HOSPITAL SERVICE SUB-COMMITTEE OF THE CENTRAL MEDICAL ADVISORY COMMITTEE

Minutes of the meeting held on Tuesday 22 June 2004 at 2.15 pm in Conference Room B.5 .2 Castle Buildings

Present:

Dr R F Houston (Chairman)
Dr I M Rea
Dr P Murphy
Dr I Orr
Ms C M Scally
Prof A B Atkinson
Dr M Parker
Mr S J A Rankin
Dr M Shields
Dr J M C Morris
Dr B Devlin
Mr C J McClelland
Mr F J Mullan
Mr L Rocke
Mr E J Mackle
Prof J Watson
Dr MM McConnell

In Attendance:

Dr I Carson
Dr P Woods
Dr D McMahon
[redacted]

1. APOLOGIES

[redacted]

2. CHAIRMAN'S BUSINESS

[redacted]

[redacted]

3. **MINUTES OF LAST MEETING**

[redacted]

4. **MATTERS ARISING**

"Best Practice-Best Care" - Update

Dr Carson gave members an update on key areas as follows:-

- The NI Clinical and Social Care Governance Support Team had been established. Anne O'Brien from the NHS Support Team had taken up the post of Director and the full multi-disciplinary team was now in post. The Team will support the development and implementation of C&SCG within HPPS organisations. Dr Carson tabled a paper detailing membership of the team and its work plan for 2004/05.

- The CHI demonstration of their methodologies with the UCHT had been completed. A report will be furnished to the Trust and the Department and widely disseminated within HPSS in the Autumn.

- A Standards and Guideline Unit had been established.

HPSSRIA had been established with responsibility for monitoring and inspecting a wide range of health and social care services delivered by or on behalf of the HPSS. Mr Brian Coulter had taken up post as Chair and the recruitment process was underway for the Chief Executive and Director posts. It is aimed to have the new Authority operational by 1 April 2005.

- National Patients Safety Agency .A joint working plan developed between the DHSSPS and the NPSA was circulated to members. It describes areas of work identified as forming the basis of a future joint working agreement with the NPSA. This is premilinary work which has not been signed off.

- The Departmental Board had agreed the parameters for negotiation of a Service Level Agreement with the National Clinical Assessment Authority. Dr Woods will meet with the Authority to formalise arrangements.

- Concerns had been flagged up regarding communications between and within HPSS organisations about the handling of safety incidents. The Department will write to HPSS organisations providing guidance on how to handle severe or major safety incidents in HPSS.

- Records Management in HPSS – A workshop had been held and a consultation exercise had been undertaken in developing definitive guidance on record management in the HPPS. It is expected that the Department will issue a guidance document on management and records at the end of August 2004.

- A paper outlining processes and linkages between appraisal, clinical and social care governance and revalidation was circulated to members. A workshop will be convened on 2 July 2004 to discuss revalidation processes with a view to a conference being held in the Autumn.

- Dr Carson outlined steps involved in appraisal and revalidation processes and evidence requirements. There are still issues that needed to be addressed in terms of quality assurance and revalidated data.

SARS Contingency Planning

[redacted]

New GMS Contract - Update

[redacted]

5. REGIONAL STRATEGY FOR HEALTH AND WELLBEING

[redacted]

[redacted]

6. **MODERNISING MEDICAL CAREERS – THE NEXT STEPS**

Members had received a paper summarising the most recent publication on the policy of reforms to medical training – " Modernising Medical Careers – The Next Steps". The document sets out in detail the next stages in implementation of the policy on Modernising Careers launched in February 2003. It focuses on the standards for Foundation programmes and the relationships between foundation programmes and specialists and general practice training. The document acknowledges that there are many practical issues to be answered and outlines where further work is needed. Key issues include:-

- The development of Foundation programmes that meet the stated objectives of the policy reforms.
- The development of new and robust assessment methods

- Impact on service delivery
- Relationship with implementation of the EWTD
- Effects on workforce numbers
- Resource consequences

Dr Woods took members through the content of the paper and highlighted the following:

