Royal College of Anaesthetists

MEETING OF COUNCIL

Minutes of the Meeting held on 12 December 2023

Members attending:

Dr Fiona Donald, President
Dr Helgi Johannsson, Vice President
Dr Claire Shannon, Vice President
Dr Russell Perkins
Professor Mike Grocott
Dr Chris Carey
Dr Sarah Ramsay
Dr Claire Mallinson
Dr Felicity Plaat
Dr Mike Swart
Professor Jonathan Thompson
Dr Sri Gummaraju
Dr Ashwini Keshkamat
Dr Ros Bacon
Dr Ramai Santhirapala
Dr Toni Brunning
Dr Elisa Bertoja
Dr Catherine Bernard
Dr Satya Francis
Dr Sarah Thornton
Professor Andrew Smith
Dr Sunil Kumar
Dr Chris Taylor
Dr Lorraine De Gray
Dr Daniele Bryden
Dr Matthew Davies
Professor Dave Lambert
Dr Matthew Tuck
Ms Jenny Westaway
Dr Giovanna Kossakowska
Dr Dave Selwyn
Dr Daphne Varveris
Dr Simon Ford
Dr Roger Sharpe
Dr Simon Maguire

In attendance: Mr Jonathan Brüün, Ms Sharon Drake, Mr Mark Blaney, Mr Graham Blair, Mr Russell Ampofo, Ms Judith Tidnam, Ms Natalie Walker and Ms Rose Murphy.

Apologies for absence:
Dr Sandeep Lakhani, Dr William Donaldson, Dr James Ralph, Dr Rashmi Rebello,

1. Welcome and apologies
The President, Dr Fiona Donald, opened the meeting and welcomed attendees.

Introduction from Regional Advisers Anaesthesia (RAA)
Dr Anoop Kumar, RAA for the North of Scotland
Dr Kumar introduced himself and gave an update. The region covers two sites: Aberdeen Royal Infirmary, the main university teaching Hospital, and Raigmore Hospital based in Inverness, which covers all subspecialties of general surgery required for the curriculum.

To date recruitment remains successful with 100% fill rates. In the north there are 65 trainees, with a third in stage one and two thirds in stages two and three. There are currently five Medical Training Initiative (MTI) trainees, one in chronic pain, and four in general surgery. In 2023 there were also four locum appointment for training (LAT) posts filled by trainees who were unsuccessful in the recruitment process.

The deanery has supported stage one trainees staying in the same place for three years, without rotation to another site. For stage two training however, there is no option but for trainees to move between the 2 hospitals. The Scottish Government has requested that posts reflect population need, so there is a plan to trial stage three training in Raigmore.

It was reported that all trainees are now on the 2021 curriculum and there have been no problems with the curriculum migration. Dr Kumar thanked the College for guidance provided on Specialist Interest Areas (SIAs). At present all trainees are granted educational time and teaching time to study for primary

and final examinations, with an option to learn about more generalist topics every quarter. Full support continues to be provided on trainee wellbeing and this was well received particularly after Covid.

Dr Kumar noted that the deanery remains committed to working with the College and implementing its recommendations, with the aim for stage three training to be provided with minimal disruption. Work also continues to support the 30% of senior trainees who are working less than full time (LTFT) and to mitigate the pressures that puts on the service. Questions have been asked about shortening training time in light of the competency based nature of the curriculum.

Dr Linzi Peacock, RAA Southeast Scotland
Dr Peacock introduced herself and noted that she is the new RAA for Southeast Scotland taking over from Dr John Wilson. She is a consultant at The Royal Edinburgh Infirmary which is a tertiary referral centre for a number of services throughout Scotland, and the major trauma centre for southeast Scotland.

Dr Peacock's objectives as RA include supporting wellbeing for trainees, to ensure a supportive and high quality training programme. Work is required in the region on supporting the new SIAs, improving the regional teaching experience and delivering regional anaesthesia. Within southeast Scotland most training is based in Edinburgh, with 115 trainees across the entire training programme.

Dr Peacock outlined the current challenges within the region, which included:

