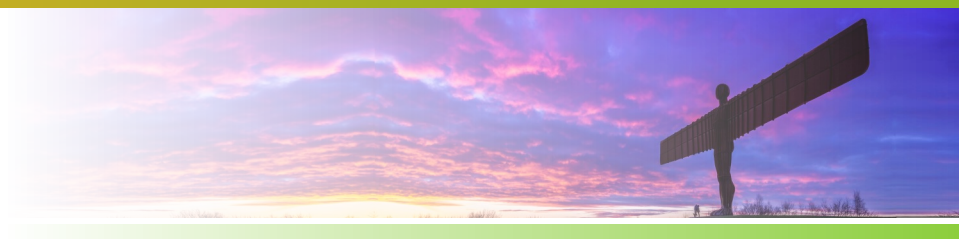
Spring Edition, 2021 | Issue 1

Psychiatry

The Northern & Yorkshire Division eNewsletter



Editorial

In this issue:

Dear Members of the Northern & Yorkshire Division,

We are proud to announce the first edition of the Northern & Yorkshire Division newsletter, specially created for members within our region.
With two editions per year, you can enjoy articles on research, audit and QI, receive College and Division updates, event information, and find out about the great work taking place throughout the Division.

More importantly, you can be a part of this exciting new resource too. We encourage you to get in touch if you would like to contribute to the newsletter in some way. After all, this newsletter is for you – the Division members, and with your assistance, we can endeavour to create a long-lasting beneficial tool.

My name is Sharon, and I am an ST6 in Dual Old Age and General Adult, based in Newcastle-Upon-Tyne. I am a trainee representative on the Psychiatry Trainee Committee with RCPsych and have been fortunate to become more directly involved with the Division through this. I completed my undergraduate degree and basic training in Ireland before moving here for higher training. It has been an excellent decision thus far and I believe we do amazing work in mental health across the Northern and Yorkshire Division.

This is what I want the Newsletter to showcase; all the innovation, patient-centred care, and progressive practice that we achieve on a daily basis in this region. I want the Newsletter to be somewhere we come to both congratulate and challenge ourselves, and I welcome all content of this nature for consideration.

Dr Sharon Holland, Newsletter Editor, Northern & Yorkshire Division

New Fellows

We would like to congratulate the following members of the Northern & Yorkshire Division who recently became Fellows of the College:

Joss Bray
David Cousins
Richard Duggins
Vikram Luthra
Manouri Senaratne
Andrew Byrne
Anitha Mukundan
Anikumar Pillai
Jonathan Richardson

Interested in becoming a Fellow of the College?

We award Fellowship as a mark of distinction and recognition of contributions to psychiatry. You're eligible if you've been a Member for 10 continuous years or more and can demonstrate significant contributions to the core purposes of the College:

- setting standards and promoting excellence in mental health care
- leading, representing and supporting psychiatrists
- working with patients, carers and their organisations.

Fellowship is open to both UK and Overseas Members, but unfortunately Affiliates and Associates can't apply.
If successful, Fellows can use the title FRCPsych once they've paid the prescribed registration fee.

TO APPLY you must complete an application that explains your contributions to the College's stated aim of patient-centred practice through: Professionalism, innovation and research, lifelong learning, fairness and inclusion, ethical practice and multi-disciplinary working.

For more information on becoming a Fellow, please contact:

membership.operations@rcpsych.ac.uk

Our Division

The Northern & Yorkshire Division supports members in the North, West and East of Yorkshire and the North of England. The Division is run by an Executive Committee which consists of:

Dr Paul Walker—Division Chair
Dr Sunil Nodiyal—Vice Chair
Dr Kedar Kale—Financial Officer
Dr Baxi Sinha—Academic Secretary—Joint
Dr Sumeet Gupta—Academic Secretary—Joint

As well as Regional Advisors, PTC Reps, ETC Reps, Mentorship Leads and Patient and Carer Reps.

We always want to hear from our members. If you would like to get in touch with the committee, please email:
Nothernandyorkshire@rcpsych.ac.uk

Executive Committee Vacancies

- Eating Disorders: Yorkshire Region
- Liaison: Yorkshire Region
- Old Age: Yorkshire Region (Shared Role)
- Child & Adolescent: North East Region
- Academic: Division Wide

We would love you to join us.

