MEETING OF COUNCIL

Edited minutes of the meeting held on Friday 18 May 2012
Aspen Suite, 4th Floor, DoubleTree by Hilton Hotel, Lincoln

Items which remain (at least for the time being) confidential to Council are not included in these minutes

Members attending:

Dr Peter Nightingale, President
Dr J-P van Besouw
Professor J Robert Sneyd
Dr Hywel M Jones
Professor Julian F Bion
Dr E Anne Thornberry
Professor Ravi P Mahajan
Dr Peter J Venn
Dr Anna Batchelor
Dr David K Whitaker
Dr Debbie M Nolan
Dr Ranjit Verma
Dr Richard J Marks
Dr Tom H Clutton-Brock
Dr Liam J Brennan
Dr Jerry P Nolan
Dr Jeremy A Langton
Dr John R Colvin
Dr Nigel W Penfold
Dr V Ramana Alladi
Dr Sumit Gulati
Dr Ian Johnson

Mrs I Dalton, RCoA Patient Liaison Group (PLG)

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

Apologies for absence: Professor D Rowbotham, Dr R Laishley, Dr S Patel, Dr B Darling, Dr I Wilson, Dr M Clancy, Dr M Nevin, Dr A-M Rollin.

COUNCIL IN DISCUSSION

CID/13/2012 President's Opening Statement

(i) The President welcomed Dr Johnson, Chairman of the National Specialty Advisory Group (NSAG) Anaesthesia/Royal College of Anaesthetists' (RCoA) Board in Wales to his first Council meeting.

(ii) The President announced the deaths of Dr Alan Marshall Barr, Dr Sidney Carter, Dr Alexander Stone, Dr Paul Buckoke, Dr Isaac Jones, Dr John Holdsworth, Dr Usha Sheorey and Dr Sakalakalavathy Manickam. Council stood in memory.

(iii) The meeting would be recorded to assist with minute-taking.

(iv) The President had attended a dinner with Mr Andrew Lansley and Lord Kakkar; discussion centred around health matters in general. It was suggested that the Advisory Committee on Clinical Excellence Awards (ACCEA) process would start today; the number of awards was unknown but would probably be the same as the previous round. It is hoped that the Doctors and Dentists Review Body (DDRB) report on the ACCEA process will be released at the beginning of June.

(v) Dr Marks gave an update on the new website. Although the website had been down for half a day since its launch, this was due to a problem with the server, not the College's software. There is a problem with security in that the system does not automatically log users out; this is a particular problem for examiners working on shared computers. The difficulty is identifying when to log people out whilst avoiding logging them out too early which could result in the loss of work. The timeframe will be set as one hour with examiners using shared computers being encouraged to log out.

The President thought that examiners had been told that they should only use their home computers to view questions; this would provide a better safety mechanism. Dr Marks pointed out the difficulty of enforcing this. Dr Brennan agreed that the Examinations Committee would enforce it. Dr Batchelor reported that her trust is encouraging staff to undertake Supporting Professional Activity (SPA) onsite; insisting that examiners use a home computer would mean they would have to do the work in the evening. Dr Marks stated that the onus to logout should be on the individual. In order to register for an account and post in forums it is necessary to complete a CAPTCHA. 71,000 unsuccessful CAPTCHAs have been recorded since the site went live thus indicating it is already under attack from spammers. Although not a major problem at present, the severity/difficulty of the CAPTCHA will be increased and the public forum for reporting problems with the website will probably have to be shut down. Username logins will be changed to something more complex. Dr Marks explained that there has been a problem with the search function and the information architecture. The search function currently shows both current pages and old pages that are in Google's cache; the way the old pages appear to Google has been changed to resolve this. Dr Marks added that whilst there are a few issues with the new website, he was pleased with it. User migration to the new system has commenced. Users have received an email informing them of the need to reregister; this is mostly complete. There have been some problems with the calendar. Dr Marks proposed that the College calendar be migrated from Outlook to Gmail to enable anyone with a Gmail account to view it; it will be updated in real time. Dr Marks highlighted some of the benefits of the website. The College now has a huge amount of autonomy and much of the work can be done in-house. Council members can set up their own user profiles; Dr Marks urged Council to be very careful when updating information as there have been concerns that enabling users to edit their own profile would result in formatting and layout problems. The President asked whether the font could be locked. Dr Marks explained that it would have to be locked for the whole website. Dr Marks pointed out that the forums are more usable, more intuitive and more customisable. An item posted in the Council discussion forum results in a notification being sent to all Council members within an hour. The new website uses Google Analytics for reporting; it is possible to see in real time what pages people are looking at, how long they remained on the page and where they came from. Dr Marks explained that there are two future plans for development. The intention is to make the *Bulletin* an integrated document that is searchable and can be linked to; it is currently on the website as a pdf. The other growth area is the use of forums for other committees. The technology is in place to give a forum to any committee that wants it. The President asked whether it would be possible to post an attachment on the forum rather than sending an email with an attachment. Dr Marks responded that it would not be possible but suggested that Dropbox could be used.