- Workforce problems. 44% of ST4 trainees work LTFT, and slot sharing is not available in Scotland. NES has indicated that the deanery should move towards the whole time equivalent model, but this has yet to be agreed.
- In 2021 and 2023 there was an uplift of specialty training (ST) numbers in Scotland, from 50 in 2019, to over 70 in 2023. Whilst there is normally a 100% fill rate in Scotland, it is noted that in August 2024 there will only be 38 posts across Scotland. With 17 CT3 due to finish in SE Scotland, there will only be approximately seven or eight jobs available.
- Previously the Scottish Government had a request for sixteen additional places but have granted only six across Scotland, which will support geographically underserved populations.
- Within the programme of 61 STs, there are four on maternity leave, two out of programme (OOP) and there is a gap of 10 full time equivalent.
- There continue to be constraints on study budgets, with NES providing only £600 per post, not per trainee and no ability to keep any underspend for use in subsequent years.
- NES have developed a national simulation strategy in Scotland, but are no longer funding it so study leave budgets have to be top sliced to provide sim sessions for IAC and IAOC competency.
- Work continues in addressing issues with rotational training, as highlighted at the recent Extraordinary General Meeting (EGM). Most training opportunities are only available in Edinburgh Royal Infirmary and other hospitals are unable to deliver parts of the curriculum. There is still a need to move around to cover the whole curriculum.
- Work continues in reviewing ACCS emergency medicine expansion. Normally there is a 100% fill rate, however in Scotland this year the ST4 EM fill rate was only 33%, therefore there are plans to expand the CT1 intake in EM which will increase the number of novices in departments and could impact on training expansion of core trainees in anaesthesia and stretch training capacity.
- Anaesthesia Associates (AAs) remain on the agenda for the Scottish Government, however, the programme expansion has not yet been determined.
- There are also plans to build an independent treatment centre within the region and trainers have been asked if trainees would be able to form part of a reliable staffing model. This seems unrealistic given the shortages.

Dr Chris Carey thanked both Dr Kumar and Dr Peacock for their work and support as RAAs and their contribution to the senior regional network for the College. Following discussions at the recent Training Committee meeting, Dr Carey clarified that time in training is clearly defined, with core training being 36 months whole time equivalent, with no exception. There is a process for accelerating higher training, which is currently three months, however this may change in the future and there is also a process for recognition of prior learning.

Dr Thornton clarified that with regard to rotational training the ask was to minimise rotations as much as possible and to make placements as long as possible when rotations had to occur. She complimented Dr Peacock on the organisation of training in SE Scotland and noted that the ATRG reps reported AiTs being happy with the current situation.

Dr Peacock clarified that there is single employer status within each region of Scotland. Currently NHS Scotland requires new email addresses when trainees change Boards, which has resulted in some problems. Dr Peacock also outlined the challenges with LTFT, with rotas being stretched and the challenges and burdens being faced by trainees who are working 100%. In one hospital, AiTs were doing 46% of their work out of hours.

To date Scotland have not pursued the CESR pathway but may have to look at it in the future, but work will also need to focus on increasing training numbers in Scotland.

Dr Ramai Santhirapala noted a recent article in the College January bulletin on LTFT, written by Nicola Hickman and the opportunity for Dr Peacock to make contact to discuss the difficulties and seek information on the solutions with rotas.

2. Council minutes

The minutes of the meeting held on 8 November were circulated:

MOTION Agreed: Council approved the minutes of the 8 November as a true and accurate record with the following corrections.

- To add Dr Catherine Bernard as present at the meeting.
- Under pages 9 and 10 – section B, The Ethics Committee, there was a request to change the sentence.
    - Is it acceptable to not use capnography during moderate sedation, citing the absence of grade A evidence supporting its specific use, *when inadvertent overdose* cannot be guaranteed, and evidence exists that it reduces sedation related adverse events?

  To read
    - Is it acceptable to not use capnography during moderate sedation, citing the absence of grade A evidence supporting its specific use, <u>when avoidance of inadvertent</u> overdose cannot be guaranteed, and evidence exists that it reduces sedation related adverse events?
- On page 11 under FPM Dean Update**,** Dr Lorraine De Gray, updated several points and noted that, for clarity, she would send through an updated version of the notes.
  ACTION: Dr Lorraine De Gray to send through updated version of the notes to the Executive Office for inclusion.

Matters arising:

Council reviewed the list of matters arising, the following points were noted:

- In relation to the Quality Improvement (QI) Lead person specification, Ms Sharon Drake noted that the word substantive has now been removed, therefore trainees will not be excluded from applying for this role. The College will now work towards ensuring all roles will be open to as many people as possible.
- There was agreement to circulate an email to consider and confirm attendance at the 2024 College Tutors Meeting once the date has been confirmed.
- There was a note for the CQ&R Board and Ms Sharon Drake to ensure that guidance on the issue of capnography in moderate sedation, as previously endorsed by the College, complies with the recommendations of the Ethics Committee. It was noted that a letter has been sent to the guideline authors to outline problems found within the sedation guidance.
- The Regulation changes have been updated as agreed by Trustees and noted by Council.

All other actions from the previous meeting and relating to the EGM are in progress or have been completed.

3. President's Update

The President highlighted the paper circulated in the pack, which noted her meetings and commitments as President since the last Council meeting. The President also noted the following:

- That Professor David Lambert will be stepping down as Chair of the British Journal of Anaesthesia (BJA) after six years' service. She thanked him for his work and contributions to the BJA and the College since becoming chair particularly in relation to the recent negotiations. It was noted that Dr Lambert will remain as co-opted member of the BJA committee.
- The President thanked Dr Matthew Tuck and Dr Giovanna Kossakowska for their excellent work and support in their 18 month terms as co-opted elected Anaesthetist in Training (AiT) members of council which will end in March 2024.
- The President thanked Dr Russell Perkins for his role as Vice President and his support on RCoA Council.

