HOSPITAL SERVICES SUB-COMMITTEE OF THE CENTRAL MEDICAL ADVISORY COMMITTEE

THE NEXT MEETING OF THE HOSPITAL SERVICES SUB-COMMITTEE WILL BE HELD ON FRIDAY 21 OCTOBER 1994 AT 2.15 PM IN ROOM 229, DUNDONALD HOUSE.

AGENDA

1.	Apologies.	
2.	Chairman's Business.	
3.	Minutes of the Last Meeting.	
4.	Matters Arising from the Minutes.	
5.	Expert Advisory Group on Cancer - Policy Framework for Commissioning Cancer Services.	HSSC 30/94
6.	Neurology Services.	HSSC 31/94
7.	Transplant Service for Northern Ireland.	HSSC 32/94
8.	Calman Report - Progress.	HSSC 33/94
9.	Junior Doctors Hours.	HSSC 34/94
10.	The Number of Pre-Registration House Officer Posts in Northern Ireland.	HSSC 35/94 (To Follow)
11.	Applications for the Approval of New Posts.	HSSC 36/94
12.	Membership of SACs and HSSC.	HSSC 37/94
13.	Any Other Business.	
14.	Date of Next Meeting.	

PAPERS FOR INFORMATION

1995/98 HPSS Management Plan - Corrigendum.

Purchasing Function and Structures Report - Implementation of Ministerial Decisions - Circular No: HSS/PPRD5 7/94.

Hospital Services Sub-Committee of the Central Medical Advisory Committee

Minutes of the Meeting held on Friday 21 October 1994 at 2.15 pm in Room 229, Dundonald House

Present:
Dr D A J Keegan (Chairman)
Dr D A Adams
Dr I M Bali
Dr J A F Beirne
Dr M E Callender
Dr E P Corkey
Dr P Donaghy
Dr J E Galway
Dr E Hodkinson
Dr J Jenkins
Dr L Johnston
Dr F Kee
Mr W G G Loughridge
Dr M Madden
Dr J R McCluggage
Professor B G McClure
Dr W B McConnell
Dr W W M McConnell
Dr G McGinnity
Mr T O Mulligan
Dr S D Nelson
Dr S Refsum
Dr W A Ritchie
Professor R W Stout
~~Dr M J Toal~~

In Attendance:
Dr C E Hall (Acting CMO)
Dr J D Acton
Dr P G McClements
Dr P Woods
Dr V H Patterson
[redacted]

1. APOLOGIES

[redacted]

2. CHAIRMAN'S BUSINESS

[redacted]

3. MINUTES OF THE LAST MEETING

[redacted]

4. MATTERS ARISING FROM THE MINUTES

4.1 Introduction of Compulsory Induction Courses and Changing the Starting Date for Hospital and Dental Staff

[redacted]

[redacted]

4.2 **Staff Grade Post in Paediatrics at the Erne Hospital**

[redacted]

4.3 **NHS Complaints Procedures**

The Chairman advised that the consultation period on the report ended on 12 August 1994. The 35 responses received showed general acceptance of the main thrust of the report. The responses are now being analysed and it is hoped that decisions on the way forward will be taken before the end of the year.

It was noted that at the last meeting of HSSC, Mr Gault had undertaken to clarify the right to have a professional adviser during the complaints procedure. Dr Acton agreed to check the position.

