CENTRAL MEDICAL ADVISORY COMMITTEE

Minutes of the meeting of the Central Medical Advisory Committee held on Thursday 16 June 1994 at 2.00pm in Room 414, Dundonald House.

Members present:

Dr S M Lyons (Chairman)
Dr E P Beckett
Dr C A Hamilton
Dr J Jenkins
Dr H A Jefferson
Mr J A Halliday
Dr A M Telford
Dr J Wilde

Present by Invitation

Dr P Cosgrove	-	Chairman WAMAC
Dr R M Galloway	-	Chairman SAMAC
Dr W W M McConnell	-	Director of Public Health, WH&SSB
Dr D O'Reilly	-	Consultant in Public Health Medicine EH&SSB
Dr B Smyth	-	Consultant in Public Health Medicine, NH&SSB

In Attendance:

Dr C Hall (Acting CMO)
Dr P McClements
Dr M Boyle
Mr A Gault
[redacted]

1. **APOLOGIES**

[redacted]

2. **CHAIRMAN'S BUSINESS**

2.1 MINUTES OF CENTRAL ADVISORY COMMITTEES

[redacted]

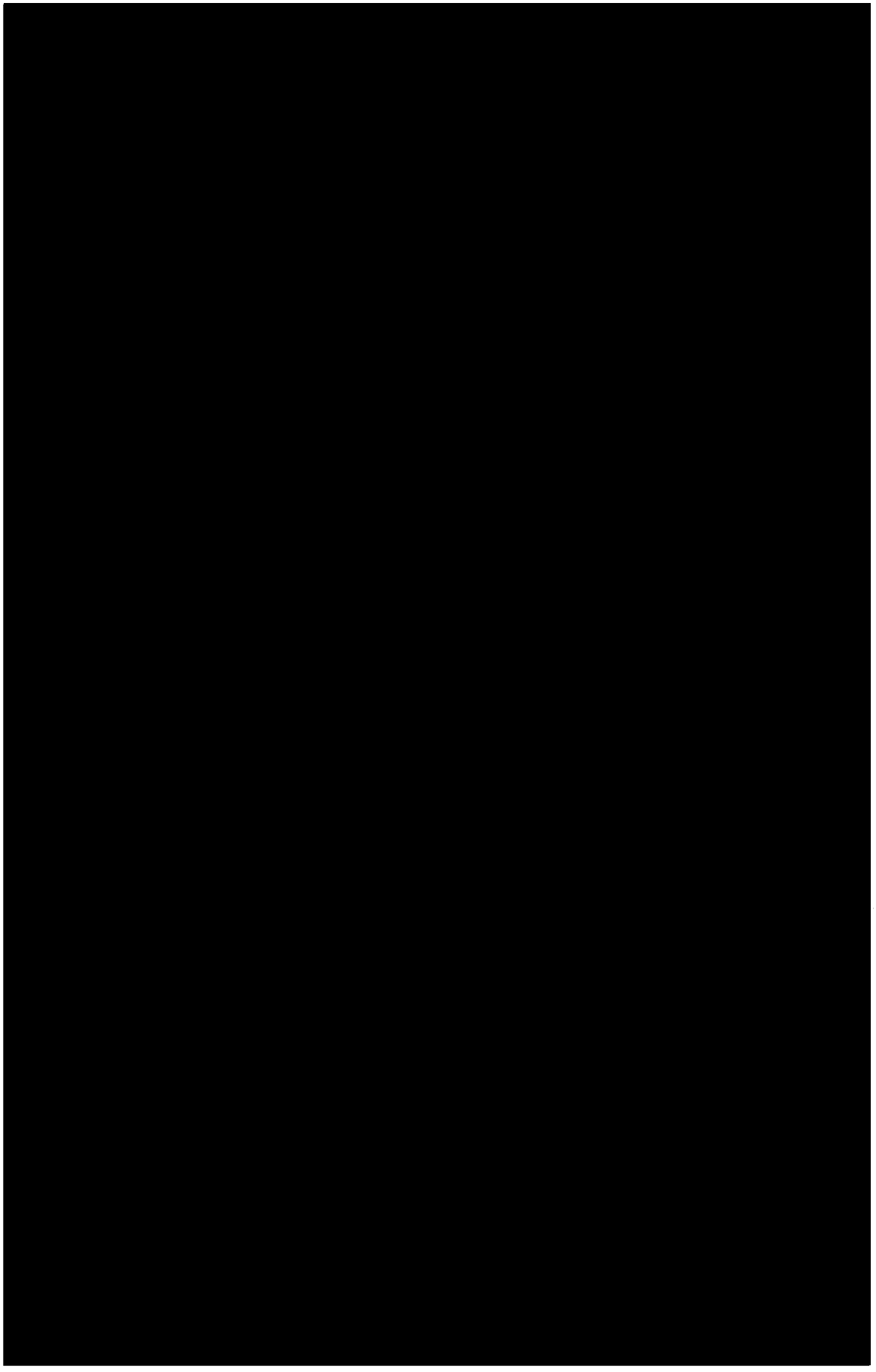
[redacted]

