Royal College of Anaesthetists

MEETING OF COUNCIL

Edited Minutes of the meeting held on 11 January 2017
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 L Brennan, President
Dr J Langton
Professor R Mahajan
Dr R Marks
Professor R Sneyd
Dr A Batchelor
Dr B Miller
Dr C Waldmann
Professor J Nolan
Dr J Colvin
Dr N Penfold
Dr S Fletcher
Professor M Mythen
Dr P Kumar
Dr G Collee
Dr J-P Lomas
Dr W Harrop-Griffiths
Professor J Pandit
Dr K May
Professor M Grocott
Professor E O'Sullivan
Dr D Bogod
Dr K Ramachandran
Dr L Williams
Dr F Donald
Dr I Johnson
Dr H McLure

Mr R Thompson, RCoA Lay Committee
Dr A-M Rollin, Clinical Quality Advisor

In attendance: Mr T Grinyer, Ms S Drake, Mr R Ampofo, Mr M Blaney, Ms K Stillman, Mr A Woods, Dr A-M Bougeard, Ms A Regan and Ms K Edmondson

Apologies for absence: Dr J Fazackerley, Dr D Selwyn, Dr R Darling and Dr P Clyburn.

COUNCIL IN DISCUSSION

CID/1/2017 Governance
(i) Board Structure
Council received a paper that defined the proposed four boards, the areas of activity covered by each and a suggested structure. Professor Mahajan explained that if Council wished the board structure to be fully operational by September 2017 more detailed discussion would need to take place at the strategy weekend in May 2017. Subject to Council's agreement today, the President would make recommendations to Council for the appointment of Chairs and Vice-Chairs who would be tasked with devising operational details for their respective boards by May. It was noted that Council could approve the move to a board structure without the approval of an Annual General Meeting (AGM).

The President explained that one of the first pieces of work, if the board structure was approved, would be to look at the work of existing committees and working groups and to consider, whether or not they meet the College's strategic aims. Consideration would be given whether those committees/working groups not meeting the criteria needed to continue or whether their function could be merged with another committee/working group.

Council discussed:
- The possibility of the boards, meeting, possibly monthly or bi-monthly, on a Wednesday morning with Council meeting later the same day.

- The wider inclusivity and engagement of Council members in leadership roles as a result of the board structure.
- Whether or not the Communications and External Affairs Board should run in parallel to the other boards or whether it should be restructured to take a global view and to interact with the other boards. It was noted that an important aspect of the Royal College of Anaesthetists' (RCoA) work will be the development of policy which will fall within the remit of Communications and External Affairs. Each board will have an Officer member to ensure interaction and liaison amongst the Boards.
- Financial management and the responsibility of the board. Each board will have oversight of its budget with the Finance Board ultimately looking at financial issues. The scheme of delegation will set out the various levels of devolved responsibility.

Council approved the content of the paper and agreed that the College should move forward as proposed. Council approved the motion as set out in M/1/2017.

(ii) Election of Trainee Members of Council

The recent election highlighted a major problem with the current Ordinances that would need to be rectified for the October 2017 Council election, when there would be a further trainee vacancy. It was proposed to seek the 2017 AGM's endorsement for the following rule change to College Ordinance 5.1(1)c from:

c. two members, who are Fellows by Examination of less than four years' standing, elected by Fellows by Examination of less than four years' standing;
to
c. two members, who are trainees and Fellows by Examination, elected by trainees;

Council was asked to agree a way forward to enable sufficient notice to be given to Fellows and Members that a motion will be submitted to the AGM in March 2017. The Trainee Committee had unanimously supported the recommendation.

Council discussed:
- Inclusion in the definition of a trainee of those in out of programme activities in training roles who remain engaged with the College.
- The challenge of identifying trainee members using existing College systems. This will be addressed by the Technology Strategy Programme (TSP) but in the meantime it will be necessary to triangulate to obtain the most complete electoral roll possible for the next trainee election.
- The pros and cons of allowing trainees earlier in their career to stand for Council. If a CT1 doctor was appointed they may not decide to proceed in the specialty but would still be an elected Council member.
- Identification and eligibility to vote of those who have taken a break in their training programme. The President confirmed they will be eligible to vote if they are registered with the College and in good standing.
- Any ambiguity highlighted by the work in terms of triangulation will be discussed by the Audit and Internal Affairs Committee before the next election, or by Council if decisions need to be made.
- Potential disenfranchisement of post-Certificate of Completion of Training (CCT) trainees who, having finished their training programme, are not a trainee or a consultant. It was confirmed that they will be eligible to vote in elections for consultant vacancies.

