**Title:** Medical Director’s Report

**Report to:** Trust Board

**Date:** 28 November 2016

**Security Classification:** Public Board Meeting

**Purpose of Report:**

This is the fifth Medical Directors Board Report.

It includes:
- Smokefree
- Quality Improvement
- New contract and rota issues
- Visits and clinical engagement
- External engagement and activities
- Clinical Work

**Recommendations:**

The Trust Board is asked to note the report.

**Sponsor:** Maria Kane, Chief Executive

**Report Author:**

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**Report History:** Regular Report

**Budgetary, Financial / Resource Implications:** No particular matters to highlight

**Equality and Diversity Implications:** No particular matters to highlight

**Links to the Trust’s Objectives, Board Assurance Framework and / or Corporate Risk Register:**

The associated risks are managed through the Risk Register and Board Assurance Framework.

**List of Appendices:**

- None
1. Introduction

1.1 This report describes the work of the Medical Director, principally since the last Board Meeting on 26 September 2016.

2. Smokefree

2.1 The Trust continues to make good progress towards implementation of the Trust’s Smokefree Policy on 17 January 2017. As the date approaches, the Smokefree Implementation Committee has been meeting fortnightly and has been well attended, and now has good representation from all boroughs.

2.2 The Implementation Committee has engaged with staff in all boroughs, has developed communication materials (banners, posters, and leaflets), and has developed the new Trust Smokefree Policy together with an inpatient protocol and a Pharmacotherapy Protocol describing how Nicotine Replacement Therapy (NRT) is to be provided on inpatient units within 30 minutes when needed. Open meetings have taken place in each borough (with varying success). Training (both e-learning- level 1, and face to face- level 2) have been launched.

2.3 While concerns persist about the effective support to be provided to smokers newly admitted to wards, the Trust is also focussing on the community teams. These need both to advise and support service users at risk of admission, and also those discharged from wards on NRT who need advice and help if they are not to resume smoking immediately. There is an ongoing need for engagement of ward staff, who will be offered practical training in the delivery of NRT, in addition to the more theoretical training available on-line.

3. Quality Improvement

3.1 Together with other members of the Executive Management Team, I am getting involved in the development of Quality Improvement in the Trust. I attended the two Haelo collaborative sessions, on 31 October and 21 November, and am sponsoring three collaborative groups at Wormwood Scrubs, the Phoenix Unit and in the Haringey Acute wards. I also attended the ‘Haelo Hosts’ conference in Salford on 11 and 12 November. The conference was fascinating and well delivered, and demonstrated the importance of inspirational personal narratives in motivating staff to participate in quality improvement. I continue to progress work with Haelo to develop Quality Improvement Fellows as part of changes to the current role of Deputy Medical Director.

4. New contract and medical rota issues

4.1 I am meeting regularly with Mark Vaughan, Executive Director of Workforce, colleagues from Medical HR, Gareth Jarvis, the Guardian of Safe Working, and doctors in training to plan the implementation of the new contract from 1 April 2017. This is progressing well, and new rotas have been drawn up and costed. The BMA have formally ended the dispute, and it seems probable that the contract can be implemented without difficulty.

4.2 On 4 November I met with Steve Powis, Medical Director RFH, Mark Berelowitz, CAMHs lead RFH, Mike Greenberg, Paediatrics lead RFH, Ruth Ouzia, Senior Ops Manager Children’s Servcie’s RFH, and Eamann Devlin and Neil Snee (from Barnet CCG) to discuss the future of the interim protocol for CAMHs cover to Barnet A&E, which has now been in place for over a year but remains a source of concern to our consultants. We were again assured of Barnet CCGs commitment to additional investment in CAMHs liaison services and their intention to develop a new service model which will support our consultants. While
it is encouraging that the CCG appear committed to improving the service, the new investment has been delayed previously and I and RFH colleagues emphasised the importance of making progress before the end of the current protocol on 9 January 2017.

4.3 While problems with CAMHs cover in Barnet remain unresolved, a problem is now developing in Haringey and Enfield, where the Deanery have advised the Trust that we may not ask STs in adult psychiatry to see anyone under the age of 18. CAMHs consultants in these areas have up to now been taking part in an on-call rota on the basis that the cover they provide is ‘telephone only’ (though on my advice they have not in practice declined to attend in emergency). In my view this is now unsustainable as it is a requirement of the Mental Health Act, and indeed safe clinical practice, that a child presenting out of hours should have access to CAMHs expertise, and at present the pathway for obtaining this is unclear and dependent on consultant goodwill. I will be meeting with the CAMHs medical staff on 30th November to seek a resolution.

