MEETING OF SPECIALTY ADVISORY COMMITTEE - PAEDIATRICS. TUESDAY 8 NOVEMBER 1994 AT 2.15PM ROOM 414, DUNDONALD HOUSE.

AGENDA

		Paper
1	Apologies	
2	Minutes of the meeting held on 21 October 1993	1/94
3	Matters arising from the Minutes: Report of the Sub Group on Child Heath Services	
4	Paediatric Intensive Care	2/94
5	Reporting of Equipment Defects	3/94
6	Central Medical Advisory Structure	4/94
7	Recent Technological Advances in the Specialty	5/94
8	Expert Advisory Group on Cancer - A Policy Framework for Commissioning Cancer Services	6/94
9	Manpower in Paediatrics	7/94
10	Covert Video Surveillance	8/94
11	Disability and Perinatal Care: Measurement of Health Status at Two Years	9/94
12	Purchasing Function and Structures Review Report - Implementation of Ministerial Decisions	10/94
13	Child Protection: Medical Responsibilities	11/94
14	Any Other Business	

INFORMATION

Review of the Purchasing Function and Structures in the Northern Ireland Health and Personal Social Services

MINUTES OF THE MEETING OF SPECIALTY ADVISORY COMMITTEE - PAEDIATRICS HELD ON TUESDAY 8 NOVEMBER 1994 AT 2.15 PM IN ROOM 414 DUNDONALD HOUSE

Present:

Dr A T Brown
Dr D A Brown
Dr D Carson
Prof J Dodge
Prof H L Halliday
Dr M Hollinger
Dr J Hutchinson
Dr J G Jenkins
Dr J McAloon
Mr S Potts
Dr K Sharma
Dr D Wilson
Dr J Wilson

DsPH/Reps:

Dr C Beattie
Dr F Kennedy
Dr F M Watters

Department:

Dr C E Hall (Chairman)
Dr J D Acton
Dr A Mairs
Mr M O'Donnell (Secretariat)

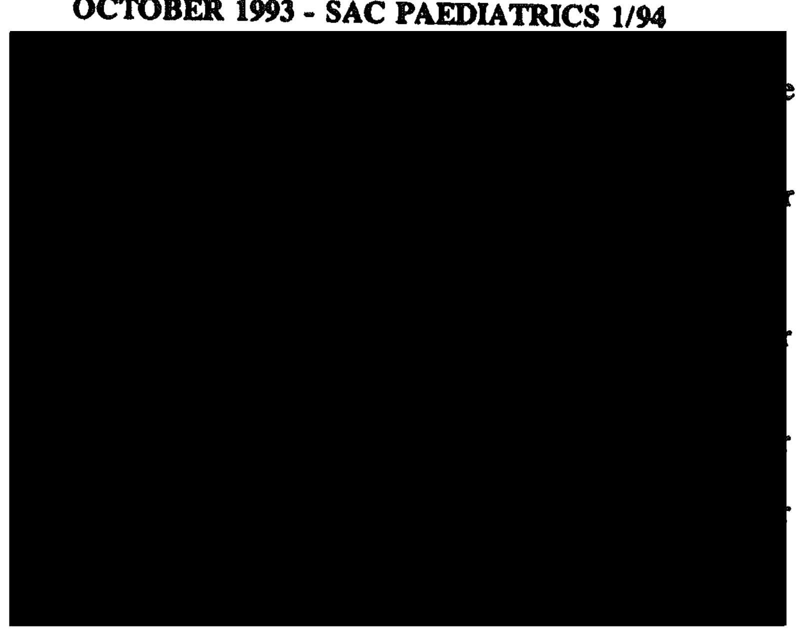
In Attendance:

Dr S Kielty (Item 4)

