HOSPITAL SERVICES SUB-COMMITTEE OF THE CENTRAL MEDICAL ADVISORY COMMITTEE

MINUTES OF THE MEETING HELD ON 31 OCTOBER 1996 AT 2.15 PM IN ROOM 229, DUNDONALD HOUSE.

PRESENT:
Dr D A J Keegan (Chairman)
Dr I M Bali
Dr J A F Beirne
Dr E P Corkey
Dr P Darragh
Prof J A Dodge
Mr J M Dunlop
Dr J E Galway
Mr J A Halliday
Dr J Jenkins
Dr L Johnston
Mr W G G Loughridge
Dr S M Lyons
Dr M Madden
Dr A Montgomery
Dr T O Mulligan
Dr J R McCluggage
Prof B G McClure
Dr H G McNeill
Dr S D Nelson
Dr V H Patterson
Dr E G J O'Neill
Dr S Refsum
Dr W A H Ritchie
Dr J Watson
Dr P Weir

IN ATTENDANCE:
Dr C Hall
Dr J D Acton
Miss J Dixon
[redacted]

1. **APOLOGIES**

[redacted]

2. **CHAIRMAN'S BUSINESS**

[redacted]

3. **MINUTES OF THE LAST MEETING**

[redacted]

4. **MATTERS ARISING FROM THE MINUTES**

4.1 **Staff Grade Post at the Breast Screening Unit in the Eastern Board**

[redacted]

4.2 **Regrading of Dr K S Salathia to Associate Specialist in Cardiology - Ulster Hospital**

[redacted]

4.3 **Transplant Services in Northern Ireland - Transplant Co-ordinator Post**

[redacted]

4.4 Regional Strategy for Health and Social Wellbeing 1997-2002

[redacted]

4.5 Cancer Services

i. Investing for the Future - Report of the Cancer Working Group

[redacted]

ii. A Framework for the Multidisciplinary Contribution to Cancer Care in Northern Ireland

[redacted]

4.6 Vacant Consultant Post

[redacted]

5. **"NEW DEAL" FOR JUNIOR DOCTORS HOURS CURRENT SITUATION AND IMMEDIATE PLANS**

Members had received a paper which describes progress towards the December 1996 targets and is based on the round of visits to all hospitals in Northern Ireland by the Regional Task Force (RTF).

Dr Acton summarised some of the main points as follows:

- At 30 June 1996 there were 1134 junior doctors in post, 6 more than one year ago.

- 25% of posts do not comply with one or more of the December 1996 targets. This could be considered disappointing but Trusts have come a long way and substantive progress has been made since 1991 when 60% of posts were contracted for over 83 hours.

- In NI Non-compliance is in the same range as elsewhere in the UK and represents a hard core of intractable posts which may prove difficult to resolve. Intensity is still a problem.

Dr Acton outlined some of the perceptions formed following RTF visits: progress is steady but not exceptional; a lot or progress has been made in the sharing of appropriate duties; out of hour cover is provided mainly by the most junior doctors, consequently, intensity is a problem in the junior grades; most consultants carry an increased workload since the introduction of the New Deal; and most consultants worked hard to provide training, nevertheless, juniors reported varying standards of training.

The paper sets out the work to be undertaken by the RTF over the next 6-12 months and the position on funding the New Deal initiative.

Dr Acton explained that a lot of work still has to be undertaken and it is clear the December 96 targets will not be gained on time. It may take time, 1-2 years before all posts are in full compliance with the targets. A substantial effort will be required to ensure progress towards the targets will be maintained and that the co-operation of management and professional groups will continue.

Dr Acton asked members to comment on:

- progress in implementing the "New Deal";
- the immediate work programme for the RTF;
- the role of purchasers in implementing the "New Deal":
- the need for additional central funding.

Members made the following comments:

- Dr O'Neill was in agreement with Dr Acton's assessment of the current situation on implementation of the "New Deal" and noted that there are significant difficulties to resolve for example, intensity of work for junior doctors. He felt that skill-mix initiatives are the way forward on intensity problems but progress on skill-mix and the sharing of appropriate duties is difficult and has put a burden on nursing staff. Dr O'Neill emphasised that central funding for skill-mix initiatives is essential to ensure progress towards the targets.