3. **MINUTES OF THE LAST MEETING**

[redacted]

4. **THE ANNUAL REPORT OF THE CHIEF MEDICAL OFFICER 1992/93 ON THE HEALTH OF THE PUBLIC IN NORTHERN IRELAND**

[redacted]



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5. ANNUAL REPORTS OF THE DIRECTORS OF PUBLIC HEALTH

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i. EASTERN HEALTH AND SOCIAL SERVICES BOARD

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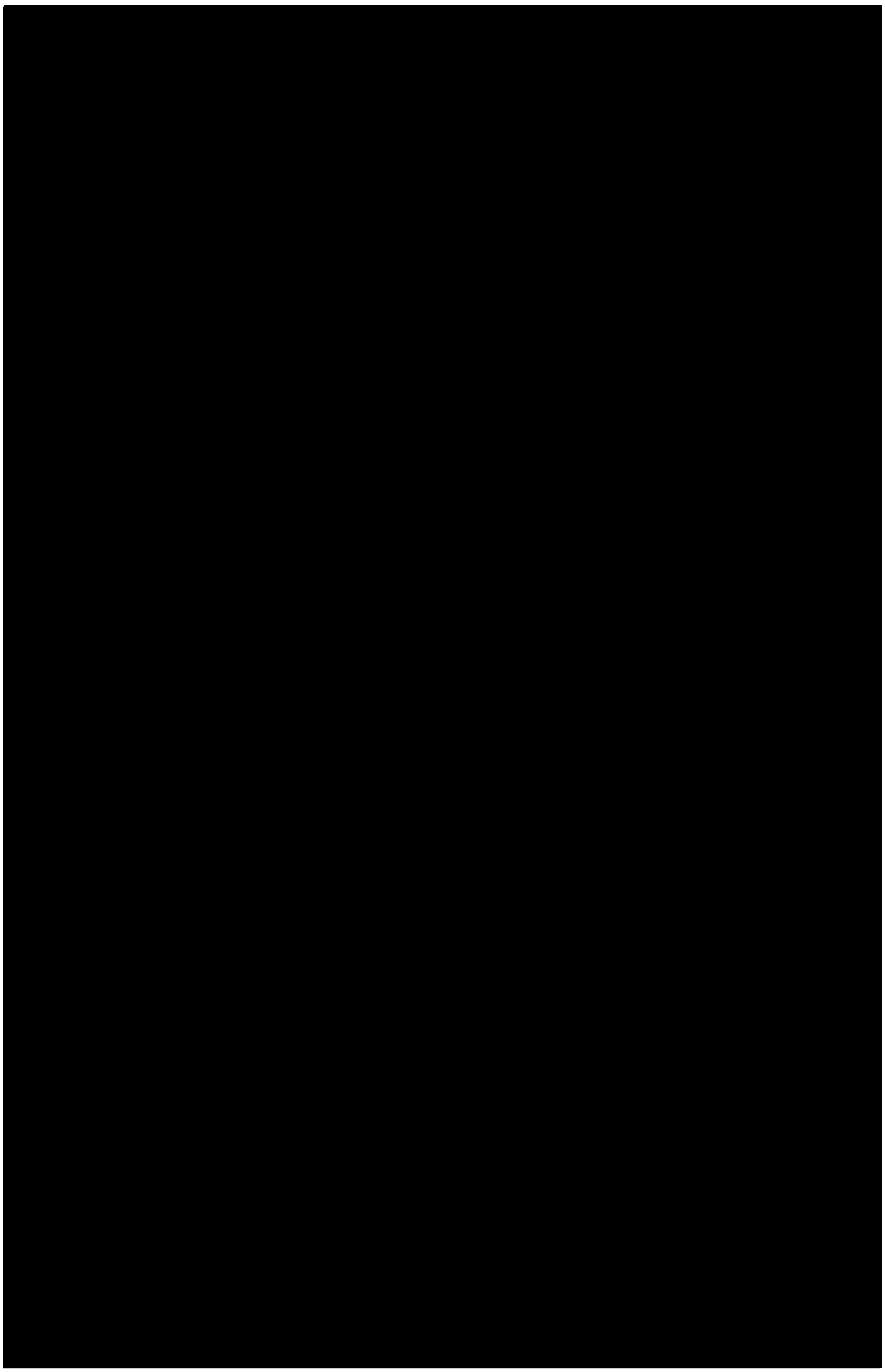
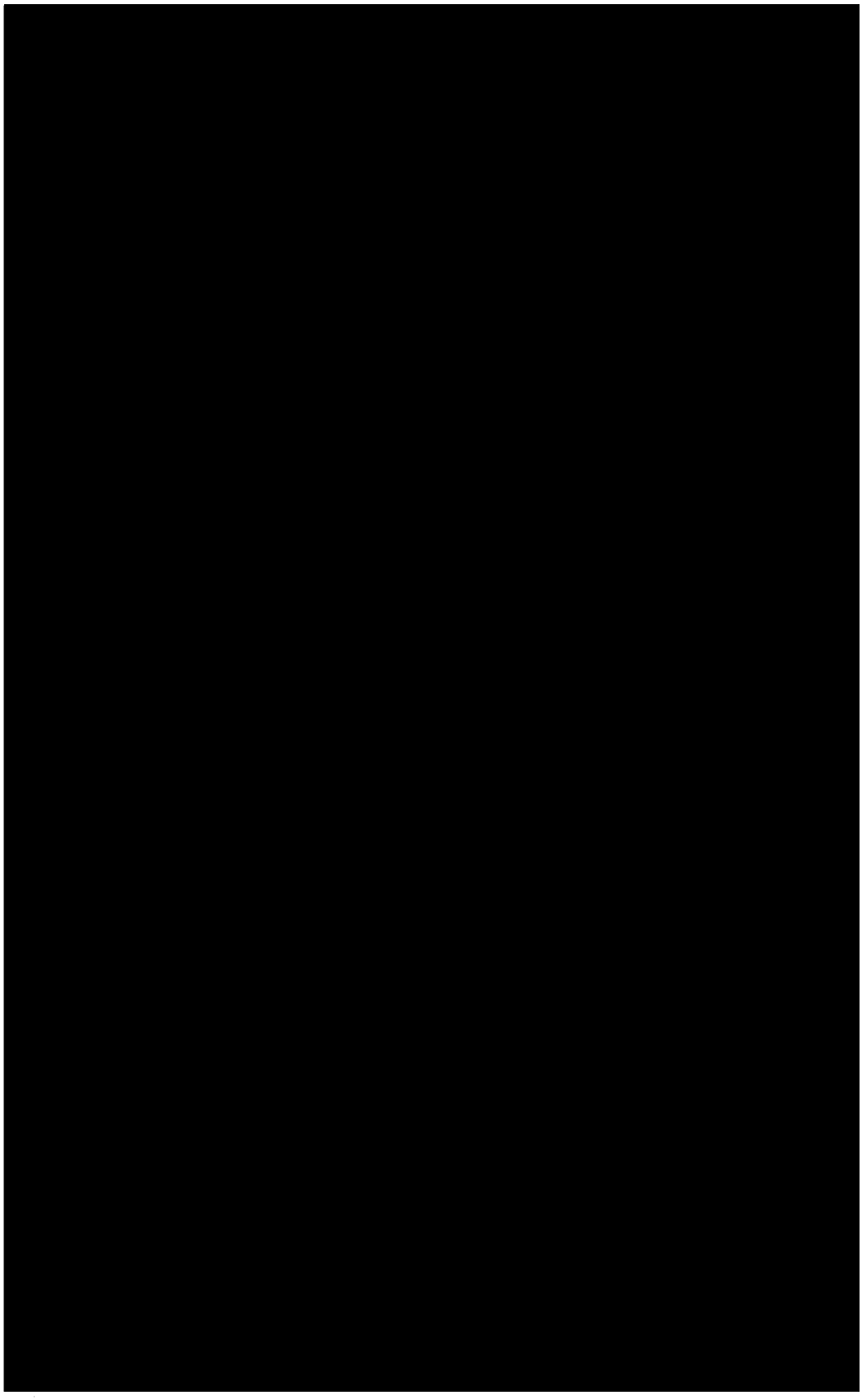