(vi) The President had attended the General Medical Council (GMC) Postgraduate Board. The GMC has undertaken three credentialing pilots which it is very pleased with; there is a lot of support around the GMC for taking this work forward.

(vii) Dr D Nolan had attended a Health & Disability in Medical Education & Training meeting. The meeting carried on from a roundtable discussion at the Academy of Medical Royal Colleges (AoMRC) and there has been input from three lay members, trainee doctors and medical students. The discussion centred on career paths, the selection procedure for undergraduates and the undergraduate curriculum. There are now a significant number of undergraduates with major disabilities; this has led onto discussion around the scope of different categories for registration, a suggestion robustly opposed by two of the lay members. The next meeting will be in November. The President stated that there had also been debate at the GMC Postgraduate

Board about different levels of registration and the fact that there will be a need for specialist counselling as occupational health is not able to do it. The GMC information system has been upgraded and linked in with the Conference of Postgraduate Medical Deans' (COPMeD) databases; this should result in improved workforce numbers and workforce data. The President reported that discussions around quality assurance had been interesting and that he had been pushing to get the Colleges back involved in visiting. The concept of having teams to visit seemed to be accepted by most people around the table. If there is a specialty area then the team would include someone from that specialty; the President had tried to push for this to be a College member albeit acting as an advisor under the GMC's umbrella. Dr Jones asked whether the matter of the College receiving the reports formally had been discussed. The President replied that it had not but that he could raise it. Dr van Besouw emphasised the importance of sharing information; the *Mid Staffs Inquiry* demonstrated that the lack of sharing of information was one of the root causes of the problem.

(viii) The President has been asked to sit on the Royal College of Physicians of London (RCPLond's) Future Hospitals Working Group. The President would be inviting ideas from Council members regarding how they see the future of the hospital, shape of training and the resulting career structure.

(ix) The President updated Council on staff changes:

a. Ms Luann Hadfield has joined the College on a full-time and permanent basis as PA to the Director of Training and Examinations.
b. Ms Sarah Wooldridge has left the RCoA as her contract supporting the Senior Management Team has come to an end.
c. Mr Chris Beddoe, IT Support Officer, has left the College.
d. Ms Jane Griggs, Anaesthesia Review Team (ART) and Patient Liaison Group (PLG) Co-ordinator, has left the College to take up a new role at Anglia Ruskin University.
e. Ms Hollie Brennan has joined the College on a temporary basis whilst a permanent replacement for Ms Griggs is recruited.

CID/14/2012 Replacement FRCA Certificate

Council agreed to a request from Dr David Francis Johnston for the replacement of his FRCA Certificate.

COMMITTEE BUSINESS

CB/57/2012 Council Minutes

The minutes of the meeting held on 18 April 2012 were agreed subject to the following amendment:

CB/54/2012 Trainee e-Portfolio Working Party Paragraph 6 To include 'Dr Batchelor thought that using the Foundation type Supervised Learning Events (SLE) for assessment would be a good thing and supports the College moving over to using SLEs.'

CB/58/2012 Matters Arising

i. Review of Action Points

S/1/2012 Developing the NIAA and HSRC It was noted that no one had sent any feedback to Professor Mike Grocott.

CID/10/2012 Obstetric Anaesthetic Update Dr Thornberry has spoken to Dr Alasdair Short who had apologised and informed her that the Intensive Care National Audit & Research Centre (ICNARC) would be following up in the next few days. Dr Thornberry noted that the Obstetric Anaesthetists Association (OAA) would take ownership of this and questioned whether it

should be asked to follow-up on this matter or whether the College should continue pursuing a response before it is handed over. The President agreed to follow this up with ICNARC.

CID/11/2012 Supporting Professional Activity The Welsh contract information has been included and the article will be published in the July edition of the *Bulletin*. The President enquired whether the document could be shared with the AoMRC. Mr McLaughlan and the President agreed to discuss whether adjustments are required before it is shared.

CID/12/2012 Intercollegiate Board for Training in Pre-hospital Emergency Medicine The President has discussed the issue with Dr Clancy. Dr Clancy is in discussion with Sir Keith Porter but there had been no further development. Dr J Nolan had received an email from Sir Keith and thought that some progress had been made with the GMC; a solution may have been found for approving the training programmes and the applicants should hear whether they have been approved or not by the end of the week.

CB/47/2012 Matters Arising The President would circulate the updated Education Outcomes Framework.