Council agreed that the proposal improved representation and enfranchisement of trainee colleagues and approved the motion as listed under M/1/2017.

CID/2/2017 President's Opening Statement

a) The President welcomed Dr Anne-Marie Bougeard, Perioperative Medicine (POM) Fellow, and Ms Katie Edmondson, TSP Co-ordinator, who were observing Council.
b) Dr Williams has taken on the role of Council sustainability lead working with Dr Tom Pierce.
c) Dr Ramachandran has agreed to be the RCoA's second representative for the National Confidential Enquiry into Patient Outcome and Death (NCEPOD).
d) Three applicants were interviewed for the position of National Institute of Academic Anaesthesia (NIAA) Grant Officer. Dr Matthew Wilson from Sheffield has been offered the position.
e) Mr Grinyer has been invited to become a Trustee, on behalf of the Academy of Medical Royal Colleges (AoMRC), of the Faculty of Medical Leadership and Management. There was currently no

conflict of interest but any arising in the future would be declared. There was no objection from Council to Mr Grinyer accepting the invitation.

f) The President announced the deaths of Dr Roddie McNicol and Dr Frederic Plumpton. Council stood in memory.
g) The RCoA's Patron, HRH The Princess Royal, will attend the Anniversary Meeting.
h) The AoMRC has issued a statement in response to the current pressures faced by the health and social care system. The President has tweeted in support of a letter sent to the Prime Minister by the Royal College of Physicians of London (RCPLond).
i) There had been no anaesthetic recipients of New Year Honours. The President has discussed with Sir Peter Simpson, Chairman of the RCoA's National Honours Committee, ways of changing the College's nomination process for the benefit of the specialty.
j) Anaesthesia received five Silver and seven Bronze awards in the 2016 Clinical Excellence Awards (CEA) round. There is concern regarding how the specialty is recognised which the President will discuss with Drs Harrop-Griffiths and Clyburn. The 2017 round will open on 28 February 2017 and close on 2 May 2017. *Post-meeting note: the closing date has been changed to Tuesday 25 April 2017.*
k) The sustainability and transformation plans (STP) policy statement has been circulated and forms the basis of the President's view in the March 2017 *Bulletin*.
l) The President thanked Drs Collee and Penfold for producing a response to Health Education England (HEE) on the future of the medical associate professions (MAP) workforce at such short notice.
m) Some trainees in England have been taken out of their normal clinical duties to assist stretched services in general medicine. The President and Vice-Presidents are working with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) to prepare a joint statement in response to the situation.
n) The next listening event for anaesthetists in training will take place at the RCoA on 30 January 2017.
o) Council members were encouraged to attend the Health Services Research Centre (HSRC) Quality Audit and Research Co-ordinators' (QuARC) meeting on 27 April 2017. Ms Drake agreed to circulate the programme to Council

Action: Ms Drake to circulate programme for HSRC QuARC meeting on 27 April 2017 to Council.

p) The President has been informed by the British Medical Association (BMA) leadership that consultant contract negotiations are ongoing and have reached an important point.

CID/3/2017 Chief Executive's Report

Mr Grinyer reported that the College staff pay consultation closed on 31 December and had yielded no significant comments that could not be dealt with through the questions and answers document or modifications to the pay policy. College staff will now receive a letter confirming that the consultation has closed and the organisation will proceed to the new policy. New staff are now being recruited to the pay policy.

The agenda for the AGM will be brought to the February meeting of Council.

With one day to go until the closure of elections for one consultant vacancy on the RCoA Advisory Board for Scotland, there has been a 39.1% turnout. There are three candidates for the vacancy.

CID/4/2017 Technology Strategy Programme – review of last three months

Mr Woods gave Council an update on TSP activity between October and December 2016.

Council discussed:

- Governance and security issues as well as potential irritations generated by the use of voicemail. Mr Woods agreed to investigate the security aspect.

Action: Mr Woods to investigate security aspects of voicemail.