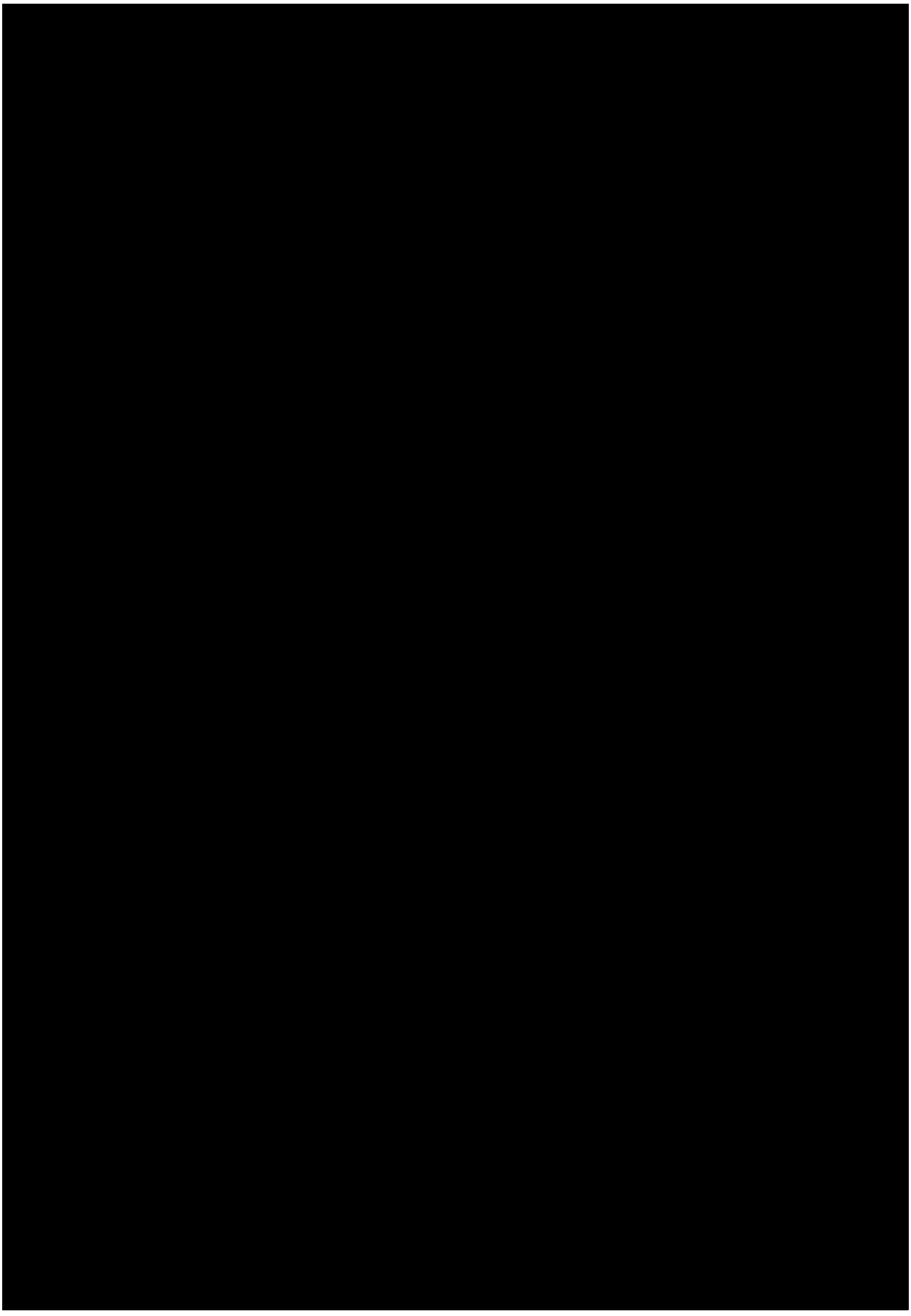
Dr Beirne said members of the medical profession were unhappy about having a majority of lay members on the panel when decisions were being taken about complaints relating to clinical judgement. He advised that discussions were taking place to look at whether the Ombudsman's jurisdiction should be extended to take on the clinical aspects of complaints. He hoped NI would follow national policy on this matter.

4.4 **Charter for Patients and Clients**

The draft Charter for Community Services was agreed by the Regional Charter Steering Group on 16 September and was issued to HSS Boards, HSS Trusts and HSS Councils for comment on 29 September. It is hoped to introduce any new standards that evolve from April 1995.