- Council noted the death of Professor Richard Clarke, past Dean of the Faculty of Anaesthetists of the Royal College of Surgeons in Ireland (1991 – 1994) and held a minute's silence in reflection.

It was further noted that following the Annual General Meeting (AGM) all motions were passed.
The elections for Council remain open until Thursday 14 December 2023, with results due to be announced on Friday 15 December.

The President highlighted points from the Board of Trustees (BoT) meeting held on 11 October to note:

- Regarding employee relations, staff turnover has increased in 2023 but remains within expected levels. Ms Tidnam noted that voluntary turnover will continue to be monitored to ensure the College is doing its best to retain staff.
- The College operational plan has been impacted by the work on the EGM and will be discussed at the BoT on December 13. Some work may have to be delayed or paused.
- Membership has increased to 26,239 and the new member acquisition is in line with previous years at 443. A new area is being reported in the membership data to update on the reasons given for RCoA membership cancellations and will continue to be monitored.
- The trustees reviewed the minutes of the Equality, Diversity and Inclusion (EDI) committee held on 14 September to note the ongoing work and updates.
- The Finance and Resources Board (F&RB) presented the annual report and accounts for review and no areas of concern were highlighted.
- The Clinical Quality and Research Board (CQRB) agreed to a revised ACSA pricing model for the independent sector.

4. CEO Update

Commenting on Conflict

The College, including the Faculty of Intensive Care Medicine and the Faculty of Pain Medicine, has commented on contentious issues in the past, including the war in Ukraine. Elected Council members, Deans and Trustees have recently taken a decision via email to not comment on the conflict in Israel and Gaza, despite requests and petitions from some members. This is because, on reflection and despite previous statements, they feel it is not in line with our charitable objects to comment on conflict.
Council reviewed a paper outlining the merits and demerits of its current stance, and considered what if any steps should be taken to standardise its approach to global issues, including conflict.
The in-depth discussion of the paper and of individual views included the following:

- Statements made by other Colleges had resulted in further statements being required in response to questions and comments from members about certain aspects of what had been written.
- In politically complex situations there is a risk of being criticised by members for not being specific enough about the issue.
- A relatively small cohort of the membership had contacted the College directly to ask the College to make a statement and the communications team continue to monitor and respond to queries made. This does not necessarily reflect the true strength of feeling but gives an indication.
- The College should remain neutral and not comment on geopolitical matters. To do so risks criticism and reputational damage and is unlikely to make any material difference to the situation.
- Reputational damage could also ensue from remaining silent.
- The most prudent action would be to be guided by our charitable objects and comply with charity commission rules and legislation and refrain from comment on things that are not within our scope.
- It may be appropriate to recommend to the BoT to remain neutral and possibly retract statements made in the past.
- Council has a duty to support members when they are affected by events and we should therefore consider making a statement acknowledging the distress of our members and offering support.
- To date there has been disappointment amongst FICM members that the Faculty has not acknowledged, or been in a position to acknowledge, the moral distress of its members and fellows in the UK about the current situation. The Faculty agreed that they did not want to make a political statement but wished to support Fellows and Members and give them a voice.
- The College Charter does not stop the College from acknowledging that problems exist, and we should find a way of acknowledging this because to not do so increases the distress of our members.

- The Faculty of Pain Medicine (FPM) Board had discussed the issue and agreed that they did not want to issue politically related statements, however, they had agreed to be more supportive and visible around the wellbeing of their Fellows and Members generally.
- Council agreed that it would be appropriate for further support and resources to be made available for the membership. There was a suggestion to review The Royal College of Psychiatrists (RCPsych) and The Royal College of Paediatrics and Child Health (RCPCH) resources and guidance.
- There is an Educational Faculty aligned with the College with experience in working in areas of conflict that might be able to offer advice, guidance, and support on what might be of practical benefit to members.
- It was also noted that the College should have a policy to guide their actions in this respect for the future.

Following the discussion Council noted that the majority opinion was that it was not appropriate to make a political statement but instead that it would be appropriate to offer support to the membership who are affected by this and other conflicts. Council agreed to take all the comments and views raised in this meeting for discussion to the next BoT on Wednesday 13 December, where legal advice would be available to support trustees in making their decision.

5. Faculty Updates

Faculty of Intensive Care Medicine (FICM) Dean Update

Dr Danny Bryden updated Council on the recent FICM Specialty Registrar (StR) survey which is the first survey led and generated by the StR subcommittee. They devised the questions with the intention of looking at what it is like to be a doctor training in intensive care medicine. Overall results relating to the training environment were positive, with some challenges mentioned around managing portfolios, rotations, obtaining training opportunities and the complexities in ICM training in reviewing future job plans. Of concern, however, were comments made by doctors in single CCT ICM programmes and from those who are dualling with emergency medicine and a medical specialty. Trainees reported the experience of being deprived of certain training opportunities, including, being missed out of training meetings, teaching opportunities, and airway training skills. They report feeling as if there is a different training experience for them as ICM trainees.