CB/52/2012 RCoA Advisory Board for Scotland Dr Brennan explained that the matter has been progressed via the Scottish Academy's Advisory Group. Dr Colvin has followed up with the Medical Director and has been assured that it has been resolved. Dr Brennan considered there to be a wider issue; if two different models of providing specialty advice were being used by Scotland and the rest of the UK then it may cause major difficulties. The President noted that Mr Bryant had provided him with some data which he hoped to take to the UK Scrutiny Group and speak to the Chief Medical Officers (CMOs) as a group.

CB/53/2012 Intercollegiate Committee for Training in Paediatric Intensive Care Medicine The President was awaiting the election of the new Vice-President before actioning.

CB/59/2012 Regional Advisers

Leicester & South Trent

Council received an update on the nominations to replace Dr Christopher Leng. There have been three nominations for the post, a ballot has been sent out and the results will be available for the next meeting of Council.

CB/60/2012 Deputy Regional Advisers

There were no appointments or re-appointments for Council to consider.

CB/61/2012 College Tutors

Council considered making the following appointments:

West Yorkshire

Dr D Odedra (St James University Hospital) in succession to Dr J I L Jones **Agreed**

North Thames Central

Dr M S George (Great Ormond Street Hospital) in succession to Dr D G Williams **Agreed**

North Thames East

Dr F M L Dancey (Barts Health NHS Trust) in succession to Dr S Nikolic (acting Tutor) **Agreed**

East of Scotland

Dr U S Mok (Perth Royal Infirmary) in succession to Dr E D Ritchi **Agreed**

CB/62/2012 Heads of Schools
There were no appointments for Council to note.

CB/63/2012 Training Committee
(i) Training Committee
Council received and considered the minutes of the meeting held on 4 April 2012 which were presented by the Chairman, Dr D Nolan. The Chairman's summary had been presented at the April meeting of Council.

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

London
South East
Dr Stephanie King
Dr Rachel Farmer

North Central
Dr Konstantinos Miltsios
Dr Raymond Ackwerh

Imperial
Dr Alexander Li*
Dr Stephan Roehr

St George's
Dr Suneil Ramessur
Dr Pallavi Dasannacharya

Nottingham
Dr William Whiteley

Mersey
Dr Carl Wright*

Northern
Dr Sally Eason

Tri-Services
Dr Robert Tipping
Dr Natalie Glover

Wessex
Dr Juliette Kemp

Wales
Dr Harsha Reddy
Dr Thomas Holmes*
Dr Shakeel Moideen

North Scotland
Dr Kay Davies

Yorkshire
West Yorkshire (Leeds/Bradford)
Dr Lorna Eyre*

***Joint CCTs in Anaesthetics and ICM**

(iii) Medical Secretary's Update
Dr D Nolan had nothing further to report.

CB/64/2012 Education Committee
Council received and considered the minutes of the meeting held on 25 April 2012 which were presented by the Chairman, Dr Clutton-Brock. There were a number of no-shows at the oversubscribed sixth form open day. A new system would be investigated to prevent a recurrence. The President suggested asking for a refundable deposit.

The organiser of the Final FRCA Courses will attend the Education Committee meetings on an annual basis to discuss feedback received for the courses.

Low attendance figures have resulted in the postponement of the Joint Intensive Care Symposium until 2013.

The Samuel Thompson Rowling Lecture will be presented at the November 2012 Current Concepts Symposium.

Dr Alan McGlennan will organise the next Annual Congress in 2013 with the assistance of a small organising committee. The President asked whether there had been any discussion regarding the date of the Congress. Ms Drake had discussed this with Dr Ramani Moonesinghe; it was felt that the Congress following Diplomates' Day was not as successful as it could have been and it has been suggested that it could be taken out of London. Dates of national courses would be looked at to try to avoid clashes. Dr J Nolan suggested that dates of regional meetings should also be considered when planning a date.

The Committee had been approached by two organisations interested in arranging a joint meeting with the RCoA. The Royal Society of Medicine (RSM) is interested in a joint meeting next year. The Committee has expressed an interest but more thought needs to be given to what is actually going to be done. The Royal College of Surgeons of England (RCSEng) would like to arrange a joint meeting on Crew Resource Management in Trauma. Dr Clutton-Brock would discuss this further with Dr Simon Mercer. The President noted that the RCSEng would want the College to use its facilities. Professor Sneyd voiced his concern about joint meetings, adding that he would be very wary about going into a partnership; if the Committee did enter one it must ensure that there is a written memorandum agreement. Dr Brennan highlighted that the Association of Paediatric Anaesthetists (APA) held a trauma session recently with some very good speakers and suggested that Dr Clutton-Brock consider this when arranging a trauma meeting.

