MINUTES OF THE MEETING OF SPECIALTY ADVISORY COMMITTEE PAEDIATRICS HELD ON TUESDAY 29 SEPTEMBER 1998 AT 2.15, PM IN CONFERENCE ROOM C3.18, CASTLE BUILDINGS.

PRESENT

Dr B Craig
Dr C Gaston
Dr M O'Connor
Dr V Boston
Dr A Black
Dr M Shields
Dr J McAloon
Dr B Bell
Dr D A Brown
Dr M Hollinger
Dr K Sharma
Dr J G Jenkins
Dr M Stewart

DsPH/Representatives
Dr A M Telford
Dr C Beattie
Dr F Kennedy
Dr R Smithson

DHSS
Dr H Campbell (Chairman)
Dr M Boyle
Dr P Woods
Mrs I Wilkinson (Secretariat)

1. ITEM 1 - APOLOGIES

[redacted]

2. ITEM 2 - MINUTES OF THE MEETING 6 NOVEMBER 1997 - PAPER 1/98

[redacted]

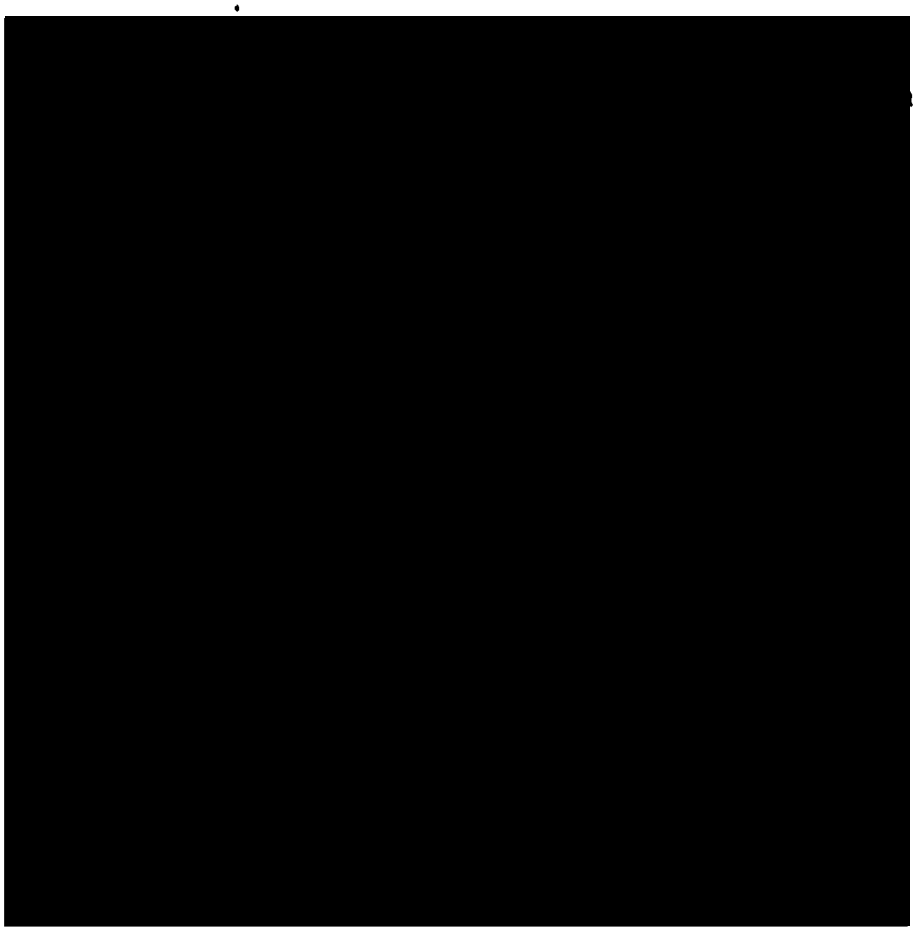
3. ITEM 3 - MATTERS ARISING

[redacted]

4. ITEM 4 - MINUTES OF THE MEETING 23 JUNE 1998 - PAPER 2/98

[redacted]

- **Report of the High Risk Pregnancy Group - Update - Paper 2A/98**



- **Report on Hospital Services for the Acutely Ill Child - Update**

CMO informed the committee that this document had already been presented to the Health and Social Services Committee. They had accepted the document on the priviso that additional costs be included, particularly the cost of a neonatal transfer service.