Several discriminatory comments towards those who have a non-anaesthetic training background were reported, and some of these have been described as bullying. These included biased behaviours around family planning, gender and career choices. StR representatives on the Board have written a report to be circulated shortly to ICM trainees and trainers with a letter, and RAAs will discuss the results of the survey further in 2024. The FICM Training, Assessment and Quality committee emphasised that they anticipate support from the relevant departments within the College to improve the training experience for this group of trainees.

Council noted these areas of concern and agreed to work collaboratively to investigate the circumstances around the differential training opportunities and working practices. Suggestions included an opportunity for a presentation at the 2024 College Tutor's meeting and at the RAA/CLAN meeting in March, to discuss the issues and address the expectations of high standards of collegiate behaviour.

Mr Russell Ampofo highlighted that the GMC Good Medical Practice 2024 guidance outlines support for colleagues who experience bullying and sexual harassment. The Equality, Diversity, and Inclusion (EDI) committee recently discussed what the College could do to support those who are experiencing these issues and work continues signposting trainees to the relevant resource available and in highlighting the requirements within good medical practice.

Faculty of Pain Medicine (FPM) Dean Update

Following the recent Board meeting held on 8 December 2023 Dr De Gray provided an update to note that:

- Work with the Anaesthesia Clinical Services Accreditation (ACSA) is progressing well, with chronic pain now part of ACSA accreditation.
- The Board will work with Getting It Right First Time (GIRFT) to invest in pain medicine, which would help raise the profile of pain medicine on the NHS agenda.
- The National Consultant Information Programme is a source available to all pain consultants, which allows review of procedures, patient demographics, complications etc. and acts as a revalidation, reflection tool and supports Continuing Professional Development (CPD).

- Work continues with NHS England (NHSE) to review the OPCS Classification of Interventions and Procedures codes.
- FPM have commenced work with the British Pain Society (BPS) on Pragmatic Personalised Care in issuing guidance that is evidence based, to help clinicians support patients that do not fit National NICE guidelines.

6. General Updates and Presentations
a & b) Anaesthesia Associates (AAs) Membership Survey Data
In mid-August and September 2023, the independent market research company, Research by Design (RbD), ran the RCoA membership survey. Overall, there were 6049 responses, 35% of the eligible membership (those working in the NHS in the UK). Mr Peter Kunzmann gave a report on the survey results and highlighted the following points (all results given here are from doctors who worked directly with AAS):

- Overall anaesthetists in Training (AiTs) tended to be negative about AAs, consultants had a more mixed view and SAS/LED doctors fell somewhere between.
- The top two concerns raised were: patient safety concerns and the impact of AAs on the training of AiTs.
- 71.5% of AiTs, who worked directly with AAs, said that the presence of AAs in the hospital hindered their training. 17.7% were neither positive nor negative, with 9% indicating it was a positive experience.
- 40.5% of trainers noted that AAs had a negative impact on the training of AiTs, 33.8% said they had neither positive nor negative impact, with 22.7% saying that they had a positive impact.
- In relation to patient safety the survey asked about respondents' confidence in AAs' ability to deliver safe patient care and successful anaesthetic outcomes. 63.4% of AiTs lacked confidence, with the view shared by 55.3% of SAS/LED doctors and 46.5% of consultants working directly with AAs.
- In response to the question on whether the presence of AAs within the hospital improved or diminished safe patient care, the results were mixed. 35.8% of AiTs who worked directly with AAs held a negative view, 34.4% held neither a positive nor negative view and 18.5% held a positive view. For SAS/LED doctors, 22.6% believed they had a negative impact, with 35.7% neither positive nor negative, 22.7% believed they had a positive impact. For consultants, however, 19.2% believed they had a negative impact, 32.8% believed neither positive nor negative impact and for plurality 42.7% believed they had a positive impact.
- For those who worked with AAs on a daily or weekly basis, 19.4% noted they had a negative impact, 21.6%, noted neither a positive nor negative impact and 54.9% noted a positive impact.
- The anomaly in the response to the questions regarding patient safety is not easy to explain.
- Overall, there was a negative response towards the expansion of AA numbers, with 89.4% of AiTs, 71.6% of SAS/ LED doctors and 60.5% of consultants who worked directly with AAs noting they were against expansion.

RbD have agreed to write and complete a report. The Policy Team will write up a synthesis report, to include a summary and data from a clinical leads survey conducted earlier in 2023. Both reports are expected to be published openly. Research continues in obtaining more information and data on patient safety, and work is taking place with NSHE Patient Safety Collaborative.

Council agreed it was important to recognise the legitimacy of the information.

Proposed College Response to EGM outcome, Anaesthesia Associates
Dr Claire Shannon summarised the position the Task and Finish group agreed following the Extraordinary General Meeting (EGM) and sought a final decision from Council on the proposed actions relating to motions one to three about AAs.