1. APOLOGIES

FURTHER ACTION

2. MINUTES OF THE MEETING HELD ON 21 OCTOBER 1993 - SAC PAEDIATRICS 1/94



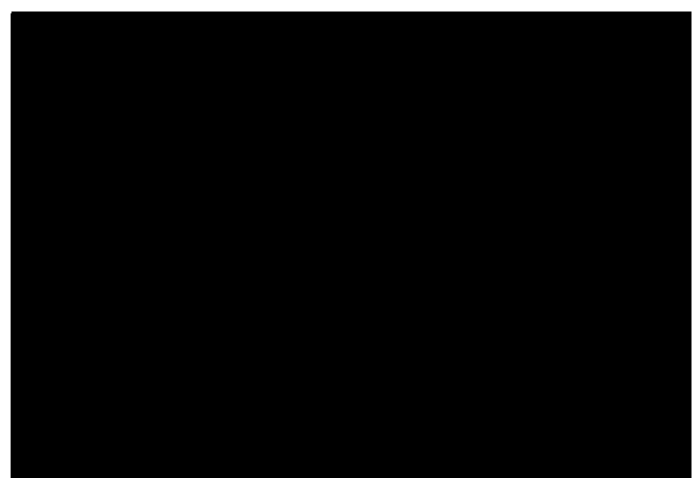
3. MATTERS ARISING

(i) Remit of SAC

Professor Dodge said he had consulted with the child psychiatrists who would be pleased to be represented on SAC. It was agreed that they would be invited to nominate a representative when SAC is reconstituted next year.

DHSS to seek nominations from child psychiatrists

(ii) Adult Cystic Fibrosis Care



(iii) Report of the Sub Group on Child Health Services

Dr Acton said the Report had been generally well received and the four Board Managers and Directors of Public Health were supportive. However, there had been some concern that nursing staff and PAMs had not had an input. He said the ME will respond to the Report before the New Year. The discussion generated by it had alerted the ME to the fact that the service is underfunded.

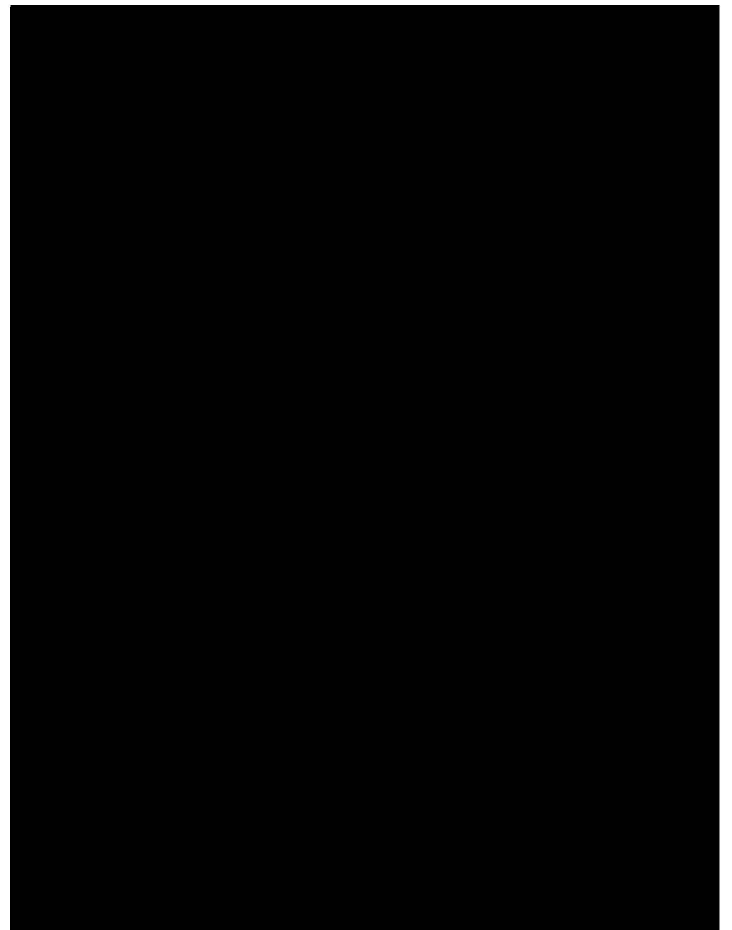
Dr Jenkins was grateful for the work done so far, but expressed the frustration in the profession at the lack of real progress. He said this was due to lack of guidance from the ME, and asked how the SAC could assist in bringing the matter forward. Dr Hall replied that the views of the SAC will be brought to the attention of the ME.