- **Paediatric Surgical Services in N.I. - Update**

Dr Telford introduced this document reporting that it had been further revised to take account of comments and concerns. The document also included timescales for implementation.

CMO thanked Dr Telford for chairing the group and advised the document would now be presented to SAC Anaesthetics to be held 20 October and SAC General Surgery to be held 19 January 1999.

There was some discussion about the changes to Paediatric Surgical Services now recommended to be provided at the Ulster Hospital.

CMO stated that she had received a number of letters from GPs expressing their concerns about these changes. She felt that these concerns were unwarranted as the Ulster Hospital would still be the first door of entry for Acutely Ill Children for assessment and possible admission. She said GPs should now refer a child to the Royal Belfast Hospital for Sick Children for head injury, or, if likely to require surgery.

CMO asked those present to highlight this issue at their own advisory committees.

5. ITEM 5 - WORKFORCE PLANNING - PAPER 3/98

Dr Woods introduced this item by reporting that the number of Consultant Paediatricians in post at September 1998 was 48, an increase of 3 on one year previously. Since 1991 this represented an average annual increase of 9.2%. Historically, Northern Ireland was under-represented in terms of consultant paediatricians in comparison with other UK countries but this under provision had lessened in recent years.

He then went on to outline the factors that would affect the size of the consultant workforce in future, highlighting increasing public expectation, technological developments and specialisation as factors that would increase requirements. However, he indicated that declining birth rate and childhood population would moderate these effects. Taking account of 7 anticipated retirements over the next decade he anticipated a total of 29 consultant vacancies in that period. Based on 5.5 years in training and allowing for losses of one specialist registrar every second year he calculated a required training complement of 19. However, he proposed that numbers be maintained at their current level of 22 to take account of the marked demand for flexible working within the specialty and also the need to develop training in various sub-specialty areas. Following discussion members endorsed this proposal.

Dr Woods then reported on the current position in a number of sub-specialty areas. He highlighted that a trainee had been appointed in paediatric cardiology in anticipation of a vacancy through retirement. Similarly, he stated the need to establish a post in paediatric A&E in anticipation of a retirement in the near future. Members endorsed this proposal.

6. ITEM 6 - PAEDIATRIC MANPOWER DEVELOPMENT - PAPER 4/98

Dr Jenkins introduced his paper on specialist paediatric medical workforce planning. He reported that, over recent years differential growth in consultant numbers between the Regional Centre and elsewhere had led to restricted availability of special advice. He felt there was a need to address this

deficiency in line with RCPCH recommendations. Issues that needed to be addressed included the avoidance of single handed specialist consultants, the ongoing need for general paediatric services at the tertiary centre and the relationship with academic paediatrics. In response CMO agreed there was a need to quantify and prioritise requirements in specialist paediatric services and that this should be taken forward on an urgent basis. Dr Jenkins reported that an informal group had met to consider this issue, consisting of himself, Drs Woods, Stewart, Hicks and Professor McClure. It was suggested that Dr Beattie would have a valuable input and there was a need for representation from QUB. Dr Woods agreed to take this forward.

7. ITEM 7 - SCREENING

- **Child Health Screening - Paper 5/98**

[redacted]

- **Antenatal Screening - Paper 6/98**

[redacted]

8. ITEM 8 - CANCER SERVICES FOR CHILDREN - PAPER 7/98

[redacted]

[redacted]

9. **ITEM 9 - THIRD ANNUAL REPORT OF THE N.I. NEONATAL AUDIT GROUP - PAPER 8/98**

Dr Jenkins introduced this report and highlighted that the temperature of inborn babies was in fact lower than the temperature of those transferred from other units. Variation between obstetric units in the use of antenatal steroids was highlighted. It was recommended that this was drawn to the attention of obstetricians. It was agreed this report should go to SAC Obstetrics and Gynaecology to be held 17 November 1998. CMO commended Dr Jenkins on his input to this report and emphasised the importance of ensuring that the audit loop was closed.