The President noted that the Joint Intensive Care Symposium was originally a College and Intensive Care Society (ICS) meeting and that the ICS then wished to have joint meetings with Emergency Medicine and Physicians. Professor Bion questioned whether this was the event that would have been taking place in the College on the 14th and 15th June as he suggests that this is either over the radar or under it. Professor Bion had heard about it but did not think that the Faculty of Intensive Care Medicine (FICM) had been involved in discussions; as part of the integrated process in the future the FICM would want to be involved. The President asked if there was an FICM representative on the Education Committee. Ms Drake explained that the Committee had asked for Professor Tim Evans to be involved this time round but there is not currently an FICM representative on the Committee.

CB/65/2012 National Institute of Academic Anaesthesia

Council received and considered the minutes of the Board and Research Council meetings held on 19 April 2012 which were presented by Professor Mahajan. The Board supported the Research Council's decision that membership of the Association of Medical Research Charities is not essential at this time; the National Institute of Academic Anaesthesia (NIAA) could only be an associate member as it is not a charity. There would be no clear benefits to paying the fee.

The Board approved the Research Council's decision to upload the Executive Summary of the NIAA's Away Day discussion paper to the NIAA's website.

Dr Eleanor Carter (University of Cambridge) has been appointed as the new trainee representative to the NIAA Board. The intention is to keep the remaining six applicants engaged; the best way to do this would be discussed with Dr Carter. Dr Ramani

Moonesinghe has been appointed as Professor Sneyd's successor on the NIAA Board with the title of NIAA Academic Trainee Coordinator.

Research Council discussed the concept of Difficult Airway Society (DAS) Professorships.

The President sought clarification on the process for the NIAA giving grants to people wishing to study overseas. Professor Mahajan explained that the College has two or three bursaries that are advertised and there is one overseas grant that is given by the Association of Anaesthetists of Great Britain and Ireland (AAGBI). Once the applications for the bursaries have come to the College they go to the NIAA for consideration. The President has been having discussions with Dr Wilson regarding the RCoA, the International Relations Committee (IRC) of the AAGBI and the NIAA working collaboratively and pooling their resources for these grants. The AAGBI is keen to stay with the IRC but Dr Wilson was happy for the RCoA and perhaps the NIAA Council to send representatives to help decide how this money should be spent. Professor Mahajan thought that would make sense; people apply to both the RCoA and the AAGBI and it can appear that decisions are made quite randomly.

CB/66/2012 Joint Revalidation Delivery Committee

Council received and considered the minutes of the meeting held on 17 April 2012 which were presented by the Chairman, Dr Brennan. Dr Brennan clarified that the Committee has been renamed the Joint Revalidation Delivery Committee to reflect its work on behalf of pain medicine and ICM. As a result the committee's Terms of Reference have been revised.

Patient feedback for revalidation has been an area of vigorous discussion and it was reiterated that it is the view of the Committee that it is important for anaesthetists to collect this element of supporting information for revalidation. The problem has been the practical delivery of patient Multi Source Feedback (MSF), particularly in the case of perioperative anaesthesia, and this was highlighted by the GMC pilot study. In order to get around these issues and obtain practical advice Dr Ramani Moonesinghe would convene a Delphi group with patient and professional representation in mid June. In addition Dr Brennan, Mr McLaughlan and Mr Don Liu would meet patient representatives from the PLG, AoMRC and national patient groups in June to discuss the issues of patient MSF for anaesthetists.

The Committee is going to progress the issue of quality improvement activities particularly in terms of National Sprint Audits coordinated by the proposed Local Audit and Research Co-ordinator (LARC) network under the direction of the NIAA.

The Committee has had an email exchange with a Fellow regarding anaesthetic workload and the minimum number of weekly anaesthetic sessions required to revalidate. It was agreed that it would not be appropriate to be prescriptive about the amount of clinical practice required to revalidate; this should be discussed by the appraiser and appraisee. However the Committee has produced some high level principles that may provide useful guidance and these would be published as frequently asked questions on the College website and in the *Bulletin*.

Dr Venn updated the Committee on the revalidation e-Portfolio project. The Finance Committee approved £7,500 to align the Continuing Professional Development (CPD) with the revalidation e-Portfolio.

Surveys of the Regional Advisers (RA) and Clinical Directors' (CD) network have been undertaken to seek opinion on how the College should be involved in remediation. The majority's view was that the RCoA should be involved but at a national/high level, for

example, in setting standards, providing published guidance and working with bodies such as the National Clinical Assessment Service (NCAS) and not in direct implementation of remediation programmes. The results of the surveys will be passed to the AoMRC Working Party on Remediation on which Dr Rollin represents the RCoA.

The final version of the *Medical Appraisal Guide* has been published and the specialty specific guidance will shortly be updated; Dr Andy Tomlinson will continue to lead on this.