Minutes of SAC to be brought to attention of Mr P Simpson

Mr Potts said the tabled letter from

Mr Stephen Brown brought together a number of concerns about the service. Dr Acton said the report was not intended to be an overview of the entire service, and asked for the views of the other members on Stephen Brown's suggestion that it would be wrong to appoint a consultant who could not undertake acute hospital work to a community post. Most members did not agree and Dr Carson felt that the term "Consultant Paediatrician in Community Child Health" should be dropped, and all consultants working in paediatrics should be referred to as consultant paediatricians.

(v) Paediatric Nephrology Service



(vi) Funding for Laparoscopic Surgery

(vii) **Regional Neonatal Intensive Care Audit Group**

4. PAEDIATRIC INTENSIVE CARE - SAC PAEDIATRICS 2/94

Dr Mairs introduced this item, outlining the background to the review and stating its purpose. He drew attention to the seven main issues raised, and asked for comments.

- It was generally agreed that there should be 8 paediatric intensive care (PIC) beds and 4 high dependency beds with the ability to alter the number of PIC beds in response to fluctuations in demand. Professor Halliday said the exact number would depend upon whether the beds would be used for post-operative recovery and neonatal care.

- Members felt that nurse staffing levels were already low, and that any increase in the number of beds would worsen this situation. Dr Kielty said that an adequate number of nursing staff was of key importance to the provision of the service. Professor Halliday asked if nursing staff were being utilised flexibly. Dr Kielty said that this was common practice. Mr Potts supported this comment, and said the service relies heavily on the dedication of nurses who work long hours.

- Professor Halliday said that transfer arrangements needed to be addressed. He said a regional outreach service may be needed. Although there are at present only 3 neonatal transfers each week, he felt that sharing the service with PICU might provide sufficient volumes to be viable. Dr McAloon said neonates are better served at present than older children. Dr Jenkins asked that

models in operation in other countries should be examined. It was suggested that this could be considered by the proposed Provincial Specialty Group.

Provincial Specialty Group to consider transfer arrangements in other countries

- Regarding the recommendation by the BPA that all children should be treated in a PICU, Dr Jenkins said Dr Mulholland had asked him to mention that he would like to see all post operative children cared for in a PICU if possible. Members agreed that this issue should be taken forward in a different forum, namely the proposed Provincial Specialty Group. Professor Dodge referred to plans for a regional trauma service which includes children. He said that members would be totally against the PICU being subsumed within the regional trauma centre. Dr Hall assured Professor Dodge that there was no intention of undermining the PICU. Dr Beattie said since some children are treated in an adult intensive care unit at present, the development of the PICU could be part funded from resources currently directed at the adult ICU.

Provincial Specialty Group to consider the post-operative care of children

- Members had no particular comments to make on the training of nurses.

- Regarding the representation on SAC Paediatrics of a consultant working in paediatric intensive care, Dr Kielty said he had been a member of the SAC some time ago. It was agreed that a nomination would be sought when the committee is reconstituted next year.

DHSS to seek nomination of consultant in Paediatric intensive care

- Dr Kielty said it was not appropriate for him to comment on links with cardiothoracic surgeons, since none were present, although they had a good working relationship.