- Dr O'Neill referred to consultants increased workload since the introduction of the New Deal and suggested there is also a need for a "New Deal" for consultants and a move towards time sensitive activities within consultants contracts. Dr Beirne agreed but indicated that the open-ended contract continued to be BMA policy.

- Members noted that consultants required more feedback from trainees on training standards and there was a need for closer accountability between the trainee and the supervising consultant.

- Dr O'Neill said it is essential that the RTF continues in existence until the targets are implemented. It is also essential that a proper mechanism for continuing central monitoring of the implementation of the "New Deal is set up. He sought a firm commitment that central monitoring arrangement will continue in Northern Ireland and that they will run parallel to the system in England.

- Dr O'Neill felt that the idea that Royal Colleges will monitor compliance with targets was unrealistic because the frequency of their visits will not lend itself to an accurate investigation of what is happening.

- Dr Acton said that the Royal Colleges and the postgraduate Deans will be monitoring working conditions for junior doctors to ensure that training is not being compromised. Purchasers also will seek assurance on hours of work, which may have an impact on the quality of care for patients. There would be a continuing role for HSS Executive in monitoring and it already sought views on progress towards the New Deal targets from HSSC. Dr Hall confirmed the need for a core group of the Regional Taskforce to support and advise the purchasers and indicated that monitoring in NI would not differ significantly from arrangements in the rest of the UK.

- Dr Watson pointed to the substantial progress in improving working conditions for doctors in training. He paid tribute to the achievement of the RTF and to the work of its junior doctor representatives. He stated that it was becoming increasingly difficult for purchasers to distinguish the requirements of the New Deal from other priorities and requirements on services. He felt it was now appropriate that the New Deal funding should be transferred to

purchasers so that the establishment of New Deal posts would not conflict with other service priorities.

- Dr O'Neill stressed that central funding is crucial to the "New Deal" initiative and he expressed the concerns of junior doctors that the progress towards the "New Deal" would be halted if the RTF and its funding for new posts was phased out.

- Dr Jenkins said that even with additional central funding it will be necessary to bear in mind the need for adequate staffing levels for other professional groups. If there are not appropriate staffing levels to enable non medical professionals to do service work they cannot take on additional burdens relating to the sharing of appropriate routine duties to relieve medical staff.

- With regard to funding Dr Acton explained that a bid for additional central funding has been made but under present financial stringencies there is little confidence of success. Dr Hall stressed that the financial situation is dire and unlikely to improve.

- Summing up the Chairman complimented the RTF on its work and said it is recognised that full compliance with the targets will require substantial effort. HSSC supported a commitment towards full compliance with the New Deal targets.

68. **IMPLEMENTATION OF THE CALMAN REFORMS FOR SPECIALIST MEDICAL TRAINING**

Dr Acton gave members a progress report. Members had received a paper which provides an update on the next group of specialities which began transition to the new grade on 1 October 1996. It also sets out the dates when transition will end in the majority of specialities which began transfer to the new grade on 1 July.

Dr Acton took members through the contents of this paper and highlighted the following:

- The specialist register grade has been introduced in 21 specialities.

- Transition to the new specialist registrar grade began in 17 specialities on 1 October 1996.

- 14 specialities will begin transition on 1 January 1997.

- The whole transition will be completed on 1 April 1997.

- Dr Acton explained there is some confusion about eligibility for entry to the new grade especially for registrars undertaking research. The groups eligible for automatic entry to the SpR grade during the commissioning phase are

defined in Section 2 of the "Orange" Guide to Specialist Registrar Training. He stressed that there was no change to the criteria for entry to the new grade.

- Financial implications - in order to increase the number of higher specialist training posts in anticipation of a consultant based service £300,000 has already been invested in the specialist registrar grade. In addition £40,000 has been made available for administrative costs of implementing the postgraduate education reforms. Further funding has been sought for 1997/98.

- Dr Acton reported that an assessment of the service impact of medical workforce policies, including educational reforms and the New Deal, on resources, primary care, hospital services and other professional groups would be carried out in a national forum. The HSS Executive would consider the conclusions of this assessment in the context of NI.

Members made the following comments:-

Dr McCluggage stressed the commitment of Specialty Training Committees to promoting research during higher specialist training. He advised that a supplement to the "Orange Book", which would recommend a flexible approach to research and academic training would be issued soon.
Dr McCluggage explained that doctors undertaking research can retain their NTN subject to agreement with the postgraduate dean and the Training Committee.