For Resolution 1, Council was advised to ask the Clinical Directors network to pause recruitment of AAs until the proposed RCoA Survey and Consultation is complete and the impact on doctors in training has been assessed and reviewed. Council discussed options two and three previously and had been largely in favour of:

- Option 2: Trustees define pause as meaning <u>to cease recruitment of new student AAs</u> but leaves existing qualified AAs in post; allows existing student AAs to continue with their training; and allows recruitment of existing qualified AAs from the pool of existing qualified AAs (if they are moving hospital) or the student AA population.

Council discussed what they thought a pause would look like in supporting option two and outlined the following points:

- This will be discussed at the next BoT with formal independent legal advice on legal liability for the College across the various options. This would consider exposure from an HEI perspective and the provision of patient services. Both CLAN and Health Education Institutions (HEIs) have given a clear understanding of the level of disruption they foresee should the resolution be enacted.
- Council should make their decision based on what they feel is best in the face of the current evidence and in a clinical context. It will then be for the BoT to consider the legal and charitable aspects.
- There is currently a slowdown in recruitment of new AA students, from a university and NHSE perspective, with around a 10% uptake compared to the previous year. The CLAN network noted that the pause in recruitment would have little or no impact at this stage. HEIs however noted that they could bear a pause for 12 months but thereafter would find it difficult to operate.
- The College will need to gather more evidence over the next few months
- The College has a duty to support patient care and to hear what the public and patients think
- In light of the current waiting times for surgery, actions to prevent the development of the anaesthetic workforce may be viewed negatively by patients and the public
- More robust data on safety would be extremely helpful
- Patients would want to be assured that the care they receive will be safe and effective
- The President noted that despite the actions being in opposition to government policy, both the Department of Health and NHSE are aware of the situation and the likely actions of the College
- The College also has a duty to support the expressed opinions of members and fellows particularly where those relate to patient safety.
- A natural point for the pause would be whilst regulation is brought in, probably until December 2024.
- During the period of the pause, work taken forward by the project group will include agreeing and defining the scope of practice for AAs and projects that will set professional guidance and standards around the role.

The President outlined that following any decisions made by Council, particularly on their preferred way forward, the matter would be discussed at the BoT. The Trustees will be mindful of their duties as defined by the charity commission and will consider this alongside the opinion of Council and legal advice in making a decision regarding enactment of the resolutions. Council agreed to take option two to the BoT for further discussion.

Following discussion **Council agreed to recommend to the Board of Trustees that they enact the second part of Resolution 1:**

- **The Council is advised to ask the College Tutors (CTs) and Regional Advisors (RAs) to ensure that doctors-in-training are given priority over AAs in their exposure to training opportunities. If CT/RAs find that is not the case then they should feed this information back to the training department, in order that the training capacity of that hospital be reviewed**.

The President noted that work is underway to refine the training capacity assessment which will be added to the guidance on AAs. To date this has not yet been published.

- For Resolution two: Council was advised to amend the Guidelines for Provision of Anaesthetic Services (GPAS) the Anaesthesia Clinical Services Accreditation (ACSA) and other relevant College documents to make it clear that local opt-outs from the College's position on the supervision of AAs are not approved by the College.

Dr Shannon noted that Council did not think that option 1 was tenable and that options 2 and 3 should be considered.

- Council considered option 2 - that Trustees implement the motion, taking the position of not supporting any extended roles for AAs until a scope of practice beyond qualification has been defined and regulation is implemented. This would be applicable to all AAs, including those who

are already undertaking these roles. It would prevent qualified AAs already working enhanced roles from continuing to do so and being trained in any further enhanced roles.

- And Option 3 that trustees implement the motion, stating that the College does not support enhanced roles for AAs until a scope of practice beyond qualification has been defined and regulation is implemented. However, to avoid impact on patient services and maintain a level of support for existing AAs, the College would make clear to departments that it does not expect AAs already undertaking enhanced roles to be removed from these services if it would impact patient services or render their roles futile, but that there should not be any further training or development of extended roles for AAs. This would allow qualified AAs currently working in extended roles to continue to do so under the supervision of autonomously practising anaesthetists, within the supervision levels specified by the department, in line with local governance procedures and prevent qualified AAs being trained in any further enhanced roles.

Council discussed the matter and made the following points:

- That they could not support non-medical anaesthetists being entirely unsupervised, or where circumstances prevent adequate supervision.
- Rules would need to ensure supervision is guaranteed.
- There is a risk that option two would undermine patient care because clinical services could be put at risk and this could be seen to be counter to our charitable objects.
- For option three there would need to be explicit rules around what supervision would look like in terms of level and proximity.
- The supervision levels for trainees could be used for AAs as outlined in the curriculum template, which allows definition of what they can do safely with immediate, local or distant supervision.
- Supervision should be 2:1 at most when providing general anaesthesia or sedation with a supervisor rapidly available to provide assistance
- To be mindful that in supporting option three that this may not be what our members expecting, therefore there would need to be clear communications, emphasising the impact on patient care and delivery and safeguards around supervision.
- Indemnity should be made clearer, however, regulation will eventually ensure clarity.
- The President clarified that the current College position is that enhanced roles are not supported and therefore must be governed by local governance. Hospitals should have local governance and safeguards in place, which their Board should be aware and supportive of.