Mr McLaughlan and Mr Don Liu represented the RCoA at the AoMRC Directors of Continuing Professional Development (DoCPD) meeting. The meeting emphasised the need to continue to support the credit-based CPD system to try to protect CPD activity and time. The President questioned whether there had been any change to the GMC's stance on this issue. Mr McLaughlan replied that he had spoken to Mr Richard Marchant who had said that he would take it to the GMC Council; nothing further has been heard. Mr McLaughlan added that it was the opinion of most people at the DoCPD meeting that the 50 hour marker should remain. Professor Sneyd suggested that the GMC should be pushed hard on this; it should be insisted that it sticks to the 50 hours which is used by regulators across the world. Dr Brennan highlighted that whilst this may be the view of the RCoA and some other Colleges it is not a unanimous view from all Colleges. The President noted that there will be opportunity to raise this issue at the July Strategy meeting. Dr Whitaker stated that the other Colleges should be reminded of their responsibilities. Dr Jones suggested that it is very important to have something to protect against the pressure coming from managers; if a figure is not stated then it would be very difficult to defend the time. Professor Mahajan noted that the revised matrix has been received well by his trust. Professor Mahajan thought however that as it is less prescriptive it is important that the number of hours is fixed. Dr Jones explained that his trust has a CPD day ten times a year but there is pressure to reduce this to five; the matrix is being used to defend the need for ten days.

Dr Venn explained that a survey was being undertaken to look at what is impacting on protected time and when Mortality and Morbidity meetings are happening and who is attending. Dr Venn hoped to have some comprehensive data to present at the College Tutors' meeting next month.

CB/67/2012 Faculty of Intensive Care Medicine

Council received and considered the minutes of the Board meeting held on 5 April 2012 which were presented by the Dean, Professor Bion. The FICM has set up an e-Portfolio group which has opened discussions with two potential providers, NHS Education for Scotland (NES) and Cyber Imagination.

Professor Bion explained that there are about 80 modules in e-Learning for Anaesthesia relating to ICM; this process will be handed over to the FICM and the Training Committee to manage. This will be done in conjunction with two previous editors, Dr Peter Macnaughton and Dr Tim Gould.

The FICM has arranged a workforce planning meeting on 9 November which will consider a number of scenarios for future staffing of intensive care services. The meeting is in conjunction with the Centre for Workforce Intelligence (CfWI), however it is not yet known whether CfWI representatives will attend or if they do whether they will bring anything of any value. Professor Bion noted that CfWI is in receipt of public money and if it is unable to deliver he would like to approach the Department of Health (DH) and suggest that the funding that goes to the CfWI for ICM should go to the FICM instead. The President reported that he had raised this issue with the DH directly and Professor Moira Livingston is interested in allowing

some of the money that CfWI would use to subcontract to be used by the Colleges but there is nothing in writing.

The FICM has agreed to provide £1000 annually to support the UK Critical Care Research Forum meeting.

The new FFICM Examination regulations have been approved.

72 posts for the new ICM training programme have been identified. There are 124 candidates for the programme, 20% of whom have also applied for anaesthesia. Professor Bion wished to congratulate the West Midlands Deanery, Dr Alison Pittard and Dr Tom Gallagher, together with the Faculty staff who brought the whole process together. Posts have been offered to 67 candidates; 48 have accepted training posts and 19 are in holding mode in relation to other applications. The President asked whether candidates who did not take up the offer but took another specialty, like anaesthesia, gave any indication that they would reapply next year. Professor Bion explained that they do not have that level of detail but he believed that some candidates will.

CB/68/2012 Finance Committee

Council received and considered the minutes of the meeting held on 2 May 2012 which were presented by the Chairman, Dr Jones. The Committee agreed to replace the rear lift at the cost of £73,798 plus VAT. The contractor is Temple Lifts. It was noted that the lift would still only go to the 4th Floor.

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

The forecast end of year position indicates a surplus of £950,000. This is in line with the College's financial strategy of (a) creating a reserve of £4 million (50% of annual income) by 2020, (b) funding day to day College activities and (c) funding the linking of 34 and 35 Red Lion Square.

The Committee received and approved draft 2012/13 budgets for the College and for the Trading Company.

The Committee received and approved the proposed 2012/13 Fees, Rates and Charges with one amendment; that the allowance for the Examiners' Dinner be increased to £75. Dr Brennan offered his thanks on behalf of the examiners. Dr Jones noted that there was a fund that examiners raised themselves to subsidise the venues which are quite expensive in London; it is hoped the increase will help offset this a little bit.

The Draft Strategy Document 2012 to 2015 is currently being written and Mr Storey will circulate once it is complete.

Dr Jones gave an update on the Eric F Green funds. The College awaits the £47,000 with anticipation but has not yet received the money as the lawyers had not yet agreed the wording of the receipt.