Spring Conference 2021-When the clapping stops

The Northern & Yorkshire Division are pleased to announce their Spring Conference, "When the clapping stops" is now available for booking., taking place 1st April 2021. Going behind the scenes of the pandemic, the conference will discuss the crucial topic of the psychological impact of COVID-19 on front-line workers and understanding of the nature of trauma experienced by acute healthcare workers.

This is chance to hear the first-hand accounts of front-line workers and the pressures they have felt during the pandemic in their respective areas, as well as personal accounts of service users who have lost love ones due to the virus.
We will be joined by RCPsych President Adrian James, who will reflect on the College's work during the pandemic and how it will continue to support its members going forward. We will also be hearing from Dr Richard Cree, Consultant in Anaesthesia and Intensive Care Medicine, who will share his experience of working in an increasingly busy Intensive Care Unit during the COVID-19 pandemic.
Dr Sarah Hopper, Consultant Clinical Psychologist and Dr Vicky Jervis, Professional Lead for Psychology, will focus on the well-being needs of front-line health care staff during the Covid-19 pandemic, - as well as offering some personal reflections on being part of a collaboration between two neighbouring

NHS trusts to support front-line staff throughout this time. Conference attendees will also have the opportunity to hear from Northern & Yorkshire Division Patient Representative, Hayley Hall, who will share her personal perspective on a surreal bereavement and personal loss during the pandemic.

This conference is a special time to reflect on the work carried out by front-line workers during the pandemic, and how Psychiatrists can support these workers in the months to follow.

GP Specialty Trainee Year 2, Dr Rachel Bloomfield, will give a talk on the importance of balancing patient care and clinical training during the pandemic. Dr Bloomfield will share a trainee's experience of the challenges of meeting training needs whilst providing patient care during a pandemic.

Poster Competitions

As part of the conference, we are holding virtual poster competitions for the following:

Medical students

FY1 and FY2 doctors

Trainees

SAS Doctors

Full details can be found on our web page.

REGISTER NOW

Upcoming Events and opportunities

International Congress

Register now for our first ever virtual International Congress! The Congress will be hosted on a new virtual platform, one that provides an immersive and interactive experience.

Network with fellow psychiatrists, Attend keynote lectures from world renowned speakers including Professor Chris Whitty, Chief Medical Officer for England, Michael Rosen, Author and Poet and Dr Fiona Godlee, Editor and Chief, The BMJ

Choose from over 60 cutting edge sessions featuring world class academics and clinicians, those with lived experience and their families and opinion leaders.
Earn up to 22 CPD points all in just one click!

View all content on demand after the event; watch not just some, but all the sessions that interest you

Explore the full programme here

RCPsych Future Archives Competition

We're creating an archive charting how mental healthcare is delivered and experienced today, and we want to hear from you. Send in your contribution and you could win a fantastic prize.

Founded in 1841, the RCPsych is celebrating its 180th anniversary in 2021.

Our knowledge about mental healthcare all those years ago is limited - because it lacks the perspectives of everyone giving and receiving mental health care.
We can't change the resources we have about mental health in the past - but we can make sure that people in the future can access a wide range of perspectives about what mental health practices, politics, services and research were like in 2020 and 2021.

To provide a broad perspective for future generations we're inviting everyone to contribute their thoughts and impressions of psychiatry and mental health services today and help create our 'Future Archives'.
Whether you're a psychiatrist, a medical student, GP, nurse, campaigner, psychologist, AMHP, occupational therapist, patient, carer, or just happen to be interested in mental health, we'd love to hear your thoughts.
We want to make our 'Future Archives' as inclusive and holistic as possible!

The closing date is **30 April 2021**.

For further details on how to apply, click here or email archives@rcpsych.ac.uk

Did someone say mentoring?

What mentoring is, and what it is not....

Mentoring is a guiding relationship, fostering the development of the mentee and often benefits from the experience and empathy from a level of expertise in the area the mentee wants to improve.

Described beautifully by Julia Pokora as "helping you to help you", mentoring relationships are not about passing on lots of advice. Instead, it involves using listening and questions to get things clear, exploring what is needed, and then being there as one possible resource of information as needed.