Following the discussion **Council agreed to recommend to the BoT that, where enhanced roles exist and provide essential patient care, they can continue. However, supervision should be 2:1 as a maximum and a supervisor should be readily available when general anaesthesia or sedation is being undertaken. No further enhanced roles should be developed until regulation is in place and the scope of practice beyond qualification has been developed.**

Proposed College Response to EGM outcome, Changes to the Guideline for the Provision of Anaesthesia Services (GPAS).

Ms Sharon Drake outlined a report in response to the EGM motion and resolution two, following Council's request to make changes to GPAS to be considered to reflect the motion. The GPAS recommendations that are affected relate to the Good Department chapter and the Guidelines for the Provision of Anaesthesia Services for the Perioperative Care of Elective and Urgent Care Patients chapter. The current proposal is to change the sentence 1.2.44 to:

- AAs should be supervised in accordance with the RCoA and Association of Anaesthetists scope of practice. The Association of Anaesthetists and RCoA currently do not support enhanced roles for AAs until statutory regulation for AAs is in place and the scope of practice is defined.
  And to omit the line: '*where such role enhancement exists or is proposed responsibility should be defined by local governance arrangements*'.

It is noted that the rest of the recommendations in the section of the chapter concerning AAs, which includes 2:1 supervision arrangements, would remain unchanged.

Council discussed setting the standard for the future, to note that:

- Whilst encouraged, GPAS is not mandatory and only acts as guidance.
- Going forward there is risk of impact on the ACSA programme should recommendations be changed as originally proposed.
- To ensure that in removing the sentence about local governance arrangements, which originally ensured a level of patient safety, there is a requirement to think about how we notify departments about what should be done to replace it.
- The College sets standards of practice rather than governance and with the levels of supervision we propose to define, hospitals will be able to assure their governance.

Council agreed to recommend to the BoT that for GPAS and ACSA they approved the removal of the phrase on local governance arrangements.

Dr Varveris asked if Council could be mindful of the concerns raised in Scotland of workforce planning, in reviewing safety issues, particularly in relation to appointment of AAs as opposed to AiTs.

Proposed College Response to EGM outcome, Rotational Training
Council had already agreed to recommend to BoT that resolution 4 on rotational training be enacted. Dr Sarah Thornton presented a paper outlining the work currently underway:

- Recent positive meetings with Regional Advisers (RAAs), the Anaesthetists in Training Representative Group, (ATRG) and the Clinical Leaders in Anaesthesia Network (CLAN), to discuss how they could impact rotational training.
- Regional Advisers recently provided examples of good practice, in which rotations are given two to three years in advance.
- The ATRG noted having an overarching mentor throughout training in addition to an Educational Supervisor in each Trust and throughout training.
- Over 50% of trainees indicated they have a lead employer in place.
- London has been in active discussion for over seven years about having a lead employer.
- Ms Moran has produced a draft for the GMC to outline flexibility between stage two and three training, which indicates trainees can stay in the same hospital longer, even if they have not passed the final examination.
- Dr Jonathan Chambers was working on a document providing guidance to College Tutors and Training Programme Directors (TPDs) on how to minimize rotation.

Proposed College Response to EGM outcome, Recruitment
For Resolution five Council was

- Advised to make the necessary requirements in order to acquaint itself with the reasons for the delay in publishing the SIR report and in discussing its findings.
- To consider whether there was evidence, on the basis of the report, whether HR records were not kept clearly and accurately.
- To consider whether they have confidence in the leadership of and senior management of Anaesthetic National Recruitment Office (ANRO).

For resolution six:

- Council was advised to set up a group, with other stakeholders, to investigate whether a centralised national recruitment centre is within the best interests of the specialty.

Dr Helgi Johannsson updated on the actions already taken to include:

- Invitations being sent to a few members to join the Task and Finish group, to include a wider range of people, so that there are appropriate resources and skill mix involved to support the work going forward.
- The validity of Multi-Specialty Recruitment Assessment (MSRA) data was discussed at the meeting in October 2023 and the College are making an application to Medical and Dental Recruitment and Selection (MDRS) for updated anaesthetics MSRA data.
- The College invited MDRS to present at the December Council meeting on National Recruitment, however they declined, and therefore the College is currently arranging a meeting with MDRS in January 2024. Outcomes will be determined following discussion with MDRS.

The reasons for the delay in publishing the SIR report would be discussed with MDRS at future meetings. It was noted that many of the action points have been completed with recruitment of extra staff the most important outstanding action.

Mr Ampofo said that he would be meeting with the proposer of the motion to clarify what was meant by the second part and that assurances were being sought from MDRS.

Council discussed whether it still had confidence in the leadership and senior management of ANRO and agreed that they did not currently have confidence in the way ANRO is delivering the service but that ultimately in view of the significant risks involved in seeking alternative recruitment solutions, would continue to work with them to urgently improve things.