CID/5/2017 Health Education England Proposal for the Development of Non-medically Qualified Clinical Practitioners

Dr Collee explained that HEE has developed its programme to develop MAPs in response to the Secretary of State's promise to provide 1000 physicians' associates to primary care by 2020. This is seen as the best opportunity to galvanise government before the next change of government to obtain statutory regulation for MAP. HEE wants to submit by the end of January an application for government to consider starting the process of statutory regulation that is thought is likely to take two years once triggered. Together with the Faculty of Intensive Care Medicine (FICM), the RCoA and AAGBI have submitted their opinion to HEE that they fully support the drive for statutory regulation but have significant concerns about the construction of the MAP curriculum planning document. HEE will go ahead with its

submission to the Department of Health (DH) at the end of the month and it was anticipated that in 10 days' time the President will receive a document for approval before it is submitted to government. Dr Collee had explained to HEE that it will not be possible for Council to approve the document within the time allowed.

None of the four practitioner groups is averse to looking at higher education institute (HEI) modules that can be common to each MAP theme but do not wish to produce a practitioner that is not skilled in a specific area. MAPs are important to the delivery of future service and patient care and undermining their competence will render them useless. The money is available to deliver the 1000 physicians' associates and there are a large number of HEIs that have seen the opportunity and are running MAP programmes. It might be necessary to accept some aspects that the RCoA and FICM do not totally approve of in the interest of progressing regulation.

Council discussed:

- Professor Sneyd declared a conflict of interest as he runs a physicians' associate programme in a university.
- HEE's current approach to supporting the programmes is idiosyncratic and random across the country.
- The assumption should not be made that funding is available. Training is mostly funded out of failure to recruit general practitioners.
- The danger of standards falling as a result of the acceleration of the programme. The most important aspect missing from the existing document is definition of the degree of supervision and autonomy MAPs will have which must be defined before it reaches the end stage. HEE is making an inadequate submission in the hope it can make it adequate by the time the government looks at it closely.
- The tight timetable did not allow for a single voice response from the RCoA and AAGBI.
- The RCoA must resist the idea of half the course being a common curriculum for all the specialties. Focussed training is required to produce people skilled in specific areas.
- What could be done to prevent the programme becoming the nursing model. Dr Collee responded that Professor Kopelman had promised to provide communal statements that the Presidents of the various Colleges would be invited to put to members of the DH when the opportunity arose.
- HEE's lack of engagement with providers. Dr Collee responded that it had been pointed out that a crucial part of the Physicians' Assistant (Anaesthesia) (PA (A)) programme involves the pairing of a parent university with clinical teaching.
- HEE no longer holds all of the money for all of the training, it only holds funds for medicine and dentistry. Local providers have to fund their own training. Any organisation employing more than 200 people has an apprenticeship levy of 0.5% for apprenticeship programmes; all health service organisations except general practice will pay this apprenticeship levy. Unless bids are submitted now regarding how to use that money it will go elsewhere. It would be useful if the money could be diverted but it was recognised other groups would also compete for it.
- Difficult to fill specialties. It has been suggested by the Director of HEE for the south geography that money could be diverted from doctor funding to finance MAP programmes.

CID/6/2017 National Clinical Improvement Programme's Call for Specialty Specific Outcome Measures for Individual Clinicians and Teams

Professor Mahajan reported that themes had emerged from Council's comments. There is no clear indication of how the clinical quality indicators might be collected, analysed or used. Many Council members therefore wished the RCoA to be cautious in its return saying that less is more at this stage. There was some assurance when the call was sent that the indicators will not be used to produce league tables. Reassurance will be required that this was in fact the case.

The indicators had been scored by 21 Council members and subsequently analysed. Professor Mahajan presented the results to Council emphasising that it will be important to keep dialogue open as clarity emerges around perioperative care.

Council discussed:

- Using six Anaesthesia Clinical Services Accreditation (ACSA) standards to inform the indicators. It was suggested that the only problem is ACSA is generic and about departments. Dr Fletcher agreed to identify six ACSA standards applicable to individuals.

Action: Dr Fletcher to identify six ACSA standards applicable to individuals.

- The requirement for precise wording in the final submission. It was suggested some of the wording is currently ambiguous.

- Council should be careful in including very rare events in the list and awareness should therefore be deleted.
- The list can be as small and uncontroversial as Council wishes and be a living document. The response could make it clear that this is new territory and the RCoA would like to start with areas that will have the confidence of Fellows and Members.
- Adding to the document will be much easier than subtracting.
- The more National Emergency Laparotomy Audit (NELA) or PQIP type data can be embedded the better.
- The final submission should include caveats. It was suggested that the last 7 bullet points of the summary detail the caveats.