5. REPORTING OF EQUIPMENT DEFECTS - SAC PAEDIATRICS 3/94

6. CENTRAL MEDICAL ADVISORY STRUCTURE - SAC PAEDIATRICS 4/94

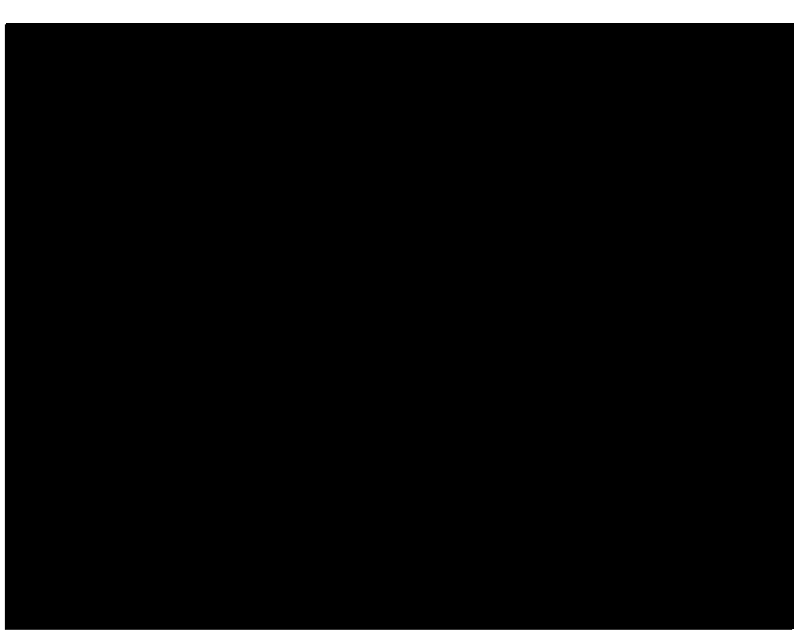
Dr Acton introduced this item, saying that the present advisory structure had been in place for eleven years, during which time major changes had occurred. The membership of all the central committees was now under review, and the advice of each was being sought. In particular, the participation of management was being offered for consideration.

Dr Jenkins felt that at the higher levels of the advisory structure, but not at SAC level, a general manager's input would be useful. He said the SACs should offer a purely professional/specialty view. Professor Halliday suggested that managers might be invited as observers. Dr Acton felt that this might inhibit open discussion by consultants. Dr Beattie said it was important to be clear about the role of each committee. She said most issues on SAC agendas do not concern managers, although manpower was less of a purely medical issue. There was general agreement that managers should not sit on SACs as either observers or members.

Regarding SAC Paediatrics, Dr Jenkins favoured the paper's final option of a Provincial Specialty Group giving nominations from each Board, with other nominations coming from the University, the NICPMDE and the Junior Doctors Committee of the BMA. He felt that SAC business could be more effectively addressed if meetings were held bi-annually. Dr Hall said that the Department's medical staff would have considerable resource problems in servicing additional SAC meetings. Dr Jenkins said that DHSS representation on the Provincial Specialty Group would be helpful. He said Dr Valerie Gleadhill, as BPA representative, would be asked to convene the group and agree its membership. The remit will be agreed at its inaugural meeting. It was agreed that Dr Gleadhill would be asked to write to Dr Hall seeking a Departmental representative.

Dr Gleadhill to be asked to write to Dr Hall

7. RECENT TECHNOLOGICAL ADVANCES IN THE SPECIALTY -SAC PAEDIATRICS 5/94



8. EXPERT ADVISORY GROUP ON CANCER - A POLICY FRAMEWORK FOR COMMISSIONING CANCER SERVICES - SAC PAEDIATRICS 6/94

9. MANPOWER IN PAEDIATRICS - SAC PAEDIATRICS 7/94

In summarising this paper, Dr Acton stated that there were now 30 consultant paediatricians in-post and the target for an average annual growth rate of 2 consultants had been achieved over the past 5 years. In addition, there was one consultant in medical genetics and 2 in paediatric cardiology. In the training grades, there were 12 SRs and 8 Rs of whom 2 were job-sharing.

Consultant opportunities over the next decade were

estimated to be 36 of which 6 would emerge through retirements and 10 would be consequential to the implementation of the Calman recommendations. The remaining 20 posts represented the target growth of 2 per year. Based on these estimates and allowing for 10% loss from the training grades, he proposed that the number of SR/Rs should be increased to 18 in 1995, ie an increase of 3 posts. However, he suggested that recruitment should not exceed 5 or 6 Regs in one year. In addition, the 3 posts specifically allocated to part-time training would be maintained. After discussion, members approved this proposal.

Dr Acton stressed that funds for the creation of new posts would be very limited in the current stringent financial conditions. As far as possible, any new higher specialist posts should be created through the conversion of SHO posts. A special case would have to be made to the ME to fund new R/SR posts which could not be created through conversion of existing SHO posts. He also suggested and members agreed that the NICPMDE, through the Paediatric Training Committee, was the body most competent to recommend the location of any new posts. The need to ensure appropriate educational approval for posts occupied by SR/Rs would also be the responsibility of the Council and would be a condition of the 50% postgraduate funding arrangements.