The President thanked Council and the Executive team for all the work they had done and said all these proposals would be taken to Board of Trustees the next day. A statement would be issued to members following the Board meeting but a lot of what we hope to do would be subject to legal advice.

c) Workforce Wellbeing Update
postponed to next meeting.

d) Training in Anaesthesia for Thoracic Surgery for Kent Surrey and Sussex (KSS)
Dr Chris Carey presented a report outlining the lack of thoracic surgery units within the boundaries of the KSS region; patient services are therefore accessed in South London at the Royal Brompton, St George's and St Thomas' hospitals. Trainees in Kent and Surrey rotate through the latter two units during stage two training rotations. Historically trainees in Sussex completed their cardiac anaesthesia training in Brighton and had access to upper gastrointestinal (GI) lists to provide an opportunity to demonstrate thoracic anaesthesia competencies, although it has long been recognised that this was a compromise position.

In 2022 the Care Quality Commission (CQC) suspended all major upper GI surgery in Brighton and the service was then moved to Guildford. Consequently, the anaesthetic trainees in Brighton were unable to complete the following learning outcome from the 2021 curriculum:

- *Demonstrates safe anaesthetic care for adults requiring non-complex thoracic procedures under direct supervision, including one lung ventilation*.

The lack of availability of suitable lists to demonstrate this learning outcome precludes stage two signoff at ST5 and could in theory therefore lead to a requirement for additional training time.

Dr Carey asked Council to discuss whether they should allow the opportunity for stage two trainees to demonstrate capabilities in techniques for anaesthesia for thoracic surgery in a simulated environment, or whether they must be capable of demonstrating it in a live patient situation.

Council agreed that the skills involved in this key capability remained important for consultants involved in acute on call and that changing parts of the curriculum for one set of trainees and assessing conduct in a simulated environment could run the risk of undermining training and could set a precedent with far reaching consequences. They were therefore not in favour of changing the curriculum requirements.

Dr Carey noted the views of Council to seek further solutions, particularly in reviewing flexibility in stages two and three and would bring this back for further discussion.

e) Examinations update
Dr Roger Sharpe provided a short update to note that:

- The January 2024 primary examination is currently oversubscribed by 65 candidates; therefore, the team will be implementing the priority system. Those most likely to be affected will be overseas candidates and some clinical fellows, who may well get places when cancellations are known.

f) Incident Affecting the TestReach Exams Management System
Dr Carey provided a paper on an incident in TestReach, which affected the storage of images that accompany exam questions in the Multiple Choice Question (MCQ) examinations.

No live examinations were affected but the event prompted questions from the leadership of the exams.

Dr Carey highlighted that further discussion would take place at ETE Board and will be brought back to a future Council for discussion.

g) Report from the Working Party on Sexual Misconduct in Theatres

item postponed to next meeting.

h) Anaesthetists in Training (AiT) update

Dr Kossakowska provided an update:

- The group attended the recent Regional Advisers meeting, to represent the training perspective on various matters, including Anaesthesia Associates (AAs) and the need to champion and utilise the training capacity document.
- The Anaesthetists in Training Representative Group (ATRG) meeting was held at the College on 21 November attended by 30 trainee representatives from schools of anaesthesia across the UK. There was encouraging representation from stage one trainees. The first part of the day informed trainees of the EGM update, examination changes, recruitment, and changes to the curriculum. In the second part of the day, representatives shared examples of excellence and areas of improvement within their regions. Current themes include, rotational training, lead employer models, supervision levels, bugs with the LLP, specific curriculum issues and regional training.
- AiTs attended the following meetings; the Life Long Learning Platform (LLP) group, the Examinations Committee Curriculum Development Group, the Academy Trainee Doctors Group and the Training Curriculum and Assessment Committee (TCA).
- The TCA Committee hopes to conduct an anaesthesia cohort study, for those starting CT1 as a core trainee or CT2 as an ACCS trainee, to both follow and monitor progression, and to review the timing and impact of various stresses that they encounter.
- AiTs recently worked on an article for the January College bulletin.
- The next face to face AiT meeting will take place in February 2024.

i) SAS Update

Dr Ashwini Keshkamat provided an update to note that:

- On 15 November she attended the General Medical Council (GMC) Round Table meeting on SAS and locally employed doctors. Two important publications were discussed, the Barometer survey 2022, which was published in October 2023 and for the first time provided separate analysis of SAS and LED doctors, and the Medical Education and Practice Workforce report which was published in November 2023. This report highlighted that the numbers of SAS and locally employed doctors on the medical register have increased substantially.
- The report also highlighted that these professionals have been treated as a single homogenous group and discussion will continue to ensure that both groups have more recognition for what they have to offer, to ensure that they feel valued and are supported to progress in their careers.
- On 1 December Dr Keshkamat attended the Academy SAS meeting. The Committee has produced a document on strengthening the SAS workforce. SAS doctors currently make up 30% of the workforce and the document recommends how they can become a stronger and better supported workforce to tackle the current workforce crisis. The Academy will contact the College to outline what they will do to support SAS and LEDS going forward.
- The Training Committee is producing guidance on support and career progression.

j) Nominations Committee

Dr Sarah Thornton provided an update:

- The Macintosh Professorship is awarded on the recommendation of the National Institute for Academic Anaesthesia (NIAA). Council ratified the Nominations Committee decision to support the nominations of Dr Ronelle Mouton and Dr Ari Ercole.