ii. **NORTHERN HEALTH AND SOCIAL SERVICES BOARD**



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iii. **SOUTHERN HEALTH AND SOCIAL SERVICES BOARD**

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iv. **WESTERN HEALTH AND SOCIAL SERVICES BOARD**

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Medical Audit - There is a need for the improved development of Medical Audit in some specialties and Units as a continued contribution to the emphasis on quality of health care. Clinical multidisciplinary audit must be developed to examine how team based care to patients can be improved.

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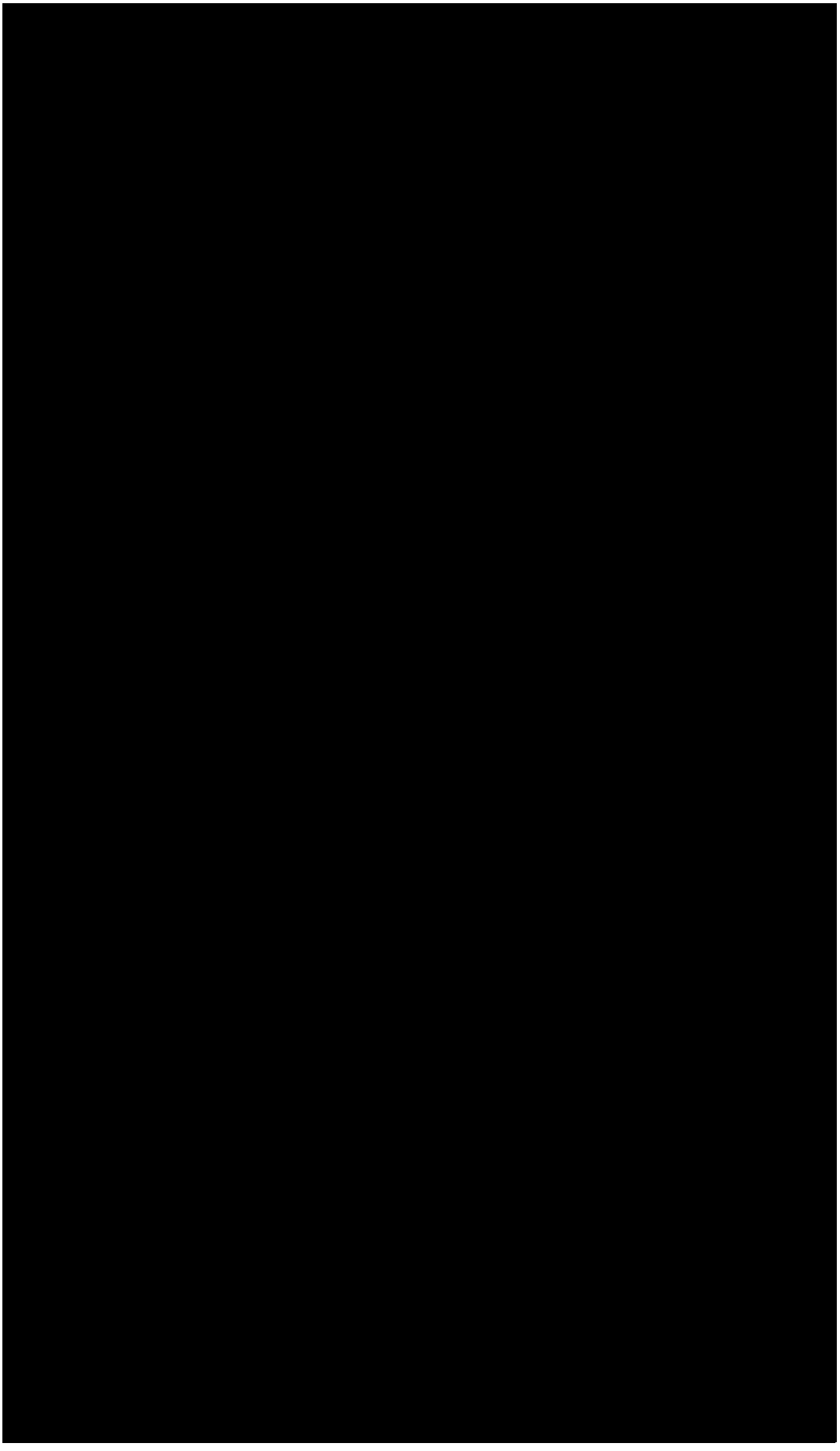

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5. THE HEALTH PROMOTION AGENCY ANNUAL REPORT 1993-94

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6. NHS COMPLAINTS PROCEDURES

The Chairman introduced Mr A Gault from the HPSS Management Executive and invited him to speak to this item.

Members had received a copy of the report of a review committee on NHS complaints procedures and a paper which summarises the recommendations of the report. Mr Gault explained that the report was commissioned by the Health Secretary, Virginia Bottomley, and the review had encompassed the health services in Northern Ireland. The report was published on 11 May and had been issued to HPSS management, Health and Social Services Councils and professional organisations for comment. Comments from the public were invited through a public press notice. The consultation period will be 3 months to 12 August.

Mr Gault outlined some of the key issues and recommendations in the report which are summarised at paragraph 4 of the paper. He explained that the changes recommended to existing NHS complaints procedures are aimed at making procedures more effective and improving service quality.

Mr Gault asked members to comment on the recommendations and on how the report might best be implemented in Northern Ireland. Discussion focused on 3 particular aspects of the report as follows:-

1. Should there be time limits for making complaints; if so what should these be.

In general the Committee expressed agreement that there should be time limits within which complaints should be made.

Dr McConnell felt there was a case for having time limits because of difficulties in respect of recall and investigation when the complaint was made months/years after the event complained of. However, he suggested there should be allowance for occasional exceptions to time limits.

Mr Halliday indicated that he supported the need for time limits for making complaints for most cases but with exceptions for some cases. He was concerned that it would be difficult to apply time limits to some cases for example, complaints in respect of Paediatric care or long term care. He suggested that the time limit for making a complaint in respect of a period of long term care should be after the period of care ended. He said that in some instances there are exceptional circumstances for example, some people only become aware there is a problem and possible grounds for complaint a long time after the event occurred.