There is some cross over with techniques, tools and skills used in coaching, but a mentor does not need to be a qualified coach and a coach may not have any experience or expertise in common with the people they are working with.

What are the benefits of mentoring?

Mentoring can help uncover hidden potential in the mentee. This could help them to reach "Eudaimonia" and offer more of themselves to their role. This will affect the care they can deliver to others and so is ultimately a good thing for patients too.

Being a mentor is a chance to give to others, which is also a route to wellbeing! The discussions can provoke a lot of self-reflection and learning for the mentor as well. You are using many of the skills you practise in your day job and can connect with other mentors for support and new ideas.

Why not have a look at the Divisional Mentorship website or ask your own organisation about getting or being a mentor?

Dr Nicola Baylis | Mentorship Lead | N&Y Division

When should I get a mentor?

Anytime! But people can find it especially helpful when they are planning or undergoing a transition or change. It might be a new role, new workplace, new culture or returning after an illness or having children. Sometimes it is personal development issues like confidence and communication with others or developing a competency in a specific skill.

Telepsychiatry: Challenges, Prospects and Future Directions - Clinician's Experience of Remote Consultations: Survey conducted in July 2020 at Bradford District Care NHS Trust

Dr Mahira Syed CT2

Introduction:
The ever-increasing pressure on mental health services was aggravated by the advent of COVID-19 and presented a huge challenge to clinical staff and management of BDCFT to maintain community and hospital based mental health and learning disability services in Bradford, Keighley, Ilkeley and Craven in Yorkshire, England.

Despite the huge challenge, mental health professionals and their expertise were needed more than ever for their existing and new patients. Within days of the beginning of lockdown, staff at BDCFT were made aware of the scale of the problem and a possible solution to providing continuity in care was through remote access to patients with telephone and video consultations.
The NHS Long Term Plan 2019 stated that digitally enabled primary and outpatient care will be mainstream within five years (1), and pre-existing evidence through meta-analysis and meta regression on small and medium numbers of randomised controlled trials suggest that video conferencing in psychiatry may be as efficacious as the face-to-face setting, but the field of research is mainly related to assessment and treatment of patients either in prisons, disasters or in remote rural settings. The efficacy of remote consultation is established in mood disorders, autism spectrum disorders, ADHD, PTSD and eating disorders. (2)

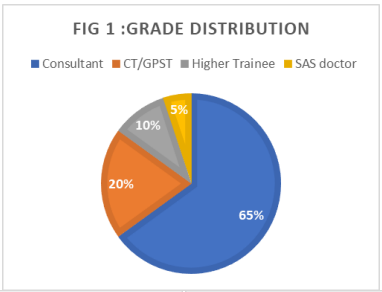
Despite evidence existing, telepsychiatry had not achieved its full potential and, along with many responsible factors, lack acceptance by clinicians is cited as the most significant factor in its limited spread. (3)
This cross-sectional service evaluation survey conducted at BDCFT in July-Aug 2020 outlines in detail the mode of remote consultation used, challenges encountered in early days of implementation, benefits and ethical dilemmas experienced at the study site.

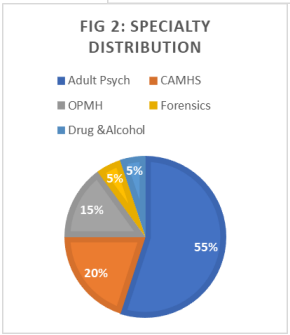
Method:
Our literature search involved the key terms 'Remote consultation', 'Virtual consultation', and 'Telepsychiatry'. The studies returned were mainly related to 'General Practice' and 'CAMHS'. Lack of available research in Adult Psychiatry remote consultation was evident.

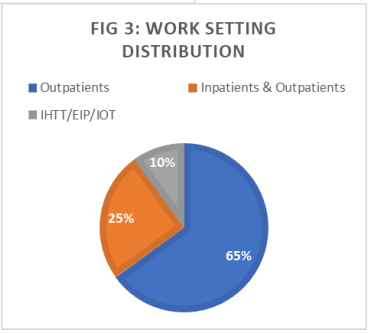
A survey was designed informed by the themes identified in the searched articles and their provided references.