The President suggested that if Council was content, intraoperative awareness and medication errors should be deleted and the resulting top four indicators submitted. It was agreed with the removal of medical optimisation from the indicator ranked one. The final version will be circulated to Council before submission.

Action: Professor Mahajan to circulate final version to Council before submission.

The President indicated he would be happy to obtain clarity from Norman Williams regarding how the data would be used.

CID/7/2017 Association of Anaesthetists of Great Britain and Ireland President's Report

Council received a written report from Dr Clyburn who was unable to attend Council. The President and Council congratulated the AAGBI on achieving its Lifeboxes for Rio target of raising £96,000.

It was noted that the AAGBI was launching its updated guideline on *Consent for Anaesthesia* on the day of the Council meeting at the Winter Scientific Meeting

STRATEGY

S/1/2017 Getting it Right First Time

The President welcomed Professor Tim Briggs and Professor Tim Evans who gave a presentation on the Getting it Right First Time (GiRFT) initiative which is being rolled out from orthopaedics to 20 different specialties including intensive care medicine.

Council discussed:

- How the analysis is intended to feed into tariffs. Professor Evans responded that, in a time of deflationary tariffs, once GiRFT has defined "what good looks like" it will be in a better position to say this is the right tariff. Professor Briggs added that if social care was separated from the NHS, more money was not required. Waste is very high and hugely variable. There is very good practice but in some places it is not great. There is a significant opportunity for the profession to drive the agenda in a clinical way with the support of Colleges, Associations and Specialist Societies.
- Whether or not the Competition Commission is likely to be a barrier as it is encouraging variation with regards to implants. Professor Briggs explained that it was necessary to make everything transparent. There is now a portal on the National Joint Registry where Trusts have to input what they are paying for various joint replacements. Once the data has been completed, every Trust will be able to see what others are paying.
- How much of the GiRFT work is showing an apparent volume affect and the power GiRFT will have to make changes. Professor Briggs explained that there is now a mandate to find solutions and to hold medical directors to account. The output so far and buy in from clinicians has been impressive. There are good examples of change such as low volume surgeons stopping and reducing their complex work.
- The focus should be on the productivity during direct clinical care (DCC) rather than the ratio between DCC and supporting professional activities (SPA). Professor Evans confirmed it was about productivity in the sessions a doctor is actually looking after patients. Professor Briggs explained that the national leads will define what a productive theatre should do and Trusts will be expected to work with everyone in the organisation to deliver that.
- Influencing areas other than orthopaedics. National leads, following their deep dives, will be asked to prepare a report highlighting problems and suggesting solutions. There is a need to free up elective capacity in order to undertake the work that needs to be done.

Professor Briggs asked if it would be useful to have a lead for anaesthesia/perioperative care. The President responded that the RCoA has an infrastructure and blueprint that defines what good looks like for the specialty and would be keen to work with the GiRFT team and Lord Carter on these initiatives. Professor Briggs indicated that there might be some funding available to support this.

COMMITTEE BUSINESS

CB/1/2017 Council Minutes
The minutes of the meeting held on 14 December 2016 were approved subject to an amendment to CID/72/2016.

CB/2/2017 Matters Arising
(i) Review of Action Points
CID/59/2016 President's Opening Statement Declaration of Interests It was noted that there is now a form all Trustees have to sign that the Charity Commission has approved.

All other actions were ongoing or complete.

CB/3/2017 Regional Advisers
There were no appointments or re-appointments this month.

CB/4/2017 Deputy Regional Advisers
There were no appointments or re-appointments this month.

CB/5/2017 College Tutors
Council considered making the following appointments/re-appointments (re-appointments marked with an asterisk):
West of Scotland
*Dr C Guha, Monklands Hospital **Agreed**
*Dr C A Slorach, Wishaw General Hospital **Agreed**
*Dr C L Harper, Queen Elizabeth University Hospital **Agreed**

North East
Northern
Dr J Thimappa (Darlington Memorial Hospital) in succession to Dr R J Geary **Agreed**
Dr A J Duggie (University Hospital of North Durham) in succession to Dr A Holtham **Agreed**

Mersey
To consider a request from the RAA in Mersey Dr Ewen Forrest for a second Tutors post at Aintree University Hospital. **Agreed**

If agreed to appoint Dr A McDonald as the 2nd College Tutor for Aintree University Hospital **Agreed**

West Midlands
Birmingham School
*Dr J Stansfield, Birmingham Children's Hospital **Agreed**

CB/6/2017 Head of Schools
There were no appointments or re-appointments this month.