5. A POLICY FRAMEWORK FOR COMMISSIONING CANCER SERVICES

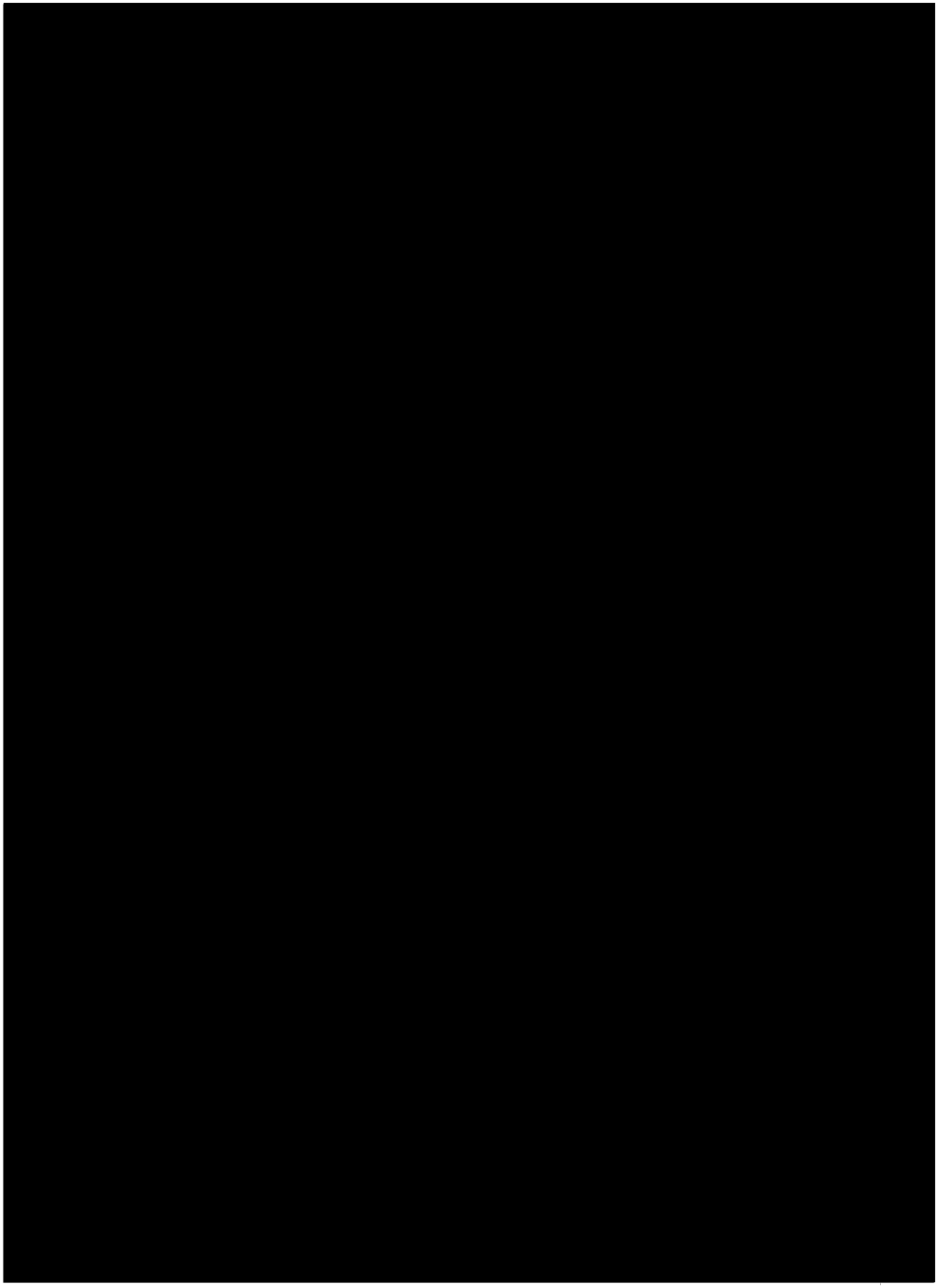
[redacted]



[redacted]

6. NEUROLOGY IN NORTHERN IRELAND

[redacted]



[redacted]

7. TRANSPLANT SERVICE FOR NORTHERN IRELAND - TRANSPLANT COORDINATOR

[redacted]

8. **"HOSPITAL DOCTORS: TRAINING FOR THE FUTURE" (CALMAN REPORT) PROGRESS AND ACTION TOWARDS IMPLEMENTATION**

Dr Acton introduced this paper which describes progress in specific areas of work essential for the implementation of the Calman Report.

Dr Acton emphasised that Calman cannot be considered in isolation from other manpower policies. These include: the "New Deal" on junior doctors' hours; "Achieving a Balance"; arrangements for funding the training grades; self-sufficiency in medical graduate and postgraduate education, and flexible training and flexible career options.

Dr Acton advised that a number of national reports linked to the Calman Report are due to be published for consultation in approximately 6 weeks' time. It is intended that HSSC should act as the major source of advice for the Management Executive in formulating its response to these national reports and that the Committee should also advise on and monitor local progress towards the implementation of the recommendations in the Calman Report.

Dr Acton outlined progress on two reports:-

- Academic and Research Medicine - One of the requirements for the award of the CCST is that every doctor must have knowledge of research methods. It is proposed there should be flexible arrangements in relation to opportunities for research during training. Dr Acton said academic medicine is an important component which needs to be encouraged and maintained and there is a will and a commitment to protect academic and research medicine.

- Unified Training Grade A working party has been established to determine

the educational framework on which the operation of the new proposed unified SR/R training grade should be based. The report is at the draft stage. It will provide guidance on the make up of the appointment panels for the UTG and on the transfer of SR/Rs to the new grade. The Medical Royal Colleges will publish guidance on the curricula and programmes for higher specialist training in the new unified training grade together with proposals for appraisal of trainees. It is anticipated that the report will be available at the beginning of December.