5. **Visits and clinical engagement**

5.1 On 2 November I attended the excellent BEH Mental Health Law Conference; the teaching on mental capacity was of immediate value in my clinical work as I conducted a capacity assessment using the new material the following week.

5.2 On 7 November I led a Berwick learning event at the Chestnuts Community Centre on the subject of ‘Leaving Hospital Safely’. An audience of 70 (our largest to date excepting the Patient Safety Conference in January) heard a powerful and moving account from a bereaved carer. Rebecca Harrington, Non Executive Director of the Trust then presented the NICE guidelines on Transition between Mental Health Inpatient Settings and the Community ([https://www.nice.org.uk/guidance/ng53](https://www.nice.org.uk/guidance/ng53)), based on her experiences of chairing the development group, and I summarised lessons learned from a series of relevant SI investigations.

5.3 On 8 November I chaired the Clinical Cabinet. There was a lively debate about the role of the Cabinet in bringing together services of similar types across our borough Directorates. In addition to the Clinical Networks (8 of which are now functioning well across the organisation and reporting to the Cabinet), it was felt that the Cabinet had a role in bringing a clinical perspective to changes within the organisation. Some concern was expressed that the current plans to develop the Adult Pathway, while positive and creative, might also lead to an unhelpful divergence in service models across the organisation. It was suggested that there is now a need for a process of sharing local plans for the pathway across the organisation, and making sure that any significant differences in proposed service models across the organisation are fully understood and justified. This has been agreed by the Clinical Directors.

6. **External engagement and activities**

6.1 The new National Medical Director for Mental Heath, Professor Tim Kendall, has established a national network for mental health MDs, which has held two telephone conferences; at the first on 5 October we heard from Stephen Firn on new care models for tertiary services, and at the second on 2 November we heard from Paul Farmer about ‘holding NHS England to account for the delivery of the mental health transformation’. I also attend the London Medical Directors meeting, most recently on 12 November.

6.2 From 11-14 October I attended the first residential session of the ‘NHS Leadership Academy Director Programme’ in Leeds. I am one of 21 participants on the programme, none of whom are psychiatrists, and the majority are in leadership roles in acute Trusts or CCGs. While exposure to the wider NHS was initially daunting, the group bonded quickly. I look forward to developing my leadership skills and capabilities in a very different setting.
from anything I have been used to. The course continues for a further year, and I am grateful to the Trust for the opportunity.

6.3 I have continued to attend the STP Clinical Cabinet approximately fortnightly throughout the period, and also meetings of the NCL Mental Health Steering Group. It appears that the quality of the mental health element of our STP has been acknowledged by a national assurance review, but it will remain a challenge to ensure it is given sufficient time at the Clinical Cabinet.

6.4 On 3 November I met with Professor Glyn Lewis at UCL to discuss the possibility of developing further clinical academic roles within the Trust. This is challenging at present as UCL is not encouraging expansion in the numbers of academic staff, and post become available only as others vacate them. In addition it might be necessary for the Trust to fund some academic time in addition to the clinical part of the job. This will only be possible if an appointment would result in the delivery of recruitment to studies for which we receive funding from the CRN, but this is an option we will be exploring.

6.5 On 18 November I attended the Strategic Clinical Network for London. Having focused on standards for Early Intervention, Health Based Places of safety and perinatal services (for which BEH has recently obtained funding together with C&I and Tavistock and Portman) we are now considering our priorities for the next year, and I am advocating strongly for a clear focus on the future development of community mental health teams, particularly the sort of models of working across the primary secondary care boundary we are developing in BEH through our adult pathway.

7. Clinical Work

7.1 Since my last report I have done 20 sessions (10 days) of clinical work, seeing approximately 70 patients in clinic in addition to home visits (and a rare Mental Health Act assessment in the community), providing supervision for the clinical team, liaising with GPs and visiting the inpatient wards.

7.2 I continue to develop my interest in patients with autistic spectrum disorders who do not have learning disability (‘Asperger’s syndrome’), who are presenting with increasing frequency to services. I am now seeing about 12 people regularly in the clinic, and will describe their presentations and needs, and plans for service development, in more detail in future reports.

Ends.