Digital Covid-19 Guidance for Clinicians by the Royal College of Psychiatrists was reviewed for further guidance. (4)
All survey questions were provided with a free text area for elaborated points of view. A request to complete the survey was sent through a link in an email and all responses were anonymised. The study protocol was approved by the Audit/QI Department of the Trust.

Results:
The survey response rate was 26% (Questionnaire was sent through online link to about 75 doctors of all grades working across trust, 20 responses were submitted). Demographic details included Grade, Speciality, and Work Setting of respondents and are given below in pie chart 1, 2 and 3, respectively.



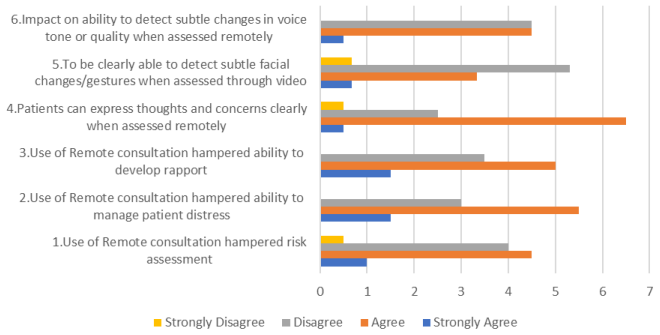




It was interesting to note that during first lockdown, respondents did 70% telephone, 20% video and only 10% face to face consultations. Among video platforms, 58.33% were using 'MS teams' vs 41.67% using 'Attend Anywhere'. 95% of respondents had no training prior to initiation of remote consultations and 42% reported to be a 'little' concerned about using remote technology. However, 55% reported using remote consultations as an overall 'average' experience.

45% reported remote consultations hampered their abilities to assess risk, 55% reported they were hampered in managing patient distress and 50% reported they were hampered in building rapport with patients. 53.33% of respondents disagreed that video consultations have enabled them to clearly appreciate subtle facial changes and gestures and they explained that clear limitations were there, even to detect changes in voice and tone quality.

Fig 4: Responses to the questionnaire



Despite clear concerns, 45% were likely to continue remote consultations post-pandemic and 50% were likely to recommend it to more patients.

Free Text questions were asked in four themes:

- Ethical Dilemmas
- Positive experiences
- Negative experiences/challenges
- Suggestions for improvement of remote consultations

Ethical dilemmas highlighted in responses were related to confirming patient identification on the phone, confidentiality in complex cases of domestic violence, and safeguarding of younger and older populations. One of the free text comments explains "In a case of domestic violence, unable to tell if perpetrator was listening in, did not want to put young person more at risk."

Positive experiences reported by the cohort centred on themes of convenience, flexibility, COVID-19 safety and practicality with shielding patients, feasibility with younger patients/families/carers, and MDT meetings held out of area and on inpatient units. Another respondent explains "sometimes appointment is very appropriate for a phone call, such as discussion about a medication, follow up or to establish wellbeing".

Challenges that were highlighted involved risk assessment in psychosis and cognitive/hearing impairment, rapport building, managing patient distress and connectivity issues hampering consultations.

Suggestions for improvement given by respondents included video medium to be made user-friendly and leaflets/guidelines to be made available to clinicians and patients, balanced approach to be used for remote and face to face consultations guided by clinical needs, patient feedback to be collated, and formal training should be rolled out to all clinicians through a programme that considers feedback and evidence as it emerges with time.

Discussion:

With remote consultations introduced in mental health at unprecedented speed, this study was conducted in the early days of set up at BDCFT, with definite limitations. The study cohort largely identifies with the experiences of remote consultations in other specialities, as described in existing literature.

An interesting point to note is that there was no response to the survey from clinicians in inpatient settings of BDCFT, potentially indicating absence of virtual consultations during early pandemic. However, it will be interesting to repeat this survey and explore for feedback from inpatient clinicians further to the expansion of this technology to our wards.

While convenience and flexibility were regarded as the main benefit, clinicians at BDCFT highlighted that MDT meetings with several parties, connectivity can be an issue causing it to be a frustrating and time-consuming experience.

Some concerns were reported about video mode regarding ease of use, nervousness to share email address with patients, possibility to get recorded without consent, with another respondent explaining: "I feel very self-conscious on video as I can see myself."

