Portfolio Group. Dr Venn informed Council that there is a parallel sub-project going on amongst a cohort of Colleges to develop an e-Portfolio to support individual consultants within the appraisal system. The RCoA now has to decide whether it continues with or withdraws from the process; debate is ongoing. The outcome will depend on which company gets the contract, the opinions of other Colleges and the cost. By the time Council next meets there should be a clearer understanding of whether or not the RCoA will withdraw or continue. Dr Tomlinson thanked Dr Venn for his work in this area.

Dr Tomlinson wished to express his gratitude to Mr Don Liu for his work on revalidation.

CB/44/2011 Royal College of Anaesthetists' Advisory Board for Wales

Council received and considered the minutes of the meeting held on 6 October 2010 which were presented by the Chairman, Dr Jones. The Deputy Chief Medical Officer (CMO) had indicated that the Welsh Assembly Government (WAG) was reviewing the Welsh Medical Committee Network.

Two areas of concern at the moment are critical care services and training issues; there are too many small units and issues around manpower and out of hours work. As well as concerns about service versus training in the ICU there is concern from trainees about achieving competencies within the curriculum. Professor Bion indicated that the FICM would be happy to help with this difficult problem.

A consultation has been received via the Welsh Academy regarding a review of maternity services in Wales. There will be a robust response from the RCoA, Royal College of Paediatrics and Child Health (RCPCH) and Royal College of Obstetricians and Gynaecologists (RCOG) to the document which does not reference any recent reviews of maternity services or address care packages which women may require.

CB/45/2011 National Institute of Academic Anaesthesia

Council received and considered the minutes of the Board meeting held on 27 January 2011 which were presented by the Chairman, Professor Mahajan. The Board had approved the revised NIAA terms of reference and the upgrading of the website.

The Board had decided it would produce an annual report with a target publication date of August 2011; this would be separate to the RCoA's annual report and would be used to showcase the work of the NIAA and raise its profile.

The Board approved the final version of the HSRC Strategy.

Two new members had been welcomed to the Board; Mr David Hepwoth (PLG representative) and Professor Nigel Webster (Chair of the *British Journal of Anaesthesia* Board).

11 BOC grant applications had been received; the process of inviting peer reviewers to assess applications was underway.

The Board had reviewed a report from the Grants Officer. The NIAA has awarded almost £1.5million in total with almost £400,000 awarded in the last round.

It is now possible to register on the NIAA's website for news updates.

Delegate numbers for the NIAA Study Day for Academic Trainees are higher than last year.

The HSRC is supporting the European Surgical Outcomes Study (EuSOS).

The HSRC will be collaborating with the London Clinic to develop a HSRC Research Fellowship Programme.

The Board had received an update from Colonel Peter Mahoney.

CB/46/2011 Royal College of Anaesthetists' Advisory Board for Scotland

Dr Colvin gave a verbal report of the meeting held on 3 March 2011. Dr Colvin thanked the President and Mr Bryant for attending the meeting. Workforce is the Board's key business currently. The CT1 recruitment round is progressing well; the quality of applicants is perceived to be high and most posts should be filled.

The Board had supported changes to its terms of reference regarding the wording of trainee member.

There is a developing programme of work on safety in response to the Government's strategy. Dr Colvin thanked the Safe Anaesthesia Liaison Group (SALG) for co-opting a Scottish member. As the delivery of service and training diverge within the UK there are increasing challenges in maintaining the same standards.

Dr Colvin had circulated a report of a meeting with the Scottish CMO. It had been a positive meeting and there are opportunities to continue to engage with Government and postgraduate institutions.

CB/47/2011 Equivalence Committee

Council received and considered the minutes of the meeting held on 13 January 2011 which were presented by Dr Thornberry. Three applications were considered, only one of which was recommended for inclusion on the Specialist Register.

Council received and considered the minutes of the meeting held on 10 February 2011 which were presented by Dr Thornberry. Five applications were considered, two of which were recommended for inclusion on the Specialist Register. The Committee had discussed the possibility of producing a *Bulletin* article on good practice in writing structured references for equivalence applications. Dr Venn offered to find a volunteer and link with the GMC.