Mr Simon Scott has been appointed as the RCoA's media advisor and has been engaged to work one day a week over the next six months. He has already been given three topics as potential media items for the College to put forward.

CB/69/2012 Workforce Planning Strategy Group

Council received and considered the minutes of the meeting held on 1 May 2012 which were presented by the Chairman, Dr van Besouw. Dr van Besouw noted that the lead on workforce planning, CfWI, had been woeful and had not met any of its deadlines to date. It is the opinion of the Workforce Planning Strategy Group (WPSG) members that they need to garner the intelligence to drive the debate on workforce development in anaesthesia as it is not going to come from a top down analysis. To that end the WPSG has engaged with a number of different agencies to look at the delivery of service across the country. The WPSG has also engaged with the GMC regarding what is happening with training numbers and CCT output and has engaged with the DH which has done a piece of work on how trainees progress through the system.

The Foundation Trust Network has produced what its idea of a future workforce might be in response to the CfWI document. A similar document has been produced by the Association of Surgeons; both seem to suggest that the waypoint in career and changes in the consultant career structure are going to be the way forward. Dr van Besouw thought it would be up to the Colleges and perhaps the Academy to decide how much they support the development of this strategy which means that a consultant as we know it today, i.e. someone who on completion of CCT goes into a fully fledged consultant role, will be the model for the future. The RCoA needs to decide how much it will support or not support that agenda as there is a groundswell towards a tiered consultant structure not only in terms of responsibility but potentially also in terms and conditions of service.

The DH has asked the WPSG to suggest what numbers should go into ST training for next year. It was noted that if the numbers are over estimated it will result in people with CCTs not having jobs to go into.

The President has been asked to sit on the Shape of Training workgroup led by Professor David Greenaway and stated that he would value a steer from Council on this very important debate.

Dr Marks noted that there seems to be the feeling that what we need to do is to get better data and the results will be apparent. This seems to be a fundamental flaw, the problem is that it is a moving target and there are so many other factors that are changing. The RCoA has limited control over what it can do as a College as there are so many external factors. Dr Marks thought that the profession was probably moving towards a tiered consultant of some form; how this is managed and how it is managed contractually will need to be decided. Dr Colvin noted that in Scotland employers and the British Medical Association (BMA) have not managed to negotiate terms and conditions; the reality is that while employers are continuing to push that they cannot afford consultants they are actually employing consultants on contracts with resident evening shifts and on call in them. Dr Colvin felt that the College would end up in a high risk position if it became involved in terms and conditions. There has been dialogue in Scotland around job planning, the shape of consultant posts and the concept of career progression. Dr Whitaker expressed the opinion that the RCoA should not give any oxygen to the idea of tiered consultants. Dr Langton expressed concern regarding the friction this may cause between existing and new consultants. Professor Bion thought that there was no doubt that terms and conditions are important but expressed the view that the conversation should start with what kind of health service do we want, and suggested that the Colleges are in a fundamental position for developing policy. The AoMRC has brought together a Working Group on Seven Day Working, Co-chaired by Professor Bion, to develop policy; it is hoped the Working Group will have some outline by August/September. The first thing is what kind of future do we want

