Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

A University Teaching Trust

Title:	Medical Director's Report
Report to:	Trust Board
Date:	2 October 2017
Security Classification:	Public Board Meeting

Purpose of Report:

This is a regular report from the Medical Director to update the Trust Board on his activities since the last meeting, including matters he is required to report to the Board.

The report provides an update on the following issues:

- Smokefree
- Objectives and Initiatives
- Medical management and clinical leadership
- External engagement
- Clinical Work
- The Learning from Deaths Agenda

Recommendations:

The Trust Board is asked to note the report.

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Report History:	Regular Report
Budgetary, Financial / Resource Implications:	Smoking cessation training continues to be funded from existing budgets, and other costs of smokefree are noted in the report.
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

Report

1. Introduction

1.1 This report describes the work of the Medical Director, principally since the last Trust Board Meeting on 18 July 2017.

2. Smokefree

2.1 The smokefree policy and the possible impact of its implementation on fire incidents on wards was discussed at the Board in July, and subsequently by the Executive. Following this, in August I issued a reminder to all wards that Trust policy requires that smoking materials are destroyed when confiscated from patients (in line with the approach to other contraband such as alcohol) rather than returned to them for leave or discharge. This is necessary to ensure that periods of leave do not lead to confrontation over stored cigarettes, or to a return to the culture of 'smoke breaks' which we have so successfully ended.

2.2 I also took the opportunity to circulate the useful Care Quality Commission (CQC) briefing note on smokefree, which clarifies that smokefree is not in itself to be regarded as a blanket restriction, but that searches must be carried out on the basis of individualised risk assessments rather than in a blanket fashion. I have worked with the Associate Director of Communications, Karl Heidel, to revise and distribute new smokefree leaflets incorporating the experiences of the first six months of smokefree. I also continue to work with the Trust's Fire Safety Adviser, Frankie Faria, and the Director of Estates and Facilities, John Mills, on the consequences of smokefree. While there were no ward fires in August, a welcome improvement, there have been a number of episodes of smoke detectors being triggered by vaping, which will need to be addressed by restricting vaping only to areas where it can be done without risk of triggering alarms, or causing nuisance to others, in line with our vaping protocol. Smoking continues to be an issue in outside spaces, and I have been in discussion with the Medical Director of the Royal Free London NHS Foundation Trust about smoking on the Barnet and Chase Farm Hospital sites, where they provide the site security.

2.3 We were congratulated on our approach to smoking cessation by Diane Farmer of Public Health Haringey, who met with Karl and I in July to discuss possible collaboration on the 'Stoptober' campaign, which she leads on locally, and we hope to distribute their materials.

3. Objectives and Initiatives

3.1 Physical health care

3.1.1 The new physical health care leads are now in post and Andy Graham, Executive Chief Operating Officer / Acting Chief Executive, and I met with them on 27.7.17 to discuss what we hope they will be able to achieve, based on the actions agreed at the Quality and Safety Committee in May. They are Edwin Soda (Enfield), Taz Mhizla (Barnet) and Farai Zhawari (Haringey), and they will join Gavin Shields of the Specialist Services directorate who is already in a similar role.

3.1.2 I have drafted a Physical Health Care Strategy which sets the agreed actions in a wider context and proposes actions for the next three years; this has been discussed with the Executive, Clinical Directors and the Physical Healthcare Committee (on 21.9.17). A final draft will be presented to the Quality and Safety Committee in November.

3.2 Suicide strategy

3.2.1 A draft of the Suicide Strategy will be taken to the Quality and Safety Committee in November, based on the work at the Berwick event in May 2017 and the Patient Safety Conference in June 2017, as described in my last report.

