HOSPITAL SERVICES SUB-COMMITTEE OF THE CENTRAL MEDICAL ADVISORY COMMITTEE

Minutes of the meeting held on Wednesday 18 May 1994 at 2.15 pm in Room 229, Dundonald House

Present:
Dr D A J Keegan (Chairman)
Dr I M Bali
Dr M E Callender
Dr E P Corkey
Prof J P Dodge
Dr R M Galloway
Dr J E Galway
Mr J A Halliday
Dr J Jenkins
Dr L Johnston
Mr W G G Loughridge
Dr M Madden
Dr J R McCluggage
Dr W B McConnell
Dr W W M McConnell
Dr J McMahon
Mr T O Mulligan
Dr S D Nelson
Dr J M W Park
Dr S Refsum
Dr J Watson
Dr F Watters

In Attendance:
Dr J F McKenna (CMO)
Dr J D Acton
Dr A Gault
[redacted]

1. **APOLOGIES**

[redacted]

2. **CHAIRMAN'S BUSINESS**

[redacted]

[redacted]

3. MINUTES OF THE MEETINGS ON 26 JANUARY AND 9 MARCH

[redacted]

4. MATTER ARISING FROM THE MINUTES

4.1 **Report of a Sub-Group on Child Health Services in Northern Ireland**

[redacted]

4.2 **Introduction of Compulsory Induction Courses and Changing the Starting Date for Hospital and Dental staff**

Dr McConnell said that the Western Board's Area Medical Advisory Committee had expressed reservations about the proposals for changing the starting date for PRHOs and SHOs. One of the AMAC's concerns related to potential accommodation difficulties especially in smaller hospitals. He noted that at its last meeting HSSC had supported the introduction of compulsory induction courses but had signalled reservations about changing the starting date. Some other members raised the question of whether junior doctors could be required to work past the last date of their current contract. Dr Acton stated that the co-operation of junior doctors would be essential but they would not be compelled to do so.

Dr Acton explained that much of the HSSC's views had been taken into account and the Management Executive had decided to introduce the revised starting date in line with the rest of the United Kingdom so that junior doctors would not encounter difficulty in taking up appointments outside the Province. He assured members that these arrangements would be monitored.

4.3 **Review of the Purchasing Function and Structures in Northern Ireland**

Members had received an update on this item. A copy of a letter from the Chairman of CMAC and the Chairman of HSSC to Mr J Hunter, Chief Executive of the Management Executive which sets out the main points emanating from the Committees' discussions on this topic was tabled.

5. **JUNIOR DOCTORS HOURS**

Members had received a report on progress towards the December 1994 targets for contracted hours of work for junior doctors. Dr Acton tabled a paper which gave a summary of the contracted hours worked by junior doctors at 31 March 1994.

Dr Acton advised that in 1991 52% of junior doctors and dentists in Northern Ireland were contracted for more than 83 hours per week. The March 1994 survey identified only one doctor now contracted to work over 83 hours. This survey also showed that 360 junior doctors (33%) are working in excess of the December 1994 targets and it is on this group that employing authorities and the Regional Task Force were now focusing their activities to reduce hours.

Measures which employing Authorities may use to reduce hours and intensity of junior doctors work were set out in the paper.

The Management Executive has made a recurrent sum of £1.2m available from 1994/95 for additional medical posts and other measures to improve working conditions for junior doctors. This will be allocated on the advice of the Task Force against bids from Provider Units. It is intended that at least 80% of this money should be used to create consultant and other career grade posts.

Members were asked to comment on the difficulties in meeting the 1994 target and on the measures available to reduce hours and intensity of work of junior doctors.

A press release on a consultation document - "A Policy Framework for Commissioning Cancer Services" produced by an Expert Advisory Group on Cancer was tabled for members information. The Group proposes new structures for cancer services based on a network of expertise in cancer care, reaching from primary care through specialist Cancer Units, in local district hospitals to highly specialised cancer centres.