CB/7/2017 Training Committee
(i) Chairman of the Training Committee's Update
Dr Penfold reported that the RCoA will engage with the London Academy to produce a survey looking at novice training. The President added that there is huge pressure on time and resources and there is a need to ensure the next generation is properly initiated into the specialty.

(ii) Certificate of Completion of Training

Council noted recommendations made to the GMC for approval, that CCTs/Certificate of Eligibility for Specialist Registration (Combined Programme) [CESR (CP)] be awarded to those set out below, who have satisfactorily completed the full period of higher specialist training in anaesthesia. Those names marked with a # have also been recommended for sub-specialisation in Pre-Hospital Emergency Medicine.

Anglia
Dr Douglas Bomford
Dr Preeti Dewan
Dr Priti Kamath

London
North Central
Dr Sotiris Nicholas
Dr Kate Sherratt
Dr Michael Gilhooly
Dr Suyogi Jigajinni

South East
Dr Adam Yarnold
Dr Samantha Black
Dr Oliver Blightman
Dr Uvie Brigue
Dr George Christodoulides

Northern
Dr Reema Ayyash

North West
Dr Matthew Stagg
Dr James Wilson
Dr Emma Baird
Dr Pradip Patel

Scotland
North of Scotland
Dr Jolene Moore

West of Scotland
Dr Lia Paton Joint ICM

Dr Philip Tildsley

Severn
Dr Kate Crewdson Joint ICM
Dr Lynn Fenner
Dr Alice Braga

Wessex
Dr Helen Bryant

West Midlands
Birmingham
Dr Olivia Kelsall Joint ICM

Stoke
Dr Naveed Javed
Dr Michael Dixon
Dr Binu Raj
Dr Ifeanyichukwu Uchendu
Dr Dipali Verma

Warwickshire
Dr Jaimin Patel Joint ICM
Dr Narcis Ungureanu

Yorkshire and Humber
East
Dr Khaleda Ayyash

South
Dr Sailaja Pothuneedi

CB/8/2017 Revalidation Committee

The Chairman, Dr Marks, presented the minutes of the meeting held on 8 November 2016, drawing Council's attention to:

- GMC's four yearly report on revalidation. The issues highlighted in the report are identical to those discussed by the Revalidation Committee. The report, scheduled for release at the end of the week, is upbeat and says that revalidation is going well and is doing what it is supposed to do. It also suggests that many of the public are not aware that revalidation takes place. The GMC is considering the possibility of changing the name from revalidation to relicensing. It also wishes to tweak how it moves forward for more junior doctors and possibly introduce it earlier in their training. The GMC wishes to look at the unnecessary burden and bureaucracy for doctors; it is aware that some Trusts are using revalidation to request information which the GMC does not require. The GMC has suggested that Colleges should look at the supportive information they provide. There is particular concern about doctors in short-term locum positions who do not have a responsible officer. The commonest source of enquiries to the RCoA's revalidation helpdesk is those with non-standard careers. It was agreed that Mr Ampofo should circulate the report to Council.

Action: Mr Ampofo to circulate GMC report on revalidation to Council.

- Future of the revalidation committee. Dr Marks suggested that looking forward the RCoA should consider recruiting members who as part of their job plan have direct involvement with revalidation, e.g. responsible officers or appraisal leads in trusts.

CB/9/2017 International Short-life Working Party
The Chairman, Dr Langton, presented the minutes of the meeting held on 22 November 2016, drawing Council's attention to:

- *INT/45/16 Governance structure* An interim structure has been devised that will feed into the governance review.
- *INT/45/16 Project criteria*
- *INT/46/16 Global partnership public strategy document* A paper will come to Council in February 2017.