Members then considered a number of sub-specialties. Dr Acton stated that a second appointment had recently been made to specialist training in Medical Genetics as recommended by SAC. Members agreed that training numbers should be maintained at 2 in anticipation of a 3 consultant service in the future and welcomed the Consortium's commitment to a second consultant post soon to be advertised.

Members noted that the Consortium had recently approved funding for a consultant post in paediatric neurology and a consultant post in paediatric nephrology.

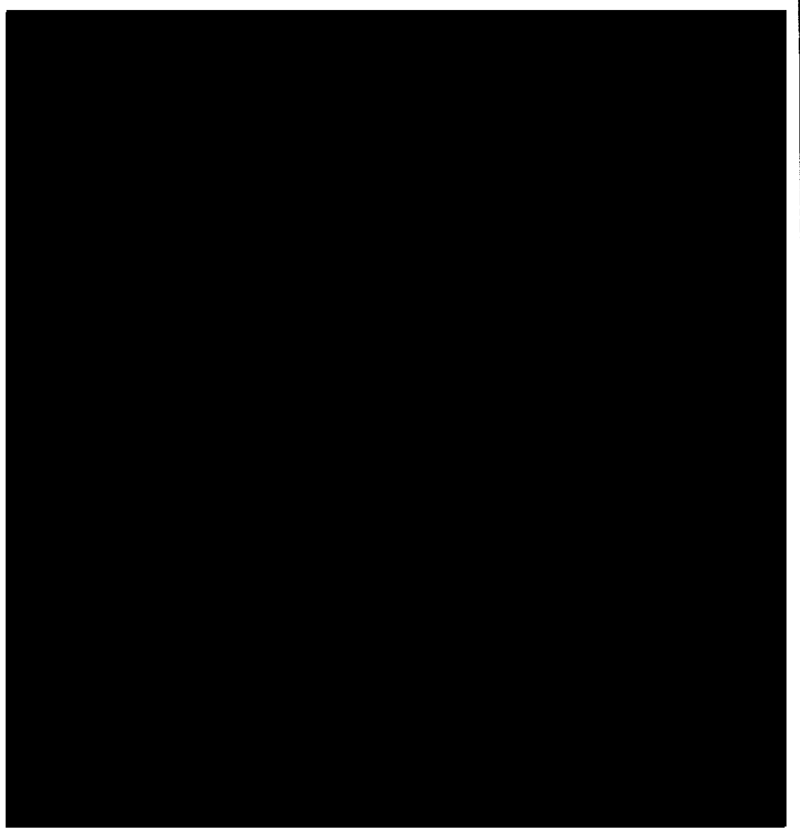
Members discussed training in the community and noted progress in expanding training opportunities in higher specialist training. Limited progress only had been made at the SHO basic specialist grade mainly because funding arrangements had not historically provided for this training. It was agreed that the ME would co-operate with the NICPMDE Training Committee in promoting funded and

educationally approved SHO posts combining hospital and community training.