CMO explained that this document signals changes in the way in which future health services will be provided. The implications are that better results are achieved by specialist expertise.

Dr Watson said that there were many reasons for supporting service rationalisation as the appropriate way forward. The message that rationalisation of services will result in better services must be given out to the public and the profession. However, he stressed the need for capital development on the viable sites before rationalisation could be implemented.

Dr McConnell feared that a message on rationalisation issued by the Government/Department would be misunderstood by the public as an excuse for cuts in health services. Members agreed that the medical profession have a responsibility to make it clear that rationalisation was needed to enhance patient's care and not to save money.

Professor Dodge noted that many small children are being seen by adult specialists and there was a need to draw clear professional boundaries and address medical professionals' attitudes to the specialisation of services.

Mr Mulligan sought clarification about references in the paper to: "reduction of the number of tiers, especially after midnight"; the use of overseas doctors; and that hours worked by junior doctors should be included as a quality criterion within all service contracts.

Dr Acton explained there was a lack of research in relation to levels of activity in hospital wards at night and this area needs to be examined. Reduction in the number of tiers was but one of a number of measures available in reducing hours but was not always appropriate and usually needed to be supported by skill-mix initiatives. The appropriate use of overseas doctors, but only within the proper training programmes approved by the Postgraduate Dean, could be a further measure to reduce junior doctors hours. With regard to the quality criterion, the Task Force was concerned that a junior doctor working outside the new Deal targets was not receiving proper training. In the PRHO grade a greater proportion of doctors are working outside of the 1994 target and meetings had been held with the Dean about these concerns.

Dr McCluggage referred to documents which set out the duties of the PRHO grade and indicates that the Specialist Training Programme must be made available to all grades of doctors in training. These documents are available to educational supervisors.

6. **HOSPITAL DOCTORS: TRAINING FOR THE FUTURE**
THE CALMAN REPORT - PROGRESS

Members had received a progress report which summarises relevant UK developments following on the Calman Report and the Management Executive's plan for carrying the recommendations forward in Northern Ireland.

Dr Acton highlighted some of the main UK developments as follows:

- The Department of Health had set up 3 working groups to take forward; General Practice training, academic and research interests, overseas doctors.

- There are other additional working parties in related areas which have a bearing on the implementation of Calman proposals: UK working parties on Disciplinary Procedures, Locums, and Review of Guidance of Doctors' Performance.

- The Department of Health has set up the National Training Number Implementation Steering Group.

- The Medical Manpower Standing Advisory Committee was reviewing the manpower needs over a 20+ year timescale and, in particular, recommending the annual intake of medical students into the consultant appointment system.

- The Standing Committee on Postgraduate Medical and Dental Education are tackling the first stage of establishing the standards and principles governing the relationship between service and training.

- The Medical and Royal Colleges and Faculties are designing a new training curriculum for each medical specialty and the criteria for the award of the CCST.

- A UK working party has been convened to clarify the principles underlying the new unified training grade.

Dr Acton outlined some of the Working Groups' main proposals:

- Locum Doctors - There should be a central register of locum doctors which would contain regular reports from their centres of employment and any poor performance by locums would be noted.

- Unified Training Grade - The working party had identified problems relating to the entry requirement for the new grade. A group had been set up to look at appointment procedures and at the system of assessment for the grade. It is planned to introduce the UTG in Northern Ireland at the same time as the rest of the UK-probably August 1995. Once the principles have been defined, negotiations will take place in a UK forum to determine the terms and conditions of service for the new grade.

- Consultant Appointment Procedures - This Group has finalised its report and has recommended that there is a continuing need for statutory requirements in relation to consultant appointment procedures.

- Funding of medical and dental training posts - The funding of 50% of the salary costs of training posts may need to be increased to 100% once progress towards more structured and time-consuming training has started.