- Members noted that trainees undertaking research incur financial loss as a result of the break in their career. Also there is pressure within the system to acquire research qualification for career progression.

- Dr Lyons drew attention to organisational and workforce planning issues. He said one difficulty is the filling of training post vacated by doctors conducting research overseas. For example, up to 20% of anaesthetic trainees could be undertaking research or overseas at the same time. It was recognised that there is no simple solution to this problem.

- Dr Galway highlighted an anomaly which needs to be addressed. He noted there is no provision for staff grade doctors who wish to re-enter the training programme to enter the SpR grade. In response, Dr Beirne said such staff grade doctors should write to the Specialist Training Committee seeking advice on what is required to obtain a CCST.

- Discussion ensued on the financial implication of implementing the Calman reforms. Members noted the statement in the paper that "the pace of Calman implementation must be influenced by the resources available and the ability of services to adapt to the inevitable changes in the delivery of patient care which will flow from the more structured and shorter curricula".

- Dr O'Neill expressed concern about the lack of adequate funding for the implementation of the Calman reforms. It was recognised that consultant expansion in NI was better than elsewhere in GB but he felt that NI was beginning to lag behind the rest of the UK in terms of additional funding being made available for consultant posts and for implementation of the postgraduate educational reforms.

- Dr Lyons supported the need for additional funding to secure progress towards the Calman reforms but suggested that the present pattern of hospital services in the Province militated against efficient postgraduate education. In response, Dr Acton pointed out that consultant expansion over the past 5 years in NI had averaged in excess of 3% per year. He stressed the commitment to the implementation of Calman reforms but was concerned that the transition from a service dependent on junior doctors to a consultant provided service had major implications for the organisation of patient services and for PGME.

  In conclusion, the Chairman said that HSSC recognised the concerns expressed about the lack of funding for the implementation of the Calman reforms and the administration costs of implementing the postgraduate educational reforms. HSSC strongly supported the view that additional resources are required.

7. **REVIEW OF ARRANGEMENTS FOR FUNDING POSTGRADUATE MEDICAL AND DENTAL EDUCATION**

Dr Acton explained that the NHS Executive had recently issued a consultation document, "Funding PGMDE" which reviews the arrangements for funding postgraduate medical and dental education in England.

Similar commitments to a review have been given in NI. Members had received a paper which considers the PGMDE issues raised in the NHSE review in the context of NI. If members wish to have a copy of the full document they should contact Dr Acton.

Dr Acton took members through the conclusions and recommendations of the English report and sought members comments. The following two recommendations will be implemented in England from April 1997. The remaining conclusions and recommendations have been issued for comments to NHS managers, and Professionals and associated organisations in England. Discussion focused on the following recommendations.

i. **Postgraduate Deans will fund 100% of the basis salaries of Pre-Registration House Officers (PRHOs)**

Dr Acton explained that the GMC is currently reviewing the PRHO year and may see the PRHO as an extension of the undergraduate year which focuses on practical training in the clinical setting. He sought members' views on the benefit of 100% funding of PRHO posts through the Dean's budget in NI.

Dr Acton also sought members' views about the effects of delaying the implementation of this recommendation in NI until April 1998 because Trusts have already moved into contracting arrangements for 1997.

Dr McCluggage said that the NICPGMDE strongly supported this recommendation which would give educationalists more control over PRHOs.

Dr McCluggage was in favour of delaying implementation until April 1998 and stressed this recommendation should be implemented in the context of NI and to the benefit of the Province.

HSSC gave its strong support to this recommendation.

ii. **The Funding of ADHs of flexible trainees to be responsibility of Trusts**

Members noted that this is current practice in NI.

iii. **Data requirements and availability**

The review revealed limitations in the present PMDE information system in England and recommended the upgrading of information systems. Dr Acton pointed out that NI has similar problems and data is often unreliable in relation to PRHOs and SHO grades. The recommendation may have implications for upgrading information systems in NI.

Dr O'Neill welcomed this recommendation but felt that the proposed improvements for data requirements should be extended to include data on all junior doctors.

iv. **Promotion of flexible training**

Members were asked to comment on the demand (including "hidden" demand) for flexible training and how opportunities can be improved.