3.2.2 I spoke on the subject of 'Talking about Suicide' to 200 GPs at the Barnet Clinical Commissioning Group's (CCG) Annual General Meeting (AGM) held at Allianz Park on 7.9.17, together with Cathy Wainhouse, Consultant with Barnet Child and Adolescent Mental Health Services (CAMHS), who spoke on suicide and self-harm in adolescents. The talks were well received and there were a number of powerful interventions from members of the audience with experiences to share.

3.2.3 I spoke on the same subject to a much smaller event at the North East London Faculty of the Royal College of GPs on 12.9.17; the format was of 'speed teaching' for groups of 4-5, which is a better format for learning and teaching on a subject which evokes strong feelings in GPs and often exposes challenges at the interface between primary and secondary care. I expect that one aspect of our Suicide Strategy will be offering teaching of this type to GPs and to other staff groups, as Rachel Gibbons our Suicide Lead has already done in Haringey.

3.3 Serious Incident (SI) Investigation

3.3.1 On 13.7.17 I attended a pre-publication meeting at NHS England (NHSE), together with members of the Patient Safety Team and Carole Bruce-Gordon, Acting Director of Quality and Integrated Governance for our lead commissioners, to review our action plan in response to the independent inquiry into EF, which was then published by NHSE in August (https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2017/08/2014_17458-Mr-EF-Final-Report-.pdf). The action plan is largely complete but will return to the Barnet Serious Incident Review Group (SIRG), and then to the Trust Wide SIRG for final sign off.

3.3.2 Data on SIs was presented to the Quality and Safety Committee on 12 September 2017.

3.4 Enablement

3.4.1 Our Enablement Clinical Strategy, in the form of 'Live, Love, Do', is now informing all aspects of the Trust's work and vision, such as the Quality Improvement (QI) collaboratives, as I was able to describe at the Trust's AGM on 18.9.17.

3.4.2 We have now completed work on the specification for an invitation to tender for the provision of work by a Third Sector organisation to provide additional support for co-production and culture change to embed the approach. We expect to award the contract in November for commencement in January 2018, and we will also be appointing to a Trust post to link with the external organisation.

3.5 Research and Development (R&D)

3.5.1 The retirement of two senior members of the R&D staff in recent months, Paul Robinson and Lawrence Ratna, provides us with an opportunity to develop a new academic post along the lines of the successful collaboration with University College London (UCL) represented by Liz Sampson's post and projects. I am working with Ilyas Mirza, R&D lead for the Trust, and Professors Glyn Lewis and Helen Killaspy at UCL, to develop a joint academic post with clinical session based in the new rehabilitation service being developed at the Chase Farm Hospital site. We have agreed funding, and a joint clinical senior lecturer/honorary consultant job description and will be advertising shortly.

4. Medical Management and Clinical Leadership

4.1 I have had a number of formal meetings with medical staff in recent weeks, in addition to my usual informal discussions; these include attending Local Implementation Groups (LIGs) in Haringey (30.8.17) and Barnet (1.9.17) and meetings with medical staff in Enfield on 19.9.17 and Barnet on 20.9.17. I attended the Local Negotiating Committee (LNC) on 13.9.17 together with medical HR colleagues. These meetings inform my comments below.

4.2 Trainee doctors and medical rota issues

4.2.1 I welcomed new Senior Trainees (ST) and Core Trainees (CT) to the Trust at their induction on 2.8.17, and launched the latest round of the 'Medical Director's book prize', which is already attracting entries.

4.2.2 We continue to have no reported issues with breaches of the new trainees' contract, though it was noted at the LNC that new doctors rotating to us in August were not given the necessary details to upload breaches if there were any, so we have agreed we will accept them retrospectively now upload details have been supplied.

4.2.3 The Senior Trainees full shift rota, which involves a single ST doing a shift based at the S.136 suite at Chase Farm Hospital, rather than two on-call STs per night as previously, seems to have been very successful in eliminating contract breaches since its introduction earlier this year. It has also been well received in terms of training experience, and has the great advantage that STs and CTs are now based in the same place at night and can work together - STs can teach, and CTs can get 'case based discussions' signed off for their portfolios.