CB/48/2011 Professional Standards Committee

Council received and considered the minutes of the meeting held on 17 February 2011 which were presented by the Chairman, Dr Venn. It had been agreed that future patient information/leaflets will be developed through the PLG but will come via the Professional Standards Committee to Council for sign-off.

The *Audit Recipe Book* is being revamped and rewritten. The Committee had decided that departments should be asked to complete two audit projects from the book each year; the editors will select the audits each year.

Stakeholders have been slowly put into place to support the departmental service accreditation project. Contact has been made with Dr Andy Mitchell (Medical Director, NHS London), Sir Bruce Keogh and Dr Fiona Moss. Dr Mitchell and Sir Bruce are supportive of the project; a response is awaited from Dr Moss. The project is based on *Guidelines for the Provision of Anaesthetic Services (GPAS)* rather than training; this is a deliberate move to avoid treading on the deaneries' toes. A pilot will take place to get the project off the ground and gather information on how things are currently. It will be a voluntary process; it is not compulsory five year visiting. Dr Venn added that the FICM is developing its own Professional Standards Committee and he imagined it would develop its own documentation in the future. Dr Venn added that both Faculties would be consulted to see if there is anything they would wish to see included. Anything not contained in *GPAS* would not be included at this stage as it has been made clear that *GPAS* is the RCoA's current quality standards document. Professor Bion stated that the critical care section of *GPAS* had not been updated pending establishment of the FICM. The Professional Standards Committee is putting in place a process for the development of standards in ICM. This would be expected to be harmonious with the RCoA and Intensive Care Society. The process of accrediting ICUs would fall within the FICM's remit. The FICM is keen to ensure it has standards supported by evidence; where evidence is lacking standards would be supported by consensus and ongoing research and review. Professor Rowbotham reported that the Faculty of Pain Medicine (FPM) has developed standards; the best way forward would be to work with the RCoA. The President felt that as some critical care units are not affiliated to Departments of Anaesthesia it would be useful to ensure anaesthesia, ICM and pain are sampled together. Whilst he did not wish to delay the process he saw no point in not piloting critical care. It was agreed that Professor Bion and Dr Venn would discuss this further and ensure piloting is done across both organisations.

There is a slight anxiety that the amount of critical incident reporting is reducing; possibly because people think the NPSA has been wound up. An announcement will be published in the *Bulletin* and *Anaesthesia News* encouraging departments to continue reporting incidents. Mr McLaughlan informed Council that he had been informed that as of 31 March 2011 the RCoA will stop receiving data from the National Patient Safety Agency (NPSA) regarding critical incident reports including reports to SALG. Dismantling of the NPSA's offices and function will commence on 1 April 2011. The President agreed to discuss critical incident reporting with Sir Bruce Keogh. Professor

Bion reported that the web-based data collection tool for the Matching Michigan project is being wound up because of lack of funds; this represents a significant lapse in maintaining quality in infection control in intensive care. Professor Bion and Mr McLaughlan agreed to draft a few lines for the President to include in his statement in the *Bulletin*.

CB/49/2011 Faculty of Pain Medicine

Council received and considered the minutes of the meeting held on 10 February 2011 which were presented by the Dean, Professor Rowbotham. There has been a lot of activity around the withdrawal of some pain treatments and modalities and a lot of ongoing activity regarding how to alleviate this.

The FPM is engaging with pharmaceutical companies although there is no written policy about how this should happen at Faculty level. Ms Drake reported that a small Working Group will finalise this by e-mail.

The Board supported the national registry for spinal cord implant project and the work ongoing to arrive at a solution to establish this.

The British Society of Rheumatologists (BSR) had not responded to the new version of the recommendations on the use of epidural injections for the treatment of back pain and leg pain of spinal origin. The Board agreed that if the BSR requested further changes the present document would be published without joint endorsement. Since the Board meeting the BSR has confirmed it is not content with the guideline as it stands.

It was agreed that whilst RAs elected to the FPM Board should carefully consider whether they would be able to manage both roles, demitting the RA position upon election would not be mandatory as in some areas there are limited numbers of suitable individuals.