and is this model survivable. Professor Sneyd noted that it is the RCoA's role to set standards; it is not a trade union concerned with terms and conditions. Professor Sneyd stated that the RCoA should utterly reject cutting training in half and splitting people out to become some sort of staff grade and the College should reject some sort of holding mode. Professor Sneyd highlighted that there are some exceptional/extraordinary people who want to be NHS consultants and that some of the best people are undecided about whether to go abroad. If the system messes them around for too long such individuals will be lost; the real impact on the profession would not be known for 10-15 years but the future leaders and drivers would not be in this country. Whilst this would not impact on service it would impact the nature of the whole profession, its leadership and ultimately its quality. Dr Jones highlighted that many people think that having an on call consultant resident will cure everything. This individual would be looking after 3-5 trainees who are on call covering critical care, obstetrics etc. By having a consultant deliver a service in a shift system it does not get away from the fact that a consultant on call is still required because you cannot deliver a particular aspect of care on a resident basis and also have the responsibility to look after trainees in different areas. Dr J Nolan thought it was clear that the driver was consultant delivered care but that the resources to deliver are diminishing so the profession is facing the dilemma of providing consultant delivered care without paying a premium. The College of Emergency Medicine (CEM) is struggling with recruitment because the hours/shift work are unpopular. Dr Marks suggested that what the RCoA can do is establish whether someone is trained to the point of independent practice. Looking at the current and predicted numbers there will be more people trained to CCT level than there are vacancies for consultant careers. Dr Clutton-Brock thought that there is a need to have a tiered approach and that it was inappropriate to provide an anaesthesia service with all of the individuals trained to the same level. A large proportion of anaesthesia being delivered day to day is routine and for minor procedures in low risk patients. There needs to be a team based approach with an escalation of support within it. Dr Venn noted that the Lansley reforms have meant that there will be a public service that is largely privately provided. There will be private companies with their own way of wishing to employ consultants; if there are too many doctors with a CCT they will take these jobs, they will go and work in treatment centres and will go and work in the conditions that their employer has advertised. All the RCoA can do is train them up to the level that is required and that may not be a one size fits all; the College cannot go much further than that as it does not know the form future employment contracts are going to take. Dr Whitaker thought that the RCoA should set standards but should not let resources influence its decisions. The College should decide what standards it wants and let other people figure out the resources. Professor Bion noted that 60% of patients in hospital are there because they are acutely ill; the Future Hospital Commission at the Royal College of Physicians has been set up to focus particularly on that group, as has the AoMRC Seven Day Working Group. Professor Bion thought that this provided important opportunities to develop specialist GPs who are paid a premium to provide complex care. The specialists in one distinct area of care or surgery would not be required to be on call so much should receive significantly less in terms of salary. This might be one way of modelling the future. To achieve this it is going to take 10-15 years to get near it and it would take significant support from all Colleges. Dr J Nolan highlighted that there are adverts for private treatment centres with salaries of £90,000 for a consultant anaesthetist working 45 hours a week who will be required to do some on call and antisocial work. With a position of having people who have a CCT and nothing to go into, they will take these jobs. This may mean that the system will start sorting itself out, with those that are the most competitive probably holding down the jobs in hospitals and those less so taking these other jobs. Dr Johnson raised the issue of pension; if individuals are working to their mid to late sixties it will change what they want/are able to do. Dr Venn noted that there may be a gender element; there are a large number of women in anaesthesia and while there is talk about whether a job is attractive it may be just what

some women want. There is no one size fits all position. Dr Brennan noted that the College cannot make the assumption that people want the same model of consultancy that is currently known. Dr van Besouw noted that the College has to support the workforce through revalidation so it does not just end when they get their CCT; if the College feels that there are people who are not working to a standard that the RCoA feels is appropriate then it must address that. Dr Brennan noted that what the College can do is set the standards for revalidation. Dr Gulati gave a training perspective noting that there is huge concern by the very fact that the post is being called a CCT fellowship. Trainees are unhappy with the prospect of not being able to go into a consultant job but instead going into a fellowship post which is almost an indefinite holding position. Professor Mahajan accepted there is little that can be done in terms of influencing the marketplace but the College could think about mechanisms for young consultants who are in this position of waiting and introduce a mechanism by which people can move out. There is a need to develop pathways for career progression post CCT; the impression given currently is that once a doctor has a CCT they become a consultant. Historically the Colleges have seen their responsibility end at the point of CCT but increasingly there is a need to look at supporting Fellows right through their working lives. Dr Batchelor had attended a Women in Leadership meeting; it was clear that there probably is a huge amount of equality in the hospital service which disappears completely in general practice. The vast majority of salaried GPs are women. There is a need to get rid of the idea that women are different and want something different. Dr Brennan noted that what trainees expect from their careers may not be the same as before; they may want more of a work life balance. Mrs Dalton noted that from a patient's perspective the idea of a consultant being 'trained to the point of independent practice' needed to be explained; most lay people would assume that anyone who is a doctor is trained to the point of independent practice. The point should be conveyed to lay managers that this issue is about training and quality, not just about wanting to retain rank/position. The President noted that the HENSE review on numbers of medical students going into training will probably not be out this autumn as intended, but will probably be published next year.

CB/70/2012 Quality Management of Training Committee

Council received and considered the minutes of the meeting held on 4 April 2012 which were presented by the Chairman, Dr Jones. The Committee discussed its role, structure and process, and decided that it needs to be reviewed as there are concerns that it does not have enough teeth, and whether therefore the Committee should be integrated back into training. This is for discussion and debate which will be led by Dr D Nolan. It is Dr Jones' opinion that a Quality Management of Training Committee (QMTC) process is needed as it gives support and guidance for Regional Advisers.

The Committee agreed to provide a member to join the Quality Management of Service Committee.

The distribution of Deanery reports to the College is under discussion with Miss Vicky Osgood, Assistant Director of Postgraduate Education, GMC, to see if the College can be formally sent the Deanery reports. Dr Penfold supported the fact that Deanery reports should come to the College.

It was noted that it would be helpful to view the triggered Deanery reports which are in the public domain on the GMC website. Ms Afsana Choudhury will view the triggered Deanery reports from the GMC website and do a quick keyword search on anaesthetics.