Dr Acton explained that a major exercise will be the formulation of a plan for each speciality and the changes to career and trainee numbers in Northern Ireland. Each SAC is being asked to include within its manpower for 1995 an initial allowance for consultant expansion. This will be reviewed each year.

In discussion members made the following observations:-

- Discussion centred on difficulties surrounding the implementation of the Calman recommendations. Attention was drawn to problems surrounding the reduction of the large number of SHOs in the Province and the impact of these changes on service provision.

- The importance of adequate consultant expansion as a pre-requisite to full implementation of the Calman report was emphasised.

- In response to a query about the timescale for the implementation of the Calman proposals, Dr Acton referred to the magnitude of the changes and the issues which need to be addressed and he suggested that the implementation of the Calman Report would extend to 6 years or longer.

Members were concerned that research and academic medicine should not be neglected and emphasised the importance of maintaining a flexible approach to funding research. In discussion one member suggested that funding should be part of the Unit's budget and not necessarily linked to the University. Members were advised that a report had been issued about the mechanisms for funding research in the health service and there was a strong commitment to the need for research.

9. JUNIOR DOCTORS' HOURS - PROGRESS TOWARDS THE DECEMBER 1994 TARGETS

The Chairman said members had received a report on progress towards the December 1994 targets for contracted hours for junior doctors.

Dr Acton highlighted some of the main issues:-

- A recent survey of hours worked by junior doctors shows that currently only 173 hard-pressed posts exceed the December 1994 targets. It is hoped that 60 of these posts will have their hours reduced as a result of the funding of posts by the Regional Task Force and by Units/Trusts. Some 29 career grade posts

and 15 training posts were funded this year by the Task Force but a small number of these were aimed at reducing intensity rather than hours of work.

- Dr Acton tabled the results of the September survey - Doctors in Training: Contracted Hours of Duty-Position as at 30 September 1994.

- As a result of the contracted hours of junior doctors being reduced knock on effects are emerging. The intensity of work has increased, some junior doctors are working in excess of their contracted hours and there is concern about the effect on educational and training aspects. The Task Force will visit hospitals to assess progress towards the December targets, to identify problem posts and how these can be resolved and to assess intensity of work for junior doctors and the impact of the targets on postgraduate education.

- It is estimated that approximately 40 posts may still exceed the target in December and there may be some intractable problem posts which will take longer to resolve, possibly using radical measures.

- Skill-mix initiatives can help to relieve the intensity of work. The Task Force had sought bids from Units/Trusts for funding skill-mix initiatives/research. The funds were restricted and 4 proposals were funded at a cost of £100,000.

- The Regional Task Force has also allocated £200,000 to improve the living conditions for junior doctors.

Professor Stout noted that regardless of contracted hours, the actual hours worked by junior doctors should not be more than 56 hours. He was concerned that a significant number of junior doctors worked more than 56 hours per week.

10. THE NUMBER OF PRE-REGISTRATION HOUSE OFFICER POSTS

Members had received a paper on the number of Pre-Registration House Officer (PRHO) posts.

Professor Stout drew attention to an inaccuracy in the paper. He agreed that the University has the statutory responsibility to approve hospitals and recognise an adequate number of PRHO posts for its graduates within its geographical area but this responsibility is not exercised by the Postgraduate Dean.

Professor Stout advised that 174 PRHO posts had been approved by the University at present. He emphasised that the University had not increased the number of PRHO posts to meet the service shortfall resulting from the implementation of "New Deal" targets for junior doctors.

Dr Acton said it is acknowledged that PRHO posts should not be created to fulfil service requirements. The PRHO year is an important year in a doctor's career and training needs must be the first priority. He emphasised these posts are for supervised educational experience and uncontrolled growth in PRHO posts may lead

to an increase in duties inappropriate to the grade, more unsupervised working and an imbalance in the hospital career structure.

In discussion members made the following points:-

Dr Galway suggested that PRHOs should be regarded as supernumerary doctors and their hours of work should be related to educational experience as opposed to service work.

Professor Stout agreed this should be the aim and said the PRHO post is the final year of basic medical education. However, these doctors are supposed to have professional responsibility under supervision and are not available to carry a large service load.

In response to a query about funding for PRHO posts Dr Acton said that the health service has a statutory duty to provide appropriate resources and facilities for PRHO posts.