CB/10/2017 Professional Standards Committee
The Chairman, Dr Harrop-Griffiths, presented the minutes of the meeting held on 13 December 2016, drawing Council's attention to:

- *PSC/43/2016 Life support training for post-anaesthesia care unit (PACU) practitioners* It was noted that there are various bodies producing clinical standards and the problem of inconsistency was not limited to anaesthesia. The President explained that the RCoA and AAGBI have regular dialogue and can resolve matters. The President was keen to meet with Specialist Societies in 2017 and suggested one of the agenda items could be how to ensure collaborative working. It was acknowledged that where there is no robust data, there will be a spread of opinions.

It was noted that the BBC programme *Hospital* will focus on a shortage of resources and intensive care beds along with the pressure put on patients, doctors and nurses. The President asked Ms Stillman to ensure the Communications team monitored output arising from the programme.

Action: Communications to monitor output arising from *Hospital.*

CB/11/2017 National Institute of Academic Anaesthesia
The Chairman, Professor Sneyd, presented the minutes of the Research Council meeting held on 8 December 2016, drawing Council's attention to:

- *NIAARC/12.2016/7 John Snow Anaesthesia Intercalated Awards 2017* It was disappointing that there had been no application from Northern Ireland and Wales.

CB/12/2017 Lay Committee
The Chairman, Mr Thompson, presented the minutes of the meeting held on 13 December 2016, drawing Council's attention to:

- *LCFULL/38/2016 Examinations*
- *LCFULL/40/2016 Implications of the Governance Review*
- *LCFULL/41/2016 Quoracy*

CB/13/2017 Faculty of Pain Medicine
The Dean, Dr Miller, presented the minutes of the Board meeting held on 9 December 2016, drawing Council's attention to:

- *BFPM/12.16/3.2 Non-anaesthetic Fellowship Working Party* It was recommended that the Faculty work to a timetable that will allow a motion to be taken to the March 2018 AGM if required. The outcomes from the Working Party will be included in the Faculties paper for the governance review process.
- *BFPM/12.16/3.8 National Institute for Health and Care Excellence (NICE) Lower Back Pain Guidance*
- *BFPM/12.16/3.4 Medical Use of cannabis*
- *BFPM12.16/3.13 National helpline*
- *Standards project with British Pain Society and the Clinical Reference Group* The President asked that the standards, related to specialist pain practice, be shared with Council.

MATTERS FOR INFORMATION

I/1/2017 Consultations
Council received, for information, a list of current consultations.

I/2/2017 New Associate Fellows, Members and Associate Members
Council noted the information circulated in the enclosure.

I/3/2017 Clinical Quality Enquiries
Council received, for information, a list of enquiries received by the Clinical Quality Department.

PRESIDENT'S CLOSING STATEMENT
PCS/1/2017

a) The President reported that there had been only a few working days between the December and January meetings of Council. Whilst there had been a lot of items for discussion today, consideration would be given nearer the time as to whether a meeting was required in January 2018 if there was likely to be little on the agenda.
b) February Council will commence with a Trustee only discussion from 1000 until the coffee break to enable decisions to be made about a Board of Trustees.
c) The President reiterated the College's willingness to work with GiRFT.
d) The President announced that Dr Jen Warren, a post-fellowship trainee, has agreed to address the Diplomates in 2017. Dr Warren was a gold medallist at the Invictus Games.

MOTIONS TO COUNCIL

M/1/2017 Governance
Resolved: That Council accepts the proposed changes to the structure of the College's Boards, Committees and Groups.
Resolved: To seek the 2017 AGM's endorsement for the following rule change to College Ordinance 5.1(1)c from:
c. two members, who are Fellows by Examination of less than four years' standing, elected by Fellows by Examination of less than four years' standing;
to
c. two members, who are trainees and Fellows by Examination, elected by trainees;

M/2/2017 Council Minutes
Resolved: That the minutes of the meeting held on 14 December 2016 be approved subject to an amendment to CID/72/2016.

M/3/2017 College Tutors
Resolved: That the following appointments/re-appointments be approved (re-appointments marked with an asterisk):
West of Scotland
*Dr C Guha, Monklands Hospital
*Dr C A Slorach, Wishaw General Hospital
*Dr C L Harper, Queen Elizabeth University Hospital

North East
Northern
Dr J Thimappa (Darlington Memorial Hospital)
Dr A J Duggie (University Hospital of North Durham)

North West
Mersey
Dr A McDonald 2nd College Tutor for Aintree University Hospital

West Midlands
Birmingham School
*Dr J Stansfield, Birmingham Children's Hospital