Mr Halliday emphasised it was essential that the exceptions are ruled on at an early stage and are not subject to appeal. He noted it is distressing for practitioners and staff who have a complaint made against them to be faced with a lengthy appeal mechanism.

Dr Jefferson noted that the report examined the Family Health Services complaints procedures in Great Britain. He noted the document seems to be aimed at areas in England where a larger number of complaints are received about general practitioner services compared to the number of complaints handled in Northern Ireland.

Dr Jefferson said the report recommended that the Health Services Ombudsman's jurisdiction be extended to general practitioners and to the operation by the family health services authorities of the current service committee procedures. It also suggested that the Government should examine whether practical difficulties might be overcome which prevent the Ombudsman considering complaints about clinical judgement. Dr Jefferson said that in Northern Ireland the existing complaints procedures for general practitioner services work well and he considered there was no need to extend the Health Services Ombudsman jurisdiction to complaints about clinical judgement.

2. Should complaints in respect of community care and child care be incorporated within the proposed new procedures.

Dr Jenkins supported a common system for handling complaints. It was recognised that Northern Ireland has an integrated Health and Personal Social Services structure which is different from the GB structures. Dr Jenkins considered that complaints about child care and community care

should not be dealt with under a different system and took the view that they should be incorporated within the proposed new procedures.

Dr Telford and Dr McConnell indicated that they supported the view that community care and child care be incorporated within the new procedures.

3. Who should have ownership of the Stage 2 procedures.

Mr Halliday felt that the questions in respect of ownership of the Stage 2 procedure and whether community care and child care should be incorporated within the new procedures should be considered together. He agreed there is an argument for having community care and child care within the new procedures. With regard to the ownership of Stage 2 procedures it was recognised there was a need for impartiality. The review committee had considered a number of options and one option (c) identified for Northern Ireland was that the Central Services Agency should have ownership of Stage 2 procedures. Mr Halliday supporting this option said the CSA is close to and has expertise in liaising with the medical profession. The organisation of the Stage 2 procedures by the CSA would make it easier to incorporate community care and child care into the new systems.

Dr Telford also supported the option (c) and considered it would allow the involvement of more than one provider and Board purchaser.

Dr Galloway noted that an option recommended by the review committee was that NHS Management Executive Regional Offices in England/the Management Executive of the NHS in Scotland/the Welsh Office should organise Stage 2 Procedures and he asked why this type of option had not been put forward for Northern Ireland.

Mr Gault explained that members of the review committee had looked at systems in Northern Ireland and had identified the Central Services Agency as the best option. The CSA had experience in dealing with the formal Committee procedures and offers independence from service providers.

Dr Galloway pointed out that the handling of complaints can be crucial as to whether a complaint develops into a case of litigation.
The Chairman said it is recognised that the majority of cases of litigation are taken by people who qualify for legal aid and often other complainants make complaints to get information or to test if there is a case for litigation.

The Chairman indicated that there would not be a formal response from the Committee on the recommendations in the report. It was agreed the comments made by the Committee would be recorded in the minutes.

7. CHARTER FOR PATIENTS AND CLIENTS

Members had received a paper which provides an update on the implementation of the Charter since its publication in March 1992, information on developments planned for 1994/95 and seeks comments on other areas where Charter standards might be introduced.

Mr Gault outlined key points in the paper and drew attention to the following:-

- Key objectives which had been met since the publication of the Charter.

- Hospital Waiting Lists - The number of people waiting more than 2 years fell from 5,392 in March 1990 to 691 in February 1994. The Charter guarantee has been improved still further and from April 1994 no patient should have to wait more than 18 months for all forms of inpatient treatment including cardiac surgery.

- Cancellation of Operations - The current Charter standard on the cancellation of operations has been revised from 1 April 1994. Patients should be admitted to hospital within one month of the first cancelled operation.