Definite limitations of our study include low response rate/small cohort of respondents, main bulk of data/free text comments from consultants and minimal input from trainee doctors, limiting its generalisability. Another weakness identified is the questionnaire was not piloted or validated before dissemination.

Conclusion and future directions:

Future studies with extensive search of literature emerged in pandemic can involve multiple trusts sites. With the emergence of Digital Psychiatry Special Interest Group at RCPsych (5) and other resources, it will be interesting to explore both clinicians' and patients' feedback in this emerging field. Training and confidence-building of trainees through webinars, supervision, and perhaps adding it as a curriculum competency for trainees will go a long way to promote efficient delivery of care to our patients. Equally important will be the development of efficient clinical toolkits through strong collaboration between clinical and digital leadership.

COVID-19 has unveiled opportunities to build our systems quickly, be more efficient, and adopt sustainable ways of service provision. However, with changing times, it is vital to learn, adapt and improve to achieve an essential balance between technology-based virtual care and the essence of psychiatry that is human contact.

Dr Mahira Syed, CT2 Psychiatry and Dr Himanshu Garg, Consultant Psychiatrist, Clinical Director Community Adult Services, Bradford District Care Foundation Trust.

Acknowledgements:
Mr Andy Arnfield, Knowledge Manager, Library, Lynfield Mount Hospital, BDCFT.

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Some mum's and dad's drink too much: National Association of Children of Alcoholics

Dr Karamdeep Kaur, ST4 CAMHS

I didn't cause it.
I can't control it.
I can't cure it.
I can take care of myself.
I can communicate my feelings.
I can make healthy choices.
The 6 C's of NACOA

Founded in 1990, the National Association of Children of Alcoholics (NACOA) has 4 core aims; to offer advice and support to children of alcoholics (COAs), to reach professionals who work with COAs, to raise the profile in the public consciousness, and to promote research into the problems faced by COAs and the prevention of alcoholism in this vulnerable group.

The registered charity works with COAs, indiscriminate of their age, with the understanding that a young person who has experienced an alcoholic parent will be left with those memories for their remaining years. Irrespective of the path an alcoholic parent takes, one can be a COA at age 5 or age 55, NACOA will offer support all the same.

In its 31 year history, NACOA has worked hard to provide help to COAs across the nation. They have adapted their style to keep up with the advances in technology and social media and have matched the pace of increased contacts from COAs by increasing the number of volunteers working with NACOA to help meet demand. To date, there are over 350 volunteers working for NACOA in a variety of roles from helpline counsellors to fundraisers and researchers.

2020 saw, perhaps, the most challenging time in NACOA's relatively short tenure with the spread of COVID-19. The global pandemic has resulted in the introduction of multiple local and national lockdowns, bringing with it testing times to many people; be that with changes to schooling and work, from furlough to remote working. Many COAs have found themselves confronted with the reality of the loss of usual routines - routines which once afforded the potential respite from the 24/7 experience of being a COA. The pandemic has brought further experiences of uncertainty and inconsistency with which COAs are already far too familiar.

In the 2020 Report carried out by NACOA: *Covid So Far, Lockdown and the Lost Children*, examples of the transcripts of calls made to NACOA were included; ranging from COAs expressing their concerns that their parents had taken to bulk buying large quantities of alcohol during the pandemic, to COAs speaking of how their parents have increased their drinking as a direct response to cope with the pandemic, and COAs voicing the realities of being isolated and trapped within the home with a parent who drinks too much.

COAs have spoken about their experience of mental exhaustion, anxiety and hopelessness during the pandemic, which many other people have also voiced. For COAs, the additional strain of the pandemic has impacted on their day to day lives as children of alcoholics, with resilience levels becoming increasingly depleted.

NACOA received record levels of call numbers since the pandemic reached the UK in 2020 with a 38% increase in calls overall since 2019 (looking at the second quarter of the year). Further research regarding alcohol use during COVID-19 was highlighted with the Office of National Statistics (ONS) data showing an increase in the number of alcohol related deaths from January 2020 to September 2020, with 5,460 deaths. This was up 16% on 2019 figures. NACOA has created a free "*Covid resource pack*" which is available on their website[1], with advice for COAs, and those working with COAs, with regards to the impact of the pandemic on alcohol use and the resulting effects experienced by COAs.