Discussion followed on the unified training grade. Mr Loughridge referred to a unified training scheme in Urology and said Urologists experience of this arrangement was encouraging.

With regard to progress on the Calman Report in Northern Ireland, Dr Acton advised that an internal group had been set up within the Management Executive to co-ordinate action and progress. Meetings had been arranged with the NI Council for Postgraduate Medical and Dental Education to ensure liaison and co-operation

between education and the service in the Calman implementation.

Meetings with medical representatives of service and educational interests in each major specialty will be arranged over the summer period. Draft manpower plans will be prepared for each major specialty which will act as a discussion document. The plans will take account of the Calman recommendations and their consequences for junior doctors' hours. The plans should highlight problems in training and in the delivery of services.

Dr Callender noted that Northern Ireland has a different system from Great Britain for progress within the R/SR grades and some doctors occupying registrar posts in Northern Ireland will not have the right to move into the new unified training grade and will have to compete for entry into the grade. Dr Acton recognised these NI differences and hoped that, through NI representation on national working groups, account would be taken of training arrangements in NI.

In response to a question, Dr Acton was of the view that, in responding to the Calman recommendations, each Unit/Trust will be responsible for deciding the number and pattern of medical staffing and the organisation of its patient services. The Management Executive would not wish to be involved in the local operation of services but might commission some research into how the challenges of Calman can be met.

Dr McCluggage said it was recognised that we could not look at the consequences of the Calman recommendations and junior doctors hours separately. There are many problems relating to service provision and training but it is expected that everyone will be able to work together on this. The Units will be responsible to the NI Council for Postgraduate Medical and Dental Education for the delivery of training and the Council will have responsibility for assessing and monitoring standards of training.

7. **NUMBERING TRAINEES AND POSTS IN THE SR/R GRADES**

[redacted]

8. SKILL-MIX AND THE NEW DEAL

Dr Acton introducing this paper explained that some progress had been made in reallocating duties inappropriate for junior doctors. However, there was an urgent need to look beyond the devolution of routine tasks and to seek a more radical approach to the work pattern of medical staff. This need emerges from the New Deal targets; the implementation of Calman; the increasing workload falling on doctors from new technology and increasing clinical activity.

Skill-mix is about identifying the range of tasks and responsibilities involved in providing health care, the levels of skills involved and the personnel who are most appropriate to carry them out. There has been a number of skill-mix initiatives throughout the UK and in other countries. The paper lists examples of an extension or expansion of existing professional roles.

Dr Acton said there was a need to collect information on skill-mix initiatives and evaluate their success or effectiveness. Units/Trusts will need to review skill-mix issues and adopt developments which meet their needs. There may also be a requirement for a co-ordinating, leadership role to promote skill-mix initiative and prepare agreed principles. Skill-mix is not the sole solution to problems emerging in medical manpower but is one of many solutions such as: partial shift systems, organisation of services and team working.

Members views were sought on the potential of skill-mix as a measure by which the New Deal Targets can be achieved and were asked to advise on how new initiatives can be more widely adopted.

In discussion members raised the following points:-

- Dr McConnell said it was essential that this type of approach was developed. Also skill-mix initiatives could be used as a measure to address the effects of the shift in balance from secondary to primary care. Examples of skill-mix initiatives are: the involvement of specialist nurses and nurse practitioners in areas such as varicose veins surgery; theatres and specialist occupational therapists working in clinics with orthopaedic surgeons.

- Members referred to difficulties in obtaining information about good practices in skill-mix and developments in the redefinition of professional roles. It was

agreed there was a need to gather information on these schemes, evaluate their success and to discuss the development of skill-mix with all the professional groups involved.

- The Chairman said it must be recognised that skill-mix is not a cheap option for patient care. Dr Lyons had advised him that Anaesthetists had looked at practitioner skill-mix schemes in Anaesthetics in Sweden and had found this was an expensive way to provide a service. The Chairman considered there should be a central source to look at skill-mix initiatives and their effects and to propagate these developments.