4.2.4 CT rotas present more challenges as, since the move of the S.136 suite to Chase Farm Hospital, the workload is unbalanced across the sites and is busier than previously at Chase Farm. While this has not led to breaches of the contract, we will need to review workload carefully as further services locate to the site. I continue to review the effects of interim arrangements to manage the lack of CAMHS STs in the borough, but for the moment the rotas appear adequate while our commissioners continue to work on developing out of hours CAMHS provision across North Central London(NCL).

4.3 Staff Grade and Associate Specialty Doctors (SAS)

4.3.1 The appointment of Ken Courtenay as our Trust SAS Lead has led to improvements in the support provided to them, including regular training events as well as meetings of the Trust's SAS doctors group. I attended the event on 12.7.17, and was very impressed by the engagement of the SAS doctors, of whom over 20 attended. A speaker from the Royal College SAS Committee encouraged SASs to get involved in QI projects and other Trust initiatives and gave examples of where this had been done to good effect.

4.4 Visits

4.4.1 I have visited Inpatient areas in Barnet and Enfield in the last two months, including an informative visit to the Ken Porter Ward at the Springwell Centre, and some community sites including the Early Intervention in Psychosis (EIP), the Enfield Community Support Recovery Team (CSRT), and Community Rehabilitation Teams at Canning Crescent and the Barnet and Enfield Crisis Resolution Home Treatment Teams (CRHTT).

5. External engagement and activities

5.1 I participate in the monthly teleconferences organised by National Clinical Director NHS England / NHS Improvement, Tim Kendall. We were reminded this month that a national quality improvement group is being set up to share good practice across the country, and

an early project will be an event in October 2017 to share examples of good practice in reducing out of area placements. Professor Kendall is also working on a Suicide Reduction Options Paper, advising NHS England's Board on the disbursement of the £25million funding to achieve the Mental Health Five Year Forward View objective of a 10% reduction in suicides in England within 3 years. At the September meeting we heard from Will Smart, NHSE Chief Clinical Information Officer, and James Woollard, National Clinical Advisor Mental Health Digitalisation, about prospects for digital improvement; they are working on four areas:

- How to digitalise providers - primary care are completely digitalised and paperless;
- What is needed to embed digital into the core work flow of the clinicians;
- How to connect up the health systems and STPs and use big data techniques to support population health, research and governance, in terms of treatment and local service delivery;
- Providing citizens and patients with digitalised care.

He told us that patients viewing their record on screen, as they do with banking, is already taking place and is soon to be a reality in many parts of country. We also heard from Joe Rafferty, Chief Executive of Mersey Care NHS Foundation Trust, about a number of possibilities for digital working which fit well with our own work on mobile working.

5.2 I attended meetings of the North London Partners (formerly the North Central London (NCL) Sustainability and Transformation Plan (STP)) Health and Care Cabinet on 19.7.17 and 20.9.17. This provides an opportunity to engage with clinical leaders across the system and to learn about initiatives in physical health; for example on the progress of work to limit procedures of limited clinical effectiveness (PoLCE). Mental health does not always feature as much as we would like but at the most recent cabinet Healthy London Partnership plans for the rationalisation of S.136 suites across London were presented, and the NCL part of the plan endorsed. This will see the development of a S.136 suite at the Whittington Hospital by Camden and Islington NHS Foundation Trust (C&I), in addition to our own suite at Chase Farm Hospital. The challenges of rising S.136 rates, new standards for suites, and forthcoming plans for centralised S.136 provision for young people under 18 were all discussed in detail and, given the need for commissioner support for these, the positive reception for the plans from the cabinet (which includes CCG clinical leads) was encouraging.