Dr Hodkinson drew attention to concerns about difficulties surrounding the training of junior doctors. He said that colleagues had indicated they would not be happy with artificial constraints on PRHO numbers and he pointed out that in his hospital PRHO posts had been filled by graduates from other EC countries.

Dr Hall explained that the health service has a responsibility to provide pre-registration training for graduates from Northern Ireland but not for graduates from other EC countries.

Dr Jenkins suggested that the distribution of existing PRHO posts should be examined together with the type of trainee suitable to fill these posts. He said doctors in their PRHO year are looking for professional responsibility and it would be disappointing if these doctors were not given responsible jobs.

Professor Stout advised that the University does not look at the whole distribution of PRHO posts in Northern Ireland and this matter would require further consideration.

Dr Callender supported the proposal that there should be no increase in PRHO numbers and he considered that a redistribution of PRHO posts would not be an easier matter.

Dr McConnell stressed the need to meet training requirements in all the training grades. He felt one of the measures suggested in the paper to meet services needs, incomplete rotas with other grades covering the rota gaps, would be difficult because the number of staff to cover rota gaps might not be available. He considered we should look at the possibility of restricting PRHO numbers but this would not solve training problems and we should not look at this matter in isolation from other training difficulties.

Dr Acton noted the point that restriction of PRHO numbers would not resolve all training problems. He emphasised that the PRHO year was important for doctors and there was a need to put pressure on management to take away duties inappropriate to the grade.

Members considered there was no easy answer to the question of the number of PRHO posts. Professor Stout suggested that we should not be committed to a particular figure for PRHO numbers but the figure of about 160 should be the number of PRHO posts as constrained by the educational ability of the post.

In summary the Chairman said HSSC supported a target for PRHO posts of the average annual medical graduate output from QUB and an additional 10% of this figure. If difficulties are created in relation to service shortfall these must be addressed in other ways than increasing PRHO numbers.

11. APPLICATIONS FOR THE APPROVAL OF NEW POSTS

1. Staff Grade Post in Ophthalmology at Antrim Hospital

[redacted]

2. Staff Grade Post in Accident and Emergency at Altnagelvin Area Hospital

[redacted]

[redacted]

3. **Staff Grade Post in Accident and Emergency at Coleraine Hospital**

[redacted]

4. **Staff Grade Post in General Surgery at Coleraine Hospital**

[redacted]

5. **Staff Grade Post in Paediatric Medicine at Mid-Ulster Hospital, Magherafelt**

[redacted]

12. **CENTRAL MEDICAL ADVISORY STRUCTURE**

Dr Acton informed members that it is now 11 years since the circular "Medical Participation and Advice in the Health and Personal Social Services in Northern

Ireland" was issued. Consequently it was time to review the appropriateness of the present central advisory structure.

The paper described the present central advisory mechanisms and set out options for bringing the membership of the various central committees more into line with current organisational arrangements. In particular it looked at the need for management representation and the sources of nomination for membership. He invited members to comment on the following proposals:-

Central Medical Advisory Committee - Adding a General Manager, representative of the purchasers and a Chief Executive, representative of the Trusts.

General Medical Care Sub-Committee of CMAC - Inclusion of representatives of fundholders and of community consultants.

Hospital Services Sub-Committee of CMAC - Adding one or two medical directors (nominated by the NI medical directors group) and a Board General Manager and Trust Chief Executive.

Specialty Advisory Committees - The most appropriate source of nominations for membership, having account of the progress towards trust status for hospital and community units and the increasing influence of management. Options are set out in the paper.

In general discussion members commented that the purpose of the committees is to provide medical advice to the Department and HSSC considered there would be no value in representation of a General Manager and a Chief Executive on the committees. They pointed out if it is agreed that membership of committees should include the General Manager or Chief Executive they should be representative of a group rather than of their own particular interest.

HSSC agreed that it might be desirable to include fundholders on GMCSC. Members considered that fundholders should be included on the Committee because of their expertise not because they are fundholders.

Dr Acton informed members that the paper had been discussed by other Advisory Committees and the consensus of opinion was that there might be an advantage to having one medical director on HSSC and that membership of the Committees should remain representative of the medical profession and should not include a Board General Manager and a Trust chief Executive.

In conclusion HSSC commented that the main purpose of the Central Medical Advisory structure was to provide medical advice to the Department and was of the opinion that it would not be appropriate to include management representation on the medical advisory committees. The Committee recommended that there should be no change in the membership of HSSC.

13. ANY OTHER BUSINESS

[redacted]

14. DATE OF NEXT MEETING

[redacted]

15. PAPERS FOR INFORMATION

[redacted]