- Dr Acton said if inappropriate tasks were taken way from junior doctors it was important they were involved in tasks which would ensure they gained experience in routine clinical skills for example phlebotomy.

- Dr Galway noted concern that relieving junior doctors of inappropriate duties might result in a loss of some of their practical skills and emphasised that doctor's clinical skills must be maintained.

In conclusion HSSC agreed it was important to pursue the potential of skill-mix as a measure by which the New Deal targets can be achieved.

9. **SPECIALTY TRAINING AND EMERGENCY DUTY ROTAS - ACUTE HOSPITAL SPECIALTIES - FINANCIAL IMPLICATIONS**

The Chairman said that he had received a letter from Dr Galway, Consultant Anaesthetist, Craigavon Area Hospital Group Trust about the financial consequences of the Calman recommendations and junior doctors' hours for specialty training and emergency duty rotas for acute hospital specialties especially in smaller Units.

Dr Galway outlined trainee problems in relation to tyro trainees in Anaesthesia and explained that the restriction of junior doctors' hours will result in a loss of service to an Anaesthetic Department and in a small unit this will have serious financial implications. Although this problem had been cited in the specialty of Anaesthesia it will be common to all acute specialties.

Dr Galway suggested that 2 solutions could be considered:-

- A realistic central funding by the Postgraduate faculty of all tyro trainees.

- Training of these juniors should be restricted to hospitals in which there is a 3 tier rota.

Members acknowledged the many problems associated with the implementation of Calman and junior doctors' hours and the financial implications associated with training.

Dr Bali supported the views expressed in Dr Galway's letter and considered that additional funding to train tyro trainees must be provided centrally or from the Postgraduate Council.

CMO suggested that much of specialist medical training would be centralised under the Calman recommendations.

CMO suggested that specialist training facilities may be more centralised in the future and that special arrangements for new contracts may be necessary.

The Chairman was of the opinion that the only way to address many of problems identified was by the centralisation of services.

Dr McCluggage suggested that Dr Galway should bring his concerns to the attention of the appropriate training committee in the NICPMDE.

10. STAFF GRADE POSTS

Members had received a paper which reviews the number of staff grade posts which has been approved by the Management Executive on the advice of either the Hospital Services Sub-Committee or the Regional Task Force. It also suggests criteria which the HSSC may wish to take into account when advising the Management Executive about submissions for the establishment of new staff grade posts. The circular dealing with staff grade posts was attached for members information.

There was discussion about the length of sessions. Attention was drawn to paragraph 8 of the circular which states that the staff grade contracts for a minimum average commitment of 10 sessions per week, each session being the equivalent to 4 hours work. One member indicated that sessions in his specialty are 3 hours.

HSSC agreed that this paper provides useful guidance on the role of the Committee in advising the Department on submissions for Staff Grade posts.

11. APPLICATIONS FOR THE APPROVAL OF NEW POSTS

1. STAFF GRADE POST IN PAEDIATRICS AT THE ERNE HOSPITAL

Dr McConnell advised that this post was being established as part of the planned expansion of Paediatric services at the Erne Hospital to complement the merged maternity services for the Omagh and Fermanagh Unit of Management. Following discussion with the Royal College's Regional Adviser it was considered that the creation of a staff grade post was the most appropriate way forward.

Dr Jenkins said he strongly supported the development of the Paediatric services at the Erne Hospital. He sought clarification about the reference in the application to one SHO in Paediatrics from the Regional rotation scheme.

Professor Dodge indicated that he supported the creation of the post and he explained that arrangements had been made for 1 SHO in Paediatrics to rota between the Erne Hospital and a Belfast hospital.

In response to a query, Dr McConnell assured the Committee that there would be provision for the appointee's continuing medical education and participation in clinical audit. Members suggested this requirement should be included in the job description.