10. **ITEM 10 - FIT FOR THE FUTURE**

CMO asked if members had the opportunity to comment on the document as it was important that professionals had an input at a strategic and operational level. Members sought clarification of how tertiary services would be managed within the new structure. CMO advised them of the need for a regional body similar to the Consortium to look after tertiary services.

11. **ITEM 11 - ACUTE SERVICES REVIEWS - PAPER 9/98**

[redacted]

12. **ITEM 12 - TOBACCO WHITE PAPER - PAPER 10/98**

[redacted]

13. ITEM 13 - IMPLICATIONS OF A DEVOLVED ADMINISTRATION

CMO advised the committee that by the end of this calendar year we should have in place a Health Minister, and a Health Committee. It was emphasised that for professionals this could be seen as an opportunity to have closer contact with decision makers.

14. ITEM 14 - CLINICAL QUALITY/CLINICAL GOVERNANCE - PAPER 11/98

CMO explained that new structures were being formulated to drive the quality agenda. She informed members that clinical governance will focus on the overall service performance rather than on individual performance standards.

15. ITEM 15 - ANY OTHER BUSINESS

[redacted]

FEBRUARY 1999

SAC PAEDIATRICS 29 SEPTEMBER 1998
ACTION POINTS

ACTION POINTS

[redacted]

Completion of ongoing work on specialist paediatric medical workforce planning — **Dr P Woods**

[redacted]

[redacted]

FEBRUARY 1999

CLINICAL QUALITY AND CLINICAL GOVERNANCE

Quality has been given a strong emphasis both in the Government's Discussion paper "Fit for the Future" and the English White Paper - "The NHS, Modern and Dependable". The main initiatives to drive forward the quality agenda include:

1. The introduction of a statutory duty of quality in the Health Service.

2. The development of evidence based service frameworks for service provision along the model of the Campbell report on Cancer Services.

3. The establishment of a National Institute of Clinical Excellence (NICE) to co-ordinate the production and auditing of National Clinical Standards.

4. The establishment of a Commission for Health Improvement (CHIMP) to monitor clinical standards and investigate poor performance.

5. The development of clinical governance arrangements to ensure corporate accountability for clinical performance.

The Department is currently considering the legislative requirements for the introduction of these issues including the establishment of a statutory duty of quality and legislative support to allow Northern Ireland to link with NICE and CHIMP if this is deemed appropriate. Once the legislative issues are resolved a Northern Ireland discussion document will be produced to facilitate a wider debate. In order to assist with the formulation of this discussion paper initial professional views would be welcome on:

1. The appropriateness and feasibility of using or adapting GB National Service Frameworks in Northern Ireland.

2. The establishment of a link between Northern Ireland and NICE and the interface with CREST.

3. The need to develop a separate monitoring and investigative body like CHIMP in Northern Ireland.

4. The practical implications of setting up Clinical Governance structures and arrangements in provider units.

It must be stressed that considerable progress in improving clinical quality and effectiveness has already been made in Northern Ireland in recent years. This includes the work of CREST and the development of clinical guidelines, the widespread

introduction of medical and multi-professional audit, the commitment to clinical effectiveness and evidence-based practice, the establishment of the R&D office, and the lessons learnt through risk management. Education training and professional development will continue to cement these initiatives together to improve practice and implement change. The main challenge will be to ensure that the future quality agenda builds on this existing infra-structure and avoids duplicating the excellent work which has already been done. The views of SAC are sought on how best to meet this challenge.

PHILIP McCLEMENTS

August 1998