5.3 I continue to meet regularly with Vincent Kirchner, Medical Director at C&I and also attend the London wide meeting of the mental health Medical Directors. Issues discussed included the benefits of a London wide Patient Reported Outcome Measure (PROM) (DIALOG, a therapeutic intervention developed by Professor Priebe and piloted at East London NHS Foundation Trust, has been presented to the Cavendish Square Group and we endorsed it), the locum rate cap, and challenges in maintaining compliant rotas (our successful ST rota is of interest to others). A further meeting between Medical Directors and medical HR managers across London to discuss rotas is planned to take place at South London and the Maudsley NHS Foundation Trust on 6.10.17.

6. Clinical work

6.1 I continue to see patients regularly in Barnet, where the new Personality Disorder team is becoming more embedded. We have met with the new Borough locality teams at the Springwell Centre and the Denis Scott Unit to plan how we can support them through training and supervision with challenging patients with emotionally unstable personality disorder who are not engaging in the specific therapies the team provides.

7. Learning from Deaths Agenda

7.1 Since 1.4.17 I have been chairing weekly Clinical Mortality Review Groups (CMRGs), attended by Clinical Directors (who may deputise for me) and members of the Patient Safety Team (PST). We reported our processes to the Quality and Safety Committee in July, where we also ratified the Trust's Policy on Learning from Deaths, which is now on the Trust's website.

7.2 On 21.9.17 we demonstrated the process of mortality reviews as part of the Trust Wide SIRG. We described the process of reporting, in which all deaths of people under the care of the Trust within the last 6 months are reported on the Datix system and reviewed initially by the PST and classified as expected or unexpected before being brought to the weekly CMRG. We noted that in practice the distinction between expected and unexpected deaths may at times appear arbitrary, and therefore does not determine our decision to investigate further. Options for the CMRG are to defer for more information (including requesting 24 hour reports where information held on the Datix system is insufficient), to allocate for a SI, moderate or desktop investigation, or to close on the basis of a clinical judgement that further investigation is not required and would not result in the learning of wider lessons.

7.3 We are required to report to the Trust Board data on mortality from April, following a standard template, and it is as follows:

Deaths Reported April-August 2017

Month	Total deaths reported (except LD)	Total deaths reviewed (except LD)	Avoidable deaths >50% (Except LD)	LD deaths reported
April	36	36	0	0
May	31	31	0	0
June	41	41	0	0
July	25	25	0	0
August	41	41	0	0
Totals year to date	**174**	**174**	**0**	**0**

7.4 The data reported above is the data required by national guidance on the Learning from Deaths Agenda which requires reporting of 'avoidability', but does not define this for mental health services, and it is not assessed as part of our current SI investigation processes, hence the zero reporting above. However, after discussion with other mental health Medical Directors in London we have included a simple rating of avoidability (based on a 0-3 rating used by the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI)) in our SI template, and we are piloting avoidability scoring by consensus, by directorate based SIRG panels from 1.9.17.

7.5 The guidance also asks for reporting of the number of deaths subject to a Structured Judgement Review (SJR) of case records, a process designed for acute Trusts based on a template developed by the Royal College of Physicians. This is acknowledged to be unsatisfactory for mental health and community Trusts, and our policy therefore states that we will use our existing SI template (based on Root Cause Analysis methodology) for any form of review required by our SI policy over and above the review carried out by the CMRG.

7.6 Of the 174 deaths reviewed at the CMRG from April - August, 14 have been allocated for full SI investigation, 2 for moderate investigation, and 1 for a desktop investigation, all of which will use our SI template.

7.7 Deaths in learning disability (LD) services are a particular focus of the learning from Deaths Agenda and are therefore included in the data, but as the Trust provides only a single forensic LD ward and no community LD services, such deaths within the Trust are likely to be extremely rare.

Implications

8. Budgetary / Financial Implications

8.1 There are no budgetary / financial implications as a direct result of this report.

9. Risk Management

9.1 There are no risk management implications as a direct result of this report.

10. Equality and Diversity Implications

10.1 None.

Ends.