Members noted that some reservations had been expressed about whether the staffing combination of a staff grade post and 3 SHO posts was an appropriate combination for the provision of Paediatric services in some Units. Dr Acton stated that factors such as the workload and the contribution of consultants would be taken into account and this model of staffing would need to be examined.

Dr McConnell advised that there would be an input not only from consultants but also from community based paediatric staff.

Dr Jenkins said that this was a significant model of staffing for the provision of Paediatric services and it was important that it got off the ground and was seen to be attractive.

The Chairman said that assurance had been given that the points raised by the Committee would be addressed.

HSSC agreed to recommend the approval of this post.

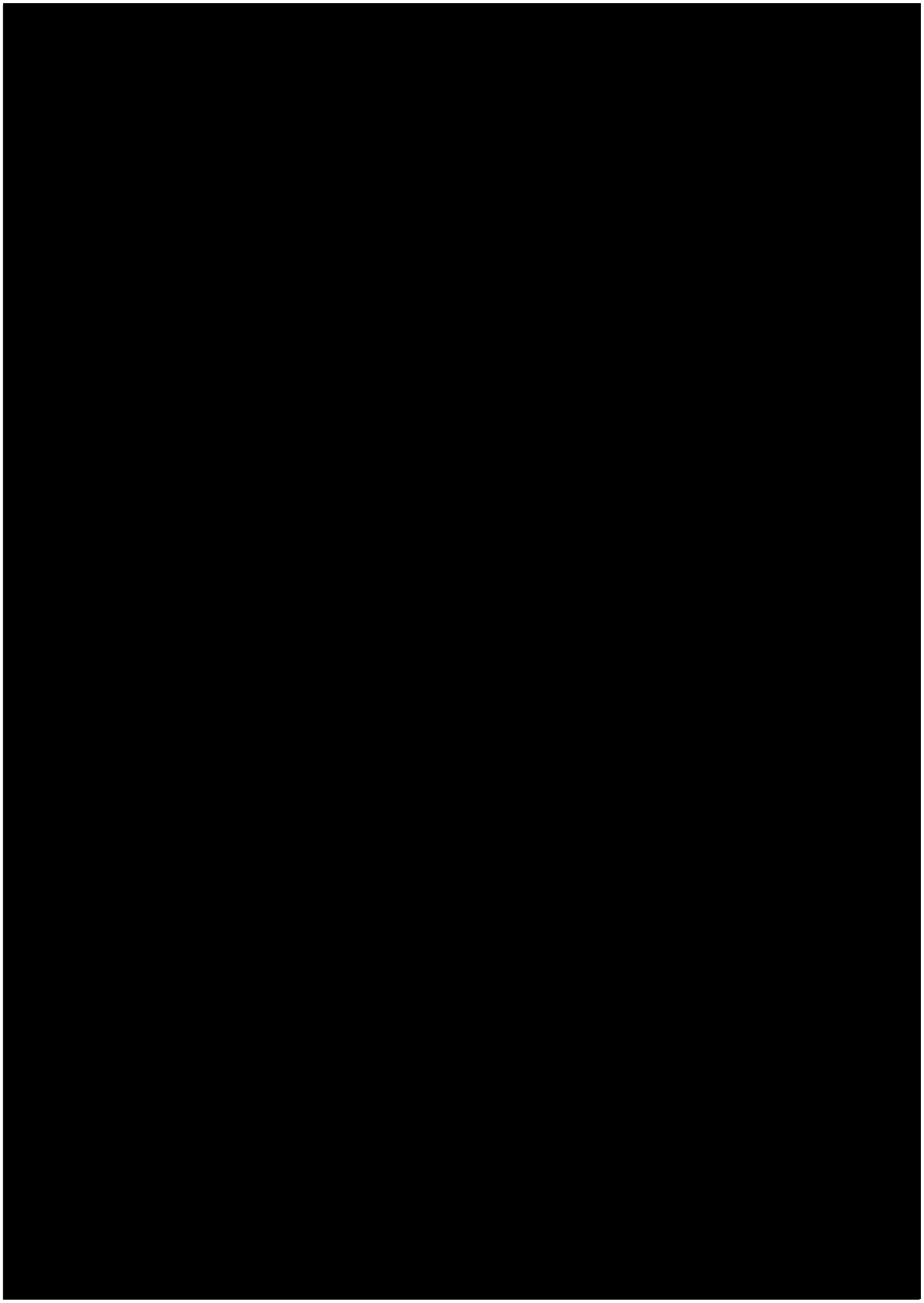
2. **STAFF GRADE POSTS (TWO POSTS) IN PSYCHIATRY OF MENTAL HANDICAP AT MUCKAMORE ABBEY HOSPITAL**