With alcohol intake increasing and social isolation mandated, NACOA continues to offer free and confidential support for COAs alongside a doubling down of efforts to increase awareness of the work they do. This year's annual COA week took place 14-20 February 2021. Their message is clear; **if you are affected by your parent's drinking, you are not alone.**

Free Helpline: 0800 358 3456

Email: helpline@nacoa.org.uk or alternatively write to Nacoa, PO Box 64, Bristol, BS16 2UH.

Website: www.nacoa.org.uk/about-nacoa
Social media: Instagram and Twitter: @nacoauk / Facebook: www.facebook.com/nacoauk
Covid opening hours: Monday to Saturday 12 noon to 9pm (email) – 2pm – 7pm (telephone)

ReferencesThe National Association for Children of Alcoholics (NACOA). *About NACOA.* NACOA, 2021 (https://nacoa.org.uk/about-nacoa [cited 6 February 2021])

[2]The National Association for Children of Alcoholics (NACOA). *About NACOA.* NACOA, 2021 (https://nacoa.org.uk/about-nacoa/about-nacoa/ [cited 6 February 2021])

[3]The National Association for Children of Alcoholics (NACOA). *Report: Covid so far, lockdown and the lost children.* NACOA, 2020 (https://nacoa.org.uk/report-covid-so-far-lockdown-and-the-lost-children/ [cited 6 February 2021])

[4]The National Association for Children of Alcoholics (NACOA). *Report: A 'new normal' for children affected by their parent's drinking.* NACOA, 2021 (https://nacoa.org.uk/report-new-normal/?slug=latest-news-events [cited 8 February 2021])

[5] The office of national statistics (ONS). *Quarterly alcohol-specific deaths in England and Wales: 2001 to 2019 registrations and Quarter 1 (Jan to Mar) to Quarter 3 (July to Sept) 2020 provisional registrations.* ONS, 2021 (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/quarterlyalcoholspecificdeathsineng-landandwales/2001to2019registrationsandquarter1jantomartoquarter3julytosept2020provisionalregistrations [cited 10 February 2021])

Clinical audit of inclusion of the Lester Tool details in the discharge documents on adult inpatient wards at Foss Park Hospital September-October 2020

Authors: Dr Kayleigh Jones, Dr Shona McIlrae, Dr Karen Ball & Dr Rohma Tahir

Background

Patients with serious mental health illness (SMI) die on average 20 years earlier than the general population. Often it is due to preventable physical health problems, the main contributor being cardiovascular disease. The side effects of anti-psychotic medication, lifestyle and difficulty accessing healthcare services all have a detrimental effect on life expectancy.

Between 2014 and 2016 NHS England worked alongside 4 pilot sites (2Gether NHS Foundation Trust, Northumberland Tyne and Wear NHS Foundation Trust, TEWV, and Mersey Care NHS Trust) to implement the Lester Screening tool as a method of improving cardiovascular health outcomes of patients with serious mental health illnesses and thus reduce premature mortality.
The Lester tool was produced in 2014 as a method for clinicians to assess the cardiovascular health of patients with SMI and then recommends the best course of action for intervention.
In May 2016 'Improving the physical health of people with serious mental health illness: A practical toolkit' was published, which contained guidelines on how best to implement the tool. This toolkit recognised that on Paris (the electronic database used by Tees, Esk and Wear Valley Trust) there was difficulty in gathering all the data need for the tool, in one place.

As Minster and Ebor wards are acute inpatient wards, where patients only stay for a brief period of time, long term interventions to improve physical health are difficult to fully implement. On discharge, every patient has a discharge letter completed; this is an opportunity to record the necessary requirements of the Lester tool. It also provides the GP with the information so that continuity of care can be achieved.
The aim of this audit was to see how often all the relevant information is recorded on the discharge paperwork, and then aim to educate the doctors completing the paper work in order to achieve full compliance, which in turn will ensure better health outcomes for our patients.

Criteria and Standards

All junior doctors working in psychiatry should be aware of the Lester Tool and its purpose. The criteria used for this audit are the parameters named on the Lester Tool –

- Smoking
- BMI (height and Weight)
- Blood Pressure
- Glucose regulation
- Blood lipids

100% of this information should be documented on the discharge document.