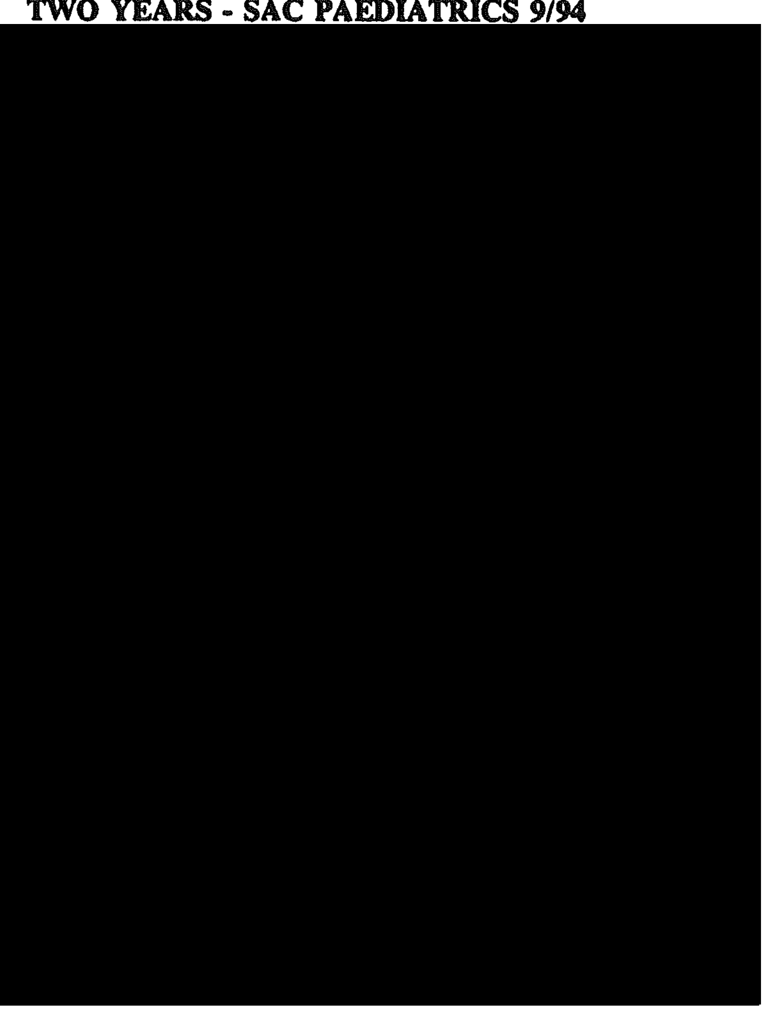
Dr Acton reported that the ME had agreed in principle to a pilot scheme to explore opportunities for the further training of CMOs and SCMOs and a recent survey of Community Units/Trusts indicated that such an initiative would be welcomed by management and medical staff. The JCHMT had also expressed its support. Dr Acton pointed out that no further action could be taken until funding for the scheme had been secured.

Professor Dodge informed members that the present lecturer in Child Health had recently been appointed to a consultant post in England. This appointment would have substantial implications for the gastro-enterology service at RBHSC and a new consultant would be required to fill the consequent service gap. He drew attention to the need to maintain the academic and research elements of the lecturer post and he hoped that the SR expansion could continue so that the intended function of the lecturer post could be protected.

10. COVERT VIDEO SURVEILLANCE - SAC PAEDIATRICS 8/94



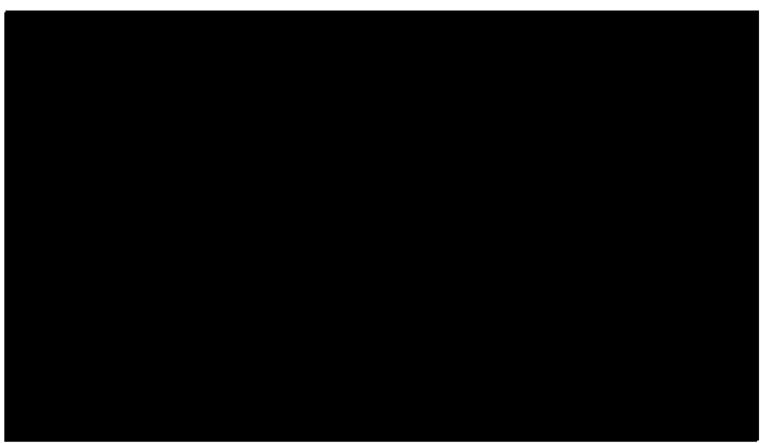
11. DISABILITY AND PERINATAL CARE: MEASUREMENT OF CHILD HEALTH STATUS AT TWO YEARS - SAC PAEDIATRICS 9/94



Dr Beattie to convene group and ask Mr Adams to nominate a senior nurse

12. PURCHASING FUNCTION AND STRUCTURES REVIEW REPORT - IMPLEMENTATION OF MINISTERIAL DECISIONS - SAC PAEDIATRICS 10/94

13. CHILD PROTECTION: MEDICAL RESPONSIBILITIES. SAC PAEDIATRICS 11/94



14. ANY OTHER BUSINESS

Dr A T Brown asked that paediatricians consider a standard age limit for transfer from paediatric to adult services, since there was at present a range from 14 to 18 years. Members agreed that lack of standard agreement often caused problems with adolescents. Mr Potts said that anaesthetists would not like to see the standard age rise above 14 years. Members agreed that this was another item that could be considered by the Provincial Specialty Group.

Provincial Specialty Group to consider standard age for transfer

Dr Hall thanked members for attending and closed the meeting.