[redacted]

3. **STAFF GRADE POST IN ANAESTHETICS AT THE ANTRIM/MASSEREENE HOSPITALS**

[redacted]

4. STAFF GRADE POST IN OPHTHALMOLOGY AT THE ANTRIM HOSPITAL



[redacted]

5. **STAFF GRADE POST IN CYSTIC FIBROSIS AT THE ROYAL BELFAST HOSPITAL FOR SICK CHILDREN**

[redacted]

6. **REGRADING OF DR SHEELAGH CHAMBERS TO ASSOCIATE SPECIALIST IN PSYCHIATRY WITHIN THE SOUTH AND EAST BELFAST TRUST**

[redacted]

12. **TRANSPLANT SERVICE IN NORTHERN IRELAND**

[redacted]

13. NHS COMPLAINTS PROCEDURE

Members had received a paper which summarises the main recommendations of the report on the recent UK-wide review of the NHS complaints procedures. The report was published on 11 May and had been issued to HPSS management, Health and Social Services Councils and professional organisations for comment. A copy of the report had been sent to members.

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

Mr Gault explained that the report was commissioned in June 1993 by the Health Secretary, Virginia Bottomley. The review had encompassed the health services in Northern Ireland. The complaints procedures for community care and child care which are the responsibilities of local authorities in Great Britain were outside the remit of the review.

Mr Gault outlined some of the key issues and recommendations in the report. He explained that the changes recommended to existing NHS complaints procedures are aimed at making procedures more effective for complainants and improving service quality. Key issues are:-

- There should be a common system for handling complaints.

- There should be a strong emphasis on rapid responses to complaints wherever possible and a greater emphasis on conciliation (Stage 1 procedures). Practitioners and staff should be trained in effective complaint handling.

- For the small minority of complaints which cannot be resolved in this way by service providers there should be a more formal process with an impartial panel of lay and professional members (Stage 2 Procedures). Panels would always have a lay majority including a lay Chairman.

  The Review Committee identified options for the ownership of Stage 2 procedures and each option was supported in some measure by some members of the Committee. The arguments for and against each

option are set out in the report.

Time Limits - The Committee was unable to agree on setting a time limit for making a complaint.

Legislation - In Northern Ireland this Department has powers under existing legislation to direct HSS Boards to introduce the new procedures.

Mr Gault invited members to comment on the recommendations in the report and to suggest how the report might be implemented in Northern Ireland. Particular aspect on which comments would be helpful are:-

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

- Who should have ownership of the Stage 2 procedures.

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

The consultation period on the report will be 3 months. Mr Gault invited the Committee to send comments not later than 12 August.

In discussion members made the following points:-

- Dr Jenkins referred to the recommendation that a response to a complainant should normally be made within three weeks of the complaint being received and pointed to the time required for obtaining notes, assessing complaints and preparing a report. He suggested this was a tight time scale and considered that about 20% of cases could not be processed within this time.

- Mr Gault said that at present 80% of complaints were responded to within 1 month and it was considered that in most cases the proposed deadline for responding to complaints could be met.