7. Boards and Reports

a) Clinical Quality and Research Board (CQR)

Dr Elisa Bertoja outlined current achievements which included:

- NAP7 being launched on Friday 17 November, this resulted in a lot of activity on social media and over 15 media articles. 30K also viewed the NAP7 baseline survey results on X.

b) Membership Media and Development Board (MMD)

Dr Ramai Santhirapala outlined current high-level achievements and information:

- The next Board meeting is due to take place on 13 December.

- The NAP7 report, was recently launched and was mentioned in the British Medical Journal (BMJ), the Sun newspaper and on LBC.
- The Bulletin communications were limited in October 2023 due to the EGM, so Dr Santhirapala requested that Council to promote the January Bulletin via key networks.
- The Winter Symposium currently has 513 delegates registered, compared to 480 this time last year.
- Other recent key events included the Joint Scottish Society of Anaesthetists/RCoA meeting, the Anaesthesia Research meeting and various online Update meetings. Council was asked should they wish to run any events, to contact the Events Teams well in advance to ensure planning.

e) Scottish Board

Dr Varveris outlined the current workforce and training development issues in Scotland and mentioned two key points:

- Nominations for the Scottish Board are now live for several elected consultant members and one trainee member.
- A meeting with the Scottish Chief Medical Officer, Professor Gregor Smith, is planned post Board meeting in February 2024. Discussions will focus on workforce issues and critical incident reporting.

f) Welsh Board

Dr Simon Ford circulated minutes of the Welsh Board from 17th October and highlighted the following points:

- Dr Ford welcomed Ms Amy Wallwork as the Board's new Policy and Public Affairs lead.
- Work continues to highlight to the Health Boards the fragility of the outsourcing governance process and to ask for clarification for the future.
- The Board will ask for clarification from a Health Board on reconfiguration plans that concern intensive care medicine (ICM) and anaesthetic services.
- The single lead employer model, although established is still having significant challenges which are disproportionately affecting less than full time trainees.
- There has been a loss of the current national transfer training programme following restructuring. To date there are significant challenges in getting this re-established to support training across several training programmes.
- The results of the ballot of Welsh junior doctors will be available soon and strikes may take place prior to Christmas.
- Nominations are open for 2 places on the Welsh board.
- At the recent meeting with the CMO, Sir Frank Atherton, discussions focussed on exploring morale of the workforce and implementation of continuous flow models to support patient progression, the need for supraregional working patterns to address waiting list backlog and the lack of visibility of the new NHS Wales Executive.

g) NI Board

No report in the absence of Dr Donaldson

8) Co-opted member reports

a) Centre for Perioperative Care (CPOC) Board

Dr Dave Selwyn provided a summary of the current work in CPOC to note that:

- RCS England hosted the CPOC round table event on Wednesday 4 October 2023
- The meeting included key stakeholders such as the Getting it Right First Time (GiRFT) team and NHSE.
- Discussions focused on future strategic alignment, leadership and prioritisation.

b) GIRFT and POM update

no report

c) BJA &RCoA Liaison Group Report

Dr Lambert referred Council to the paper that was submitted.
There were no questions.

d) PatientsVoices@RCoA Update to Council

Ms Jenny Westaway reported that:

- PatientsVoices@RCoA will be recruiting a Vice Chair in January 2024.
- Dr Felicity Plaat will lead discussions on how AAs should introduce themselves in the clinical setting.

e) Clinical leaders in Anaestheisa report

no report as Dr Lakhani was unable to attend due to clinical commitments

f) Association of Anaesthetists report

no report as Dr Davies had to leave the meeting before this item

h) Lead Regional Advisor for the RCoA

Dr Simon Maguire provided a verbal update to note that:

- He would be meeting with Sandeep Lakhani shortly to discuss the forthcoming CLAN and RAA meeting.

i) Defence Report

No report

8. Matters for information

a) New Associate Fellows, Members and Associate Members

Council noted that the information for November has been circulated electronically.

b) CCTs CESR(CP)s for Council

Council noted that recommendations made to the GMC for approval, that CCTs/CESR (CP)s be awarded to those who have satisfactorily completed the full period of higher specialist training in Anaesthesia, or Anaesthesia with Intensive Care Medicine or Pre-Hospital Emergency Medicine where highlighted.

c) Current College Consultations

Council reviewed the list of current consultations.

d & e) Regional Advisers Anaesthesia (RAA)

Council noted and approved the following changes:

- Dr David Lee to succeed Dr Richard Laird as RAA for Northern Ireland.
- Dr Theresa McGraffen to succeed Dr Paul Harrison as Deputy RAA for Western Scotland.

END OF MEETING

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