- Performance Tables - one of the commitments given by the Government in the Charter was that the public would be informed about how well their public services were performing. It is intended to publish performance tables in June 1994 on the performance of providers in certain key areas. The 6 indicators selected for 1993/94 tables are:

    - waiting times for inpatient treatment;

    - 30 minutes waiting times in outpatient clinics;

    - immediate assessment in accident and emergency departments;

    - emergency ambulance response times;

    - priority treatment for patients whose operations are cancelled;

    - day care surgery for certain procedures.

    - Charter Standards for Community Care - The Regional Charter Steering Group has set up 3 Working Groups - Social Services, Nursing and Professions Allied to Medicine which have been asked to make proposals for setting standards. The Working Groups will report by 30 June and following consultation with purchasers it is hoped to have the new standards in place by April 1995.

    - The Charter Mark Scheme - Its objective is to recognise and reward excellence in the delivery of public services.

- Cash Grant Scheme - The HPSS Management provides cash grants to individuals, or groups in the HPSS, Health and Social Services Councils and Voluntary Organisations to carry out practical projects which will result in better patient/client care. Forty six applications were received for the 1994/95 scheme and grants totalling some £32,000 were awarded to 9 applicants. Employing authorities meet 50% of the total cost of the project.

Mr Gault said it had been suggested that Northern Ireland should develop its own Charter standards rather than await developments nationally. He sought members views and asked the Committee to suggest service areas which are worth exploring.

In discussion members made the following comments:-

- Discussion focused on the publication of tables about performance of providers in certain key areas. Members acknowledged there were difficulties in meeting some of the indicators for example, that outpatients should not be kept waiting for more than 30 minutes.

- Mr Halliday noted that one way of meeting this Charter standard was to reduce the number of patients booked to be seen at outpatients clinics but this would result in patients having to wait longer for outpatient appointments.

- Dr McConnell said the public had not been consulted about the Charter standards set and perhaps they would prefer to wait more than 30 minutes to be seen at an outpatient clinic but to have a shorter waiting time for outpatient appointments. He suggested the public should be consulted about their priorities for improving services.

- The Chairman noted the reduction in the numbers of people awaiting cardiac surgery for more than 2 years and that the majority of those waiting had received an offer of cardiac surgery. He said 40% of the patients operated on in the Eastern Board had not been on the waiting list for cardiac surgery but admitted to hospital because of a requirement for urgent surgery. The Chairperson considered advice was required about how to deal with this issue. The Chairman also referred to other matters surrounding the topic of cardiac surgery in Northern Ireland for example, political pressures, headlines in newspapers and the expectations of the public.

- Dr McConnell drew attention to the recommendation in the annual report of the Director of Public Health of the Western Board that research should be undertaken as to whether treatments such as angioplasty or atherectomy are as suitable for treatment of some types of heart disease currently treated by Coronary Artery Bypass

