

## **Executive Medical Director**

### **1. Function and Scope**

The Medical Director is a member of both Trust Board and the Senior Management Team and reports to the Chief Executive. The post holder is required to lead strategic direction of general and specialist medical services across the Trust including all professional and policy development, promote the highest professional medical standards in a quality driven environment and thereby improve medical effectiveness and have oversight of clinical functions discharged by the Trust. The Medical Director also provides specialist medical advice to the Trust Board and shares corporate responsibility for the governance of the Trust and compliance with legal requirements.

The Trust Board appoints the Medical Director for three years. To date, the Trust has had three Medical Directors (part time) who continued to maintain full clinical caseloads.

The Medical Director to date has been based at Holywell Hospital with administrative support on that site. The Medical Director is not a budget holder with the medical budget being fully devolved to the operational directorates.

The Trust employs about 100 doctors across four service areas. These medical services are embedded and managed in the operational directorates. Each service area has a Lead Clinician or Clinical Director reporting to the Operational Director. The Medical Director does not have line management responsibility for medical staff but will advise on professional issues. The medical director is expected to provide the lead in; professional, disciplinary issues, job planning, appraisal, revalidation and junior doctors hours.

### **2. Services Areas**

#### **2.1. Community Paediatrics**

Dr Alison Livingstone is the Lead Clinician / Clinical Director for the community paediatric service reporting to the Director Child Health and Allied Health Services. The service is staffed by 3 consultants and 9 NCCG doctors and is based on the Masserene site in Antrim. The consultants form part of the on call system at Antrim Area Hospital and act as ward-chief on a rotational basis. The team are under considerable pressure to maintain service due to increasing demand, staff changes, impact of contract changes and financial limitations.

## **2.2. Child & Adolescent Mental Health Services**

Dr Peter Gallagher is the Lead Clinician / Clinical Director for the CAMH service reporting to the Director Child Care Services. CAMHS is a board wide out patient service, currently based in Antrim. Though sectorised into 3 teams, the service is provided by two consultants. Funding had been available for a third consultant but the Trust were unable to recruit because of a regional shortfall in trained staff.

Services are made more difficult because of the failure of adequate regional provision for inpatient treatment of children and adolescents leading to increased pressure on out patient provision and admission to adult units. Service demand continues to increase but despite this, significant improvements have been made to waiting times.

## **2.3. Family Planning**

The Trust provides Family Planning Clinics across the Homefirst area. Twenty-one medical officers (mainly part time) are managed by Dr Tara Farrington in the Child Health and Allied Health Services Directorate.

The service continues to develop despite changes in staff, the impact of new contracts and accommodation difficulties.

## **2.4. Mental Health Services**

The Mental Health Directorate represents the largest area of medical expenditure in the Trust. Dr Gerry Lynch is the Clinical Director and manages the 50 medical staff. The Trust employs a range of full and part time staff to provide medical input to; General Adult Psychiatry, Intensive Care, Psychiatry of Old Age, Challenging Behaviour, Rehabilitation Psychiatry, Addictions, Forensic and Liaison Psychiatry. In the last two years two new service areas have been developed; Assertive Outreach and Crisis Response.

The service faces many challenges in the next three years:

- Bamford Review
- Re-alignment with Causeway
- Regional inpatient provision
- Mismatch between policy and demand
- Difficulty in recruitment
- New consultant contract

### **3. Challenges**

#### **3.1. New GMS Contract**

The introduction of the new General Medical Services contract has led to a fundamental review by GP's of their work practices. In many areas this may lead to a change in service delivery with an emphasis on specific targets, prioritisation of activity and progress toward chronic disease management. Many GP's have opted out of provision of out of hours cover which is leading to alternative service provision. The new GMS contract will both impact services directly (eg Lithium Management) and indirectly (eg staffing in Family Planning).

#### **3.2. New Consultant Contract**

A new contract with new terms and conditions for all consultant staff was introduced in 2004. The implementation to this new contract differed across the UK. This has led to problems with the introduction of the contract:

- Increased costs
- Increasing level of appeals
- Poor benefits realisation
- Lack of certainty over future funding
- ?Less transparency

#### **3.3. Agenda for Change**

Agenda for Change will introduce opportunities for changed work roles and patterns for many staff. With the evolution of these roles, there is potential to impact upon demands on medical time.

#### **3.4. Modernising Medical Careers (MMC)**

A complete reform of medical undergraduate education is underway and this links to an updated format of postgraduate training and career progression. Unfortunately the latter is part implemented and part still under discussion!

- General Medical Council
- PMETB / NIMDTA
- Foundation Training / Run through Training
- Royal Colleges
- CCST / CCT

#### **3.5. Job Planning**

The new consultant contract has introduced a new form of job planning for senior medical staff.

This time consuming annual process seeks to link clinical activity to the corporate objectives. The initial plan for a highly specific, time based work schedule has proved to be too inflexible. Problems are anticipated for future job planning cycles due to fundamentals in the contract.

### **3.6. Appraisal**

Medical Appraisal was introduced in 2001 for Consultant staff and subsequently for GP's and NCCG doctors. Appraisal for doctors in training is not in place. There is a lack of clarity of roles in the appraisal of the latter in the light of MMC. Medical Appraisal is a peer based appraisal with inputs only from the appraisee and therefore is very different from traditional appraisal. Difficulties will arise with attempts to integrate appraisal with job planning **and** Revalidation.

### **3.7. GMC & Revalidation**

As a result of public concerns, the General Medical Council introduced a series of proposals to licence and revalidate doctors. These were due for implementation in Jan 2005. The Inquiry into Shipman made recommendations in Dec 2004, which directly impacted the proposals. Dr Donaldson (CMO, England) is reviewing the whole area and is expected to make recommendation in the near future.

### **3.8. European Working Time Directive**

EWTD has had a major impact on the working hours of doctors in training. The Trust has been successful making substantial reductions in the hours worked. Further reductions will be required and may lead to further changes in work patterns for service delivery. The EWTD tends to mitigate against smaller local units because of on call requirements. EWTD will impact on the work patterns of many staff groups and may impact continuity of care.

### **3.9. Workforce**

The medical workforce nationally and regionally is undergoing considerable change. The age and gender balance is changing with increasing trends toward improved work/life balance and early retirement having a marked impact on staff availability. Medical training, both undergraduate and postgraduate, has been unable to match supply to demand leading to national shortfalls in many specialist areas. The current national plan to increase undergraduate numbers and shorten specialist training (MMC) will impact but the shortfall will continue for at least the next five years.