The report recognised that the increasing proportion of women doctors and the shortage of doctors has resulted in a demand for more flexible provision of training. It concludes that some ring-fenced funds would be required for flexible training and suggest "that improved targeting of resources by deans is needed".

NI has 7 flexible training posts which have specific 100% funding held by the Dean.

Dr O'Neill considered that problems relating to opportunities and demands for flexible training have less to do with overall funding and more to do with the nature of the way that trainees are paid which results in flexible trainees being financially penalised.

In discussion members indicated that there is a steady demand for flexible trainees in specialities and in particular in Paediatrics and Obstetrics. With regard to the proposal for ring fenced funding for flexible training it was felt it would be difficult to spread the allocation of limited funding across specialities in NI.

Dean's Development Fund

The report proposed a Dean's Development fund to promote flexibility and encourage improvements and innovations in PMDE. Members noted that in NI the Dean's budget allows very limited virement from one year to the next and felt that this would be a positive step forward. It was agreed to await the outcome of the consultation on the English report.

A Fully-funded System of Education of Contracts

The report recommends that work be undertaken to assess the feasibility and implications of introducing a purchasing system for PMDE based on locality agreed contracts.

Members agreed that NI cannot undertake such a comprehensive exercise. It was agreed that we should keep in touch with developments and assess the implications for NI on the recommendations relating to the Dean's development fund and a fully-funded system of educational contracts.

8. REPORT OF THE LOCUMS WORKING GROUP

[redacted]

[redacted]

9. CLINICAL AUDIT

The Chairman introducing this item said medical audit had been in place in Northern Ireland for over 5½ years. He informed members that this topic had been placed on

the agenda to seek views about the medical audit process. He sought member's comments on:

- the commitment of the medical profession to medical audit;
- the extent of the medical professions involvement in medical audit;
- whether adequate time is set aside by clinicians for audit;
- contracting and monitoring aspects relating to medical audit; and
- whether medical audit is being used to shift resources towards better clinical practices.

Members commented as follows:

- Some members questioned whether medical practices in the Province had been changed by medical audit activities. It was suggested there were problems in using audit to move towards better clinical practices unless the results of medical audit are enforceable.
- The Chairman reported that over 700 audit projects had been undertaken last year and there was evidence that these had a very significant impact on medical practice. He drew attention to the growth in multiprofessional activities over the year and a very successful clinical audit symposium in October 1996.
- Dr Watson said he was committed to medical audit as a doctor and as a member of the Northern Board's Audit Committee. He outlined links between the Board's Audit Committee and its Area Medical Advisory Committee. He said that the Chairman of the Area Audit Committee is co-opted on the AMAC and this forms a link and engenders action as a result of audit activities.
- Members expressed concerns namely: that some specialities take action on the results of audit but others do not: participation in medical audit is compulsory for all hospital doctors and therefore there is concern that it is performed for the sake of audit rather than to address key issues; commitment to audit required time and resources.
- Dr Darragh said the Eastern Board is committed to medical audit. He felt that the enormous amount of audit activity taking place is helping the evidence-based approach to medical practice. From a purchasers' point of view audit is breaking down barriers and has resulted in the sharing of information.
- Discussion centred on the need to disseminate the results of medical audit. Dr Jenkins noted that the Clinical Resource Efficiency Support Team (CREST) had a good mechanism for disseminating the results of CREST

initiatives and suggested that this model should be used to publicise medical audit results.

- Dr Montgomery noted that good facilities, funding, a good audit Department and audit assistants to support clinicians are important factors.

- Dr Beirne questioned whether audit dealt with at Trust level is more related to the monitoring of contracts than medical audit. There was discussion about conflicting demands from Trusts and purchasers for audit and the need to ensure that the right type of audit is being performed. Also there was a need to look at the whole evidence-based approach to practice.

The Chairman thanked members for their comments and undertook to convey the views expressed to the Regional Audit Committee.

10. TOWARDS A PRIMARY CARE LED NHS - IMPLICATIONS FOR NORTHERN IRELAND

The Chairman introduced Miss J Dixon, Director, Primary Care and Purchasing Development Directorate.

Miss Dixon outlining the background to this policy and the context in which it had been developed explained that the primary care-led service is now a major focus of Government policy. It will be central in shaping our future care services. It will shape the way Boards commission services, the way Trusts provide services and, the way in which primary care will operate in future.