CB/71/2012 Equivalence Committee

Council received and considered the minutes of the electronic meeting held on 15 March 2012 which were presented by Dr Verma. The Committee received four applications, three of which were successful, with the failing application not being recommended for the specialist register due to a lack of solid and robust evidence of training and experience in chronic pain medicine.

Professor Mahajan had met with the new team in Manchester and would produce a summary of the visit for the next Council meeting.

Dr Brennan noted that the three successful applications were all for cardiothoracic anaesthesia and asked whether it was annotated on the Specialist Register that they are specifically on there for cardiothoracic anaesthesia. The concern is that these individuals are shown to have a Specialist Register entry in anaesthesia. Professor Mahajan explained that they are just listed on the register as anaesthesia it is not annotated. Dr Jones noted that it is up to the appointment committee to decide if the person is qualified but that the College should make it clear that someone can just be on the Specialist Register in cardiothoracic anaesthesia. Dr Clutton-Brock noted that there is no absolute requirement for a College representative on the appointment committee and there is concern that people who have extremely specialised knowledge are given essentially open registration. Dr Batchelor questioned how this would be policed; if an individual is on the Specialist Register how is it possible to tell that it is just for cardiothoracic. Professor Mahajan explained that unless the GMC changed the rules there is nothing that can be done. Dr Whitaker thought that this should be in the public domain and asked whether the GMC could put a note for employers on the Register. Professor Sneyd explained that this was European Legislation. The President would discuss the matter with the GMC.

Mr Storey highlighted that applications for CCT and applications for equivalence are now tax deductable; this has been added into the letter that goes to trainees applying for a CCT.

MATTERS FOR INFORMATION

I/16/2012 Publications

Council received, for information, the list of publications received in the President's Office. The President noted Dr Andy Lim's review of Council activities in the *Society of Anaesthetists of the South West Region.*

I/17/2012 Consultations

Council received, for information, a list of the current consultations. The President asked that anyone wishing to comment on the block of follow up GMC consultations do so directly rather than go via Mr McLaughlan.

I/18/2012 New Associate Fellows, Members & Associate Members

Council noted, for information, the following:

New Associate Members – April 2012

Dr Muthukumaraswamy Mohan Kumar – Medway NHS Foundation Trust
Dr Zhana Ivanova Ignatova – Hinchingbrooke Hospital, Huntingdon

New Affiliates – Physicians' Assistant - April 2012

Miss Fiona Margaret Robertston – Queen Elizabeth Hospital, Birmingham
Mr Mark Edward Baines – Hull & East Yorkshire NHS Trust

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

Dr Ellango Appuswamy – Royal Victoria Infirmary, Newcastle-upon-Tyne
Dr Ilias Kanellopoulos – Royal Hallamshire Hospital, Sheffield Teaching Hospitals
Dr Muhammad Kashif Rafique – Scarborough General Hospital
Dr Priyanthy Nadarajah - Stoke Mandeville Hospital
Dr Gangodavilage Mahesha Ireshani Dabarel – City Hospital, Birmingham
Dr Vara Prasada Subrahmanya Raju Sagi – Lincoln County Hospital
Dr Arjun Alva – Royal Victoria Infirmary, Newcastle-upon-Tyne
Dr Ioan Pah – West Middlesex University Hospital
Dr Srinivasa Shyam Prasad Mantha – The Christie NHS Trust Manchester
Dr Pavol Sajgalik – Wythenshawe Hospital
Dr Kyriaki Apostilidou – University Hospital, Lewisham.

PRESIDENT'S CLOSING STATEMENT

PCS/5/2012 President's Closing Statement

(i) Dr Verma noted the tight schedule for the next two days and asked that everyone keep to the timings. Pro-formas had been provided for each scribe which would be used to produce a report of the weekend and ultimately help develop future strategy.
(ii) The President noted that after listening to the presentation on the website it seems there is a huge amount of work still going on. The website was considered to be much better than the previous site but Dr Marks pointed out that work on the website would never be finished; work at the moment is fixing teething problems.

MOTIONS TO COUNCIL

M/16/2012 Council Minutes

Resolved: That the minutes of the meeting held on 18 April 2012 be approved with the following amendment:
CB/54/2012 Trainee e-Portfolio Working Party Paragraph 6 To include 'Dr Batchelor thought that the Foundation type Supervised Learning Events (SLE) assessment are a good thing and supports the College moving over to using SLEs.'

M/17/2212 College Tutors

Resolved: That the following appointments be approved:

West Yorkshire
Dr D Odedra (St James University Hospital)

North Thames Central
Dr M S George (Great Ormond Street Hospital)

North Thames East
Dr F M L Dancey (Barts Health NHS Trust)

East of Scotland
Dr U S Mok (Perth Royal Infirmary)

M/18/2012 Joint Revalidation Development Committee

Resolved: That the revised Terms of Reference for the Joint Revalidation Development Committee be approved.