There is a need to discuss at the President's Meeting whether a different system is required for electing RAs. The President agreed to liaise with Professor Bion regarding how the election process may work and then bring it to the President's Meeting.

CB/50/2011 Anaesthesia Related Professionals Committee

Council received and considered the minutes of the meeting held on 8 February 2011 which were presented by the Chairman, Dr Batchelor. The Committee had agreed that its minutes should be removed from the RCoA's website and replaced with a practitioner's update and information page; it was noted that other committees do not publish their minutes. Mr McLaughlan informed Council that the minutes had originally been published to update the additional interested organisations that could not attend the meetings; the need has now disappeared as all those with a continuing interest are well represented on the Committee.

It was the feeling of the clinical lead for PA(A)s and others that whilst training does not necessarily equip PA(A)s to be involved in emergence from anaesthesia, and it is not in their scope of practice, it is what often happens in everyday practice. This would be discussed further at a clinical leads PA(A) meeting; if it is the view of several, it may be brought back to Council. The President suggested it should be included on the Away Weekend Agenda.

Paperwork had been resubmitted to the Health Professions Council (HPC) for the regulation of PA(A)s. The HPC has accepted the submission.

Neither Scotland nor Northern Ireland is funding training for PA(A)s this year. In Scotland it was funded centrally until last year; this has now changed and Boards are not allocating money for it. There are not many trainees in England this year, probably due to funding issues.

The Association of Anaesthetists of Great Britain & Ireland (AAGBI) has started its survey and visits to departments with PA(A)s. Dr Wilson added that work is currently underway to gather contact details for all PA(A)s.

The clinical leads for PA(A)s and advanced critical care practitioners (ACCPs) presented their plans for taking their roles forward.

CB/51/2011 Safe Anaesthesia Liaison Group

Council received and considered the minutes of the meeting held on 7 February 2011 which were presented by the Chairman, Professor Mahajan. The hunger for learning and engagement is huge; it is disheartening that this is at a time when the NPSA is being wound up.

It has been agreed that a representative each from Northern Ireland, Scotland and Wales should be invited to join SALG.

The safety conference will take place on 3 October 2011.

Given the possibility that critical incident reporting will vanish or not exist in a way which allows meaningful access to data, the RCoA needs to consider whether it should host it in-house or abandon it completely. The President stated that at some point a costing exercise would need to be carried out for running it in-house. Dr Whitaker fully supported bringing critical incident reporting in-house; it would cost less to keep going than to start up a system again. Professor Mahajan added that in the past the RCoA had considered the possibility of consulting with the Intensive Care National Audit & Research Centre (ICNARC) and establishing perioperative critical incident reporting; the President suggested this would be worth exploring through the HSRC. Professor Bion strongly supported this adding that the RCoA and other groups together with the HSRC would be the ideal medium but the cost should not be underestimated. Mrs Rivett offered the support of the PLG; it would be glad to add weight to any argument by adding the lay perspective. Dr Wilson suggested that it should be discussed by the Joint Committee on Good Practice; if the RCoA and others host critical incident reporting and are funding a core NHS responsibility they must ensure good publicity is obtained. The President added that the matter would also be discussed further at the President's Meeting.

The NPSA's updated alert on safer spinal/intrathecal needles and connections was noted, though the new date for implementation continues to present potential problems. If there are too many connectors there is the danger of confusion. Without proper clinical evaluation it is difficult to say if one should go for the connectors available on the market or not. SALG thought it could raise awareness and act as a clinical voice if required.

CB/52/2011 Trainee Committee

Council received and considered the minutes of the meeting held on 17 February 2011 which were presented by the Chairman, Dr Patel. Council agreed that Item 2.1 on the terms of reference should be amended. Council agreed that Item 6.5 on the terms of reference should be amended to reflect that minutes of meetings should be presented formally to Council rather than only via the Training Committee.

MATTERS FOR INFORMATION

I/8/2011 Publications
The list of publications received in the President's Office was drawn to Council's attention.

I/9/2011 Consultations
Council received, for information, a list of the current consultations.