In Northern Ireland a Framework document - "Empowering Primary Care Teams to Influence the Planning and Commissioning of Health and Social Care Services in Northern Ireland" was issued in February for discussion on how best to implement in Northern Ireland the national policy of moving to a primary care-led service.

A major conference organised by the HSS Executive was held at the Dunadry Inn in June to explore the implications of the policy. Members had received the text of a speech made by the Minster at the conference. Miss Dixon drew members' attention to the following statement by the Minister - "My final message to you is that we have firmly embarked on the development of a primary care-led service in NI. The policy is not up for negotiation or debate. But how we develop it in our own Northern Ireland context is open for debate and extensive consultation. I - and the HSS Executive - will be listening. I am asking you all also to listen to one another".

Miss Dixon said that in Northern Ireland the national policy must accommodate the integrated nature of the HPSS and there will be a greater emphasis on multidisciplinary working. She advised that a consultation exercise was about to start on the implementation of the national policy in the context of Northern Ireland's integrated HPSS and on the development of the commissioning process. It is intended that policy guidance and a commissioning development framework will be issued by the end of March 1997.

In England NHS "Primary Care - the Future", an NHSE report, reflects the outcome of a Ministerial Listening Exercise completed last Spring. A White Paper, "Choice and Opportunity" has also been published, applicable to England Wales and Scotland, which outlines developmental proposals, mainly in general medical practice, which emerged from the listening exercise and which require primary legislation to be put into operation. Essentially these proposals are about facilitating voluntary piloting of different ways of contracting for the provision of primary care.

Miss Dixon emphasised the objective of commissioning which is Board led, but commissioning in which primary care has a major role at every stage of the process. Boards will be expected to play a key role in creating and maintaining links to primary care which will involve primary care representation in the full commissioning process, allowing them to be influential in shaping plans and purchasing decisions.

Dr Jenkins noted that the NHS is patient centred and was concerned that the primary care team would be used as a proxy for seeking the views of patients. In response, Miss Dixon pointed out that each Board has an HSS Council which reflects the views of patients. She stressed, however, the need for GPs, and other primary care team members, as informed assessors of need to play a part in influencing the planning, prioritisation, purchasing of, and contracting for services which are sensitive to the needs of patients.

Dr Jenkins said GPs would be both commissioners and providers of services and there were concerns they would have difficulties in fulfilling these conflicting roles in a primary care led service. Miss Dixon reminded him that Community Trusts, who were currently involved in consultations about planning and purchasing by Boards, were also both commissioners and providers.

Dr Darragh said that Boards would need to organise the means to ensure that primary care has an input into the commissioning process. There are many practical issues which needed to be addressed and there was a need to ensure that everyone works together to develop this policy.

The Chairman thanked Miss Dixon for her attendance at the meeting.

11. APPLICATIONS FOR APPROVAL OF NEW POSTS

3 STAFF GRADE POSTS - GERIATRIC MEDICINE, CARDIOLOGY AND DIABETES AND METABOLIC MEDICINE AT WHITEABBEY HOSPITAL - UNITED HOSPITAL TRUST

[redacted]

STAFF GRADE POST IN THE CARDIAC SURGICAL UNIT, ROYAL GROUP OF HOSPITALS

[redacted]

STAFF GRADE POST IN PSYCHIATRY AT THE ROSS THOMPSON UNIT ROUTE HOSPITAL

[redacted]

REGRADING OF DR G CARSON STAFF GRADE TO ASSOCIATE SPECIALIST AT THE ACCIDENT AND EMERGENCY DEPARTMENT CRAIGAVON AREA HOSPITAL GROUP TRUST

[redacted]

REGRADING OF DR A M LAWLER FROM CLINICAL MEDICAL OFFICER TO ASSOCIATE SPECIALIST IN CHILD HEALTH/AUDIOLOGY NORTH AND WEST BELFAST HSS TRUST

[redacted]

[redacted]

REGRADING OF DR BARBARA E LOWRY TO ASSOCIATE SPECIALIST IN GENITOURINARY MEDICINE AT THE ROYAL GROUP OF HOSPITALS

[redacted]

12. **ANY OTHER BUSINESS**

[redacted]

13. **DATE OF NEXT MEETING**

[redacted]