- The Department had established a steering group to oversee the implementation of the initiative. A key requisite in the short term is the design and implementation of foundation programmes by August 2005. Visits to all Trusts/ local sites are scheduled to highlight issues and determine the content of foundation programmes in outline.
- A significant transition period may be necessary while training programmes and curricula are developed. The longer term aim is a move towards a seamless training system. It is envisaged that run through specialist training programmes will be developed post foundation programme. These will lead directly to the award of CCT. Graduates in 2005 will be the first group of doctors recruited into 2 year Foundation programmes.
- At end of first year of the Foundation Programme trainees will be able to demonstrate the learning outcomes required for full registration. The second year Foundation programme will build on the first with the aim of developing the trainee to the point they are ready to enter specialist or general practice training programmes.
- A key element of the Foundation programme will be experience in a range of clinical settings, disciplines and specialties. An aim is for a greater number of experiences in and a better knowledge of general practice.
- An appraisal of local SHO posts to identify those considered appropriate for Foundation programmes is underway.

Dr Woods sought members'views. The following main points emerged:-

- Members supported the concept of Foundation programmes but expressed significant reservations about the implementation process.
- Issues of concern include:
    - The need for clarification and guidance on educational issues and the structure and educational content of Foundation programmes was highlighted.
    - The consultant's educational role, the new consultant contract, the development of the appraisal process for doctors in training. It was felt there was a need for clarification about how these elements would tie into the Modernising Medical Careers agenda.
    - The impact on the future medical workforce.

6. The remaining specialties can all generate growth in consultant numbers under the stated assumptions but there is no indication how adequate that growth might be. Table 2 attempts to illustrate this by itemising calculated training needs based on target consultant numbers 10 years hence. A major determinant in estimating future consultant needs is the professional view obtained through specialist publications and the local advisory structure. In determining SpR needs based on consultant projections, allowance has been made for migration, work-life balance issues and service development. The figures presented are a summary of the work of each SAC as considered by HSSC at its meeting in February.

7. Those specialties considered thus far are not included in this list, nor are those where current training numbers/capacity are considered adequate- ophthalmology, paediatric surgery and neurosurgery.

8. Just as there are issues about sustaining consultant numbers in some specialties, there are issues about sustaining current SpR numbers also. This factor is most notable in palliative medicine and oncology. Both training programmes have been highly dependent on support from cancer charities since the mid 1990s. This support was always envisaged as time limited and in many cases has extended beyond the term originally intended. The situation is particularly acute in palliative medicine but also introduces inherent instability in the medical oncology training programme. For this reason, it is proposed that the value of 1 post in each specialty is held to maintain current numbers.

	TABLE 3 ESTIMATED TRAINING NEEDS	SpRs 03/04	estimated SpR needs	SpR shortfall	Potential growth from current resources
1	Paediatrics	32	74	42	131%
2	Anaesthetics	59	93	34	101%
3	Radiology	33	55	22	321%
4	AE Medicine	11	30	19	251%
5	Adult Psychiatry	27	39	12	131%
6	Oncology	20	32	12	601%
7	Learning Disability	4	15	11	501%
8	Neurology	4	15	11	331%
9	Endocrinology	9	17	8	51%
10	Gastroenterology	11	19	8	131%
11	Geriatric Medicine	10	18	8	61%
12	Orthopaedics	23	31	8	341%
13	Rehabilitation	2	9	7	1501%
14	Child/Adolescent	8	14	6	51%
15	Dermatology	6	12	6	201%
16	Nephrology	5	11	6	271%
17	Haematology	11	16	5	151%
18	Microbiology	7	12	5	131%
19	Rheumatology	7	12	5	151%
20	Respiratory medicine	14	18	4	271%
21	Cardiology	21	24	3	431%
22	Genetics	3	6	3	1001%
23	Chemical Pathology	3	5	2	251%
24	GUM	4	6	2	751%
25	Histopathology	13	15	2	251%
26	Occupational Health	2	4	2	401%
27	Palliative Medicine	4	6	2	51%
28	Plastic Surgery	7	8	1	711%

9. In determining actual funding of specialties, the following factors have been taken into account.

- The disparity between current SpR numbers and estimated needs;
- Those specialties projecting low levels of consultant growth;
- Where the first two factors are broadly similar, those specialties that have received least investment in the past three years.
- Clear local policy on numbers as a result of service reviews

Paediatrics

10. This specialty shows the largest shortfall between current SpR numbers and estimated needs. Proposals to date, based on trust action plans, and funded through a separate allocation, will result in at least 8 additional SpR posts. As there are issues of availability of suitably qualified staff to take up this number of posts no further allocation is proposed.

Anaesthetics

[redacted]