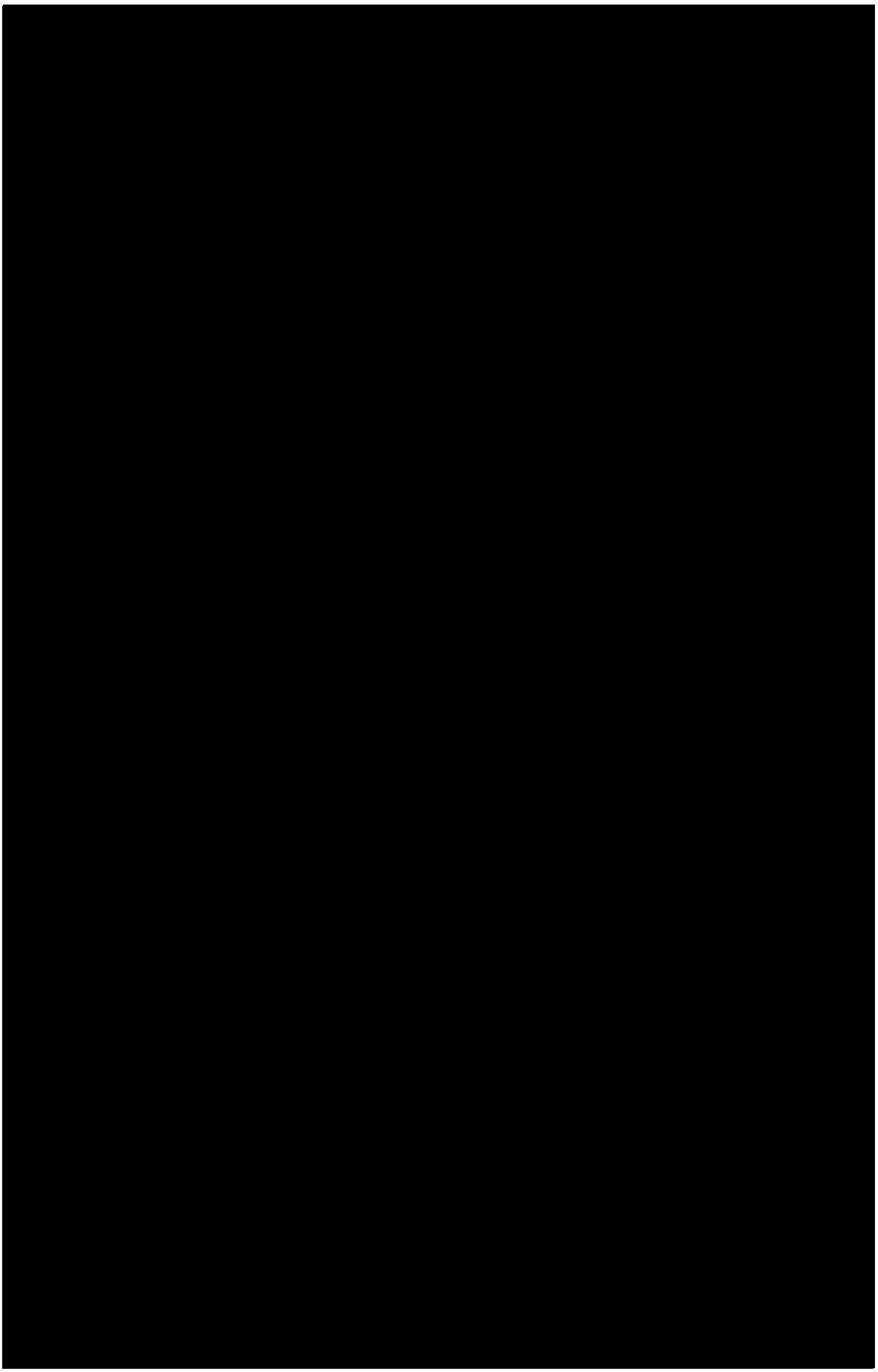
Graft. In discussion it was recognised that some alternative intervention for coronary artery disease might only push the disease process back and buy time.

- Mr Halliday drew attention to a project being carried out in the Armagh area in relation to Orthopaedic waiting lists. He explained that all GPs had agreed to hold waiting lists for orthopaedic services and to nominate patients to be seen at orthopaedic clinics. Guidelines had been agreed with GPs.

- Dr Beckett said he was involved in the Armagh scheme and drew attention to 2 important elements, bilateral meetings and the drawing up of protocols. There was concern that Boards should not jump into this type of scheme too quickly but introduce it on a localised level. It was considered this type of scheme could be extended into other specialties.

- With regard to developing our own Charter standards in Northern Ireland the Chairman suggested that a wider trawl should be issued to consultants and the medical profession in Northern Ireland about this matter. The Chairman thanked Mr Gault for his attendance at the meeting.

8. **A POLICY FRAMEWORK FOR COMMISSIONING CANCER SERVICES - A CONSULTATIVE DOCUMENT**



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9. **ANY OTHER BUSINESS**

[redacted]

10. **DATE OF NEXT MEETING**

[redacted]

11. **PAPERS FOR INFORMATION**

[redacted]