I/10/2011 New Associate Fellows, Members & Associate Members
Council noted the following:

New Associate Fellows February - 2011
Dr Martynas Juozaitis - Princess Royal Hospital, Telford
Dr Raymond McKee - Craigavon Area Hospital
Dr Olayinka Adeniyi Agbejule - Chesterfield Royal Hospital
Dr Mary Nichola Wall – Heartlands Hospital, Birmingham

New Associate Fellows March - 2011
Dr Stephen Merron - University Hospital North Staffordshire
Dr Andrea Louise Morris - Leicester Royal Infirmary

New Members February – 2011
Dr Nischala Dixit Gopal - Primary FRCA
Dr Muthukrishnan Thirukkamu - Primary FCARCSI
Dr Justine Norah Elliott - Primary FRCA
Dr Mamta Mahendrakumar Pandya - Primary FCARCSI
Dr William Andrew White - Primary FRCA
Dr Talakad Narasappa Sudarshana – European Diploma in Anaesthesiology & Intensive Care

New Member March – 2011
Dr Rajeev Kadungapuram - Primary FRCA

New Associate Member February- 2011
Dr James Alexander Hadlow - Kent & Canterbury Hospital

New Associate Member March- 2011
Dr Shaun Paul Knight - Airedale General Hospital NHS Foundation Trust

New Affiliate – February 2011
Mr Alan Hugh Taylor - Veterinary

To receive, for information, the following doctors have been put on the Voluntary Register February – 2011
Dr Susantha Dammika Chandrasiri Wanigasundara Mudiyanselage - The Whittington Hospital NHS Trust
Dr Meegahage Dona Sumudu Samanthi Irasinghe - Freeman Hospital
Dr Srinivasa Ravindra Pochiraju - Fairfield General Hospital
Dr Aristeidis Kotouzas - Darent Valley Hospital
Dr Nihad Tarek Mahmoud AbdAllah - Royal Victoria Infirmary
Dr Heramba Rao Beeraka – Milton Keynes Hospital
Dr Ana May Bonell – University Hospital Lewisham
Dr Ilans Lisagors – Lancashire Teaching Hospitals

Dr Benjamin Gibb Freeman – Oxford Radcliffe Hospitals
Dr Sarah Grace Freeman – Oxford Radcliffe Hospitals
Dr Timothy Asibey-Berko – West Wales General
Dr Andras Antal Farkas – Nuffield Health Hospital, Taunton
Dr Manesh Dewshi - Queen Elizabeth II Hospital, Welwyn Garden City

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

Dr Bhaskar Dutta - Peterborough & Stamford Hospitals Foundation Trust
Dr Amanda Leonie Mortier - Southampton General Hospital
Dr Gregory James Waight - Warwick Hospital
Dr Usamah Imtiaz Kidwai - Princess Royal University Hospital, S. London Healthcare NHS Trust
Dr Angela Pay Yin Lim - Poole General Hospital
Dr Dragan Nenadic - Kent & Canterbury Hospital

PCS/3/2011 President's Closing Statement

(i) The President thanked Professor Fee for his contribution to Northern Ireland anaesthesia and the RCoA.
(ii) The President welcomed Dr J Nolan to Council.

MOTIONS TO COUNCIL

M/11/2011 Minutes
Resolved: The minutes of the meeting held on 9 February 2011 were approved.

M/12/2011 Regional Advisers
Resolved: That the following appointment be approved:
East of Scotland
Dr William McClymont Regional Adviser for East of Scotland

M/13/2011 Deputy Regional Advisers
Resolved: That the following appointments be approved:
North West
Dr Russell Perkins to the post of Deputy Regional Adviser for the North West

Northern
Dr Tim Meek to the post of Deputy Regional Adviser for the Northern region

M/14/2011 College Tutors
Resolved: That the following appointments/re-appointments be approved (re-appointments marked with an asterisk):
North Thames West
Dr A D M McLeod [Royal Marsden Hospital]

North Thames East
Dr A Shah [Homerton University Hospital]

North West
*Dr N A Mahmoud [Royal Albert Infirmary]

Wessex
*Dr J C G Bell [Basingstoke and North Hampshire Hospital]

Leicester and South Trent
Dr N J Harvey [Glenfield Hospital]