- Dr Jenkins sought clarification on the composition of panels set up to consider complaints concerning issues relating to clinical judgement. Mr Gault explained that paragraphs 301 and 302 of the report set out the panel arrangements. The core panel would have 3 members and an additional 2 members from the relevant professions should be included if the complaint concerns issues relating to clinical judgement, however, there must be a lay majority. Dr Jenkins noted that lay panel members would require additional training to deal with issues relating to clinical judgement.

- Dr Jenkins said it was not clear whether the procedures would allow complainants and respondents the opportunity to have a professional adviser or professional representative present. Mr Gault felt there would be an opportunity for professional representation but undertook to clarify this matter.

Dr McConnell drew attention to recommendation 4 - "the complaints procedure should be concerned only with resolving complaints and not disciplinary procedures" and recommendation 6 relating to disciplinary action and said that the recommendations appeared to contradict each other.

- It was stated the complaints and disciplinary procedures were two separate processes. However, members were concerned that the recommendations contained considerable implications for the medical profession in relation to disciplinary action and it was felt that the BMA would wish to consider this document and address this matter.

- Professor Dodge said that complaints can lead to litigation and allegations of medical negligence. Staff handling the complaints will need to be counselled and doctors must have confidence in the handling of complaints by Health Authority management. Also doctors may need to contact their professional bodies for support in relation to complaints.

  Mr Mulligan believed there was a preoccupation with things which go wrong and nothing to encourage praise for good services. He suggested there should be procedures to register patients' appreciation of good health service treatment. However, in discussion it was recognised that people who value a service do not tend to take the trouble to register their appreciation.

- Mr Halliday said there was concern about the precise legal status of this document and this should be clarified.

- Dr McConnell noted that the consultation period on the report was over the summer months and made a plea for an extension of the consultation period. Mr Gault explained that the reason for this short time scale was that in the rest of the UK primary legislation and regulation will be required to implement the recommendations. The Chairman invited members to send comments on the report to him or Dr Acton for collation and presentation by 12 August.

14. CHARTER FOR PATIENT'S AND CLIENT'S

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:-

- Hospital In-patient 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 - It is intended to publish performance tables in June 1994 on the performance of providers in certain key areas.

- Charter Standards for Community Services - Some Charter Standards had been set for Community Services and in many instances the response times set for these have been inappropriate or unachievable. 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 individual projects.

Mr Gault sought members views on how HPSS should develop its own Charter Standards rather than await developments nationally . In discussion members made the following comments:-

- Members said that the Charter standards for immediate assessment in accident and emergency Departments could not always be met as treatment of the most serious cases takes greater priority. However, A&E Departments ensure the most urgent cases are treated first.

- The Charter sets out the rights of patients and arrangements for complaints and members suggested there was also a need for a Doctor's Charter. It was stated that this is being addressed to some extent as the Charter sets out the responsibilities of patients and ways they can help HPSS staff.

- Mr Halliday drew attention to a project being carried out in the Armagh area. He explained that all GPs had agreed to hold waiting lists for Orthopaedic services and to nominate patients to be seen at orthopaedic clinics. When this scheme is evaluated it is expected that it will be extended to other parts of Northern Ireland. Dr Telford suggested that followings evaluation a report on this pilot scheme be presented to HSSC.

- Mr Gault advised that the Management Executive had provided a Charter cash grant to a group of GPs in Bangor to look at Orthopaedic referrals.

- Dr McConnell suggested it would help to provide a broader picture if the number of patients waiting for treatment and the number of patients treated was published. He felt it was unfair to select individual consultants and his Board reported by specialty rather than by individual consultant.

In conclusion the Chairman said that members should give further consideration to the development of Charter standards and take a proactive role in this matter. He thanked Mr Gault for his attendance at the meeting.

15. **ANY OTHER BUSINESS**

[redacted]

16. **PAPERS FOR INFORMATION**

[redacted]