Methodology

The wards to be audited were decided. In this case, Ebor and Minster wards were chosen (the female and male inpatient wards at Foss Park Hospital)

- A defined period of time was set. In this case, September and October 2020.
- We requested a list of all discharges from Ebor and Minster wards during that time from the ward administrator, and then 20 male and 20 female patients were chosen at random from the list.
- A Microsoft Excel spreadsheet was used to document the information.
- Paris was used to access the completed discharge document from the time they were an inpatient in September or October 2020
- The physical health section of the discharge document to see if the parameters were included
- Data was recorded on,

⇒ Paris ID
⇒ Gender of the patient
⇒ Date of discharge
⇒ Smoking status
⇒ BMI
⇒ ECG
⇒ Blood pressure
⇒ Bloods (Fasting or random plasma glucose, HbA1c-Total Cholesterol/HDL ratio)

This audit was conducted at Foss Park Hospital during November and December 2020.

Data Findings

The main point to state from the data findings is that of the 40 discharge letters looked at, not one had 100% compliance. In fact, on average across both wards; only 23% of the Lester tool information was included in the documents. This demonstrates there is room for educating staff and improvements need to be made.
On Ebor ward 8 out of the 20 patients (40%) had no data recorded and on Minster 3 out of 20 (15%) had no data recorded. Across both wards, not a single patient had details about their cholesterol ratio recorded.
Below are tables showing the result for each individual factor investigated.
Ratings are recorded by colour
80% and over – green, 50-80% - Amber, under 50% - Red

Was BMI recorded?	Yes	No
Overall	35%	65%
Ebor	20%	80%
Minster	50%	50%

Were ECG results recorded?	Yes	No
Overall	42.5%	57.5%
Ebor	5%	95%
Minster	80%	20%

Was BP recorded?	Yes	No
Overall	17.5%	82.5%
Ebor	30%	70%
Minster	5%	95%

Was smoking status recorded?	Yes	No
Overall	27.5%	72.5%
Ebor	45%	55%
Minster	10%	90%

Was HbA1c recorded?	Yes	No
Overall	20%	80%
Ebor	5%	95%
Minster	35%	65%

Was Cholesterol ratio included?	Yes	No
Overall	0%	100%
Ebor	0%	100%
Minster	0%	100%

Was Glucose recorded?	Yes	No
Overall	5%	95%
Ebor	0%	100%
Minster	10%	90%

Summary of Issues Identified

It would appear that the components of the Lester tool are not widely known and the compliance falls short of what would be expected. It is hard to determine if these details were omitted as there is no clear guide to the exact details that should be included in the discharge document, or if they were not actually checked and recorded correctly during the inpatient stay.
Omission of these details on the discharge document means that there lack of clear, detailed communication with primary care services and the physical health of our patients is not safeguarded. By having 100% compliance across the trust we can meet the purpose of the Lester Tool and move toward improving outcomes and life expectancy of patient with serious mental health illnesses. Teaching on the Lester Tool was delivered at the Foss Park Steering Group as well as the junior doctor induction. A re-audit is to be carried out in May to measure the improvements made.

References

An Evaluation of the Implementation of the Lester Tool 2014 in Psychiatric Inpatient Settings 2016
The Lester Tool – Lester UK Adaptation (updated 2014)

Dr Kayleigh Jones LLB (hons) MBBS
Core trainee MHSOP Harrogate Memory Service, Tees, Esk and Wear Valley NHS Trust

Schwartz Centre Rounds: A Qualitative exploration of Panel Members' Experiences within a forensic Mental Health Service.

Dr Elshiema Hamad | Senior Registrar | Forensic Psychiatry.

Tees, Esk and Wear Valleys NHS Foundation Trust.

Introduction

High levels of stress and burnout are highly prevalent amongst frontline staff in mental health settings and this is particularly evident within forensic psychiatric services. Whittington & Richter (1) found that being repeatedly exposed to violence and aggression was a key factor in high rates of occupational stress and burnout. Yet, despite these pressures, staff are responsible for providing care to some of society's most complex individuals.

Thus, over recent years focus has turned to the relationship between staff well-being and resilience with research suggesting that fostering resilience can serve as a protective factor against occupational stress (2). In addition to this, space for reflection is seen to be vital for frontline staff to be able to take care of themselves, develop self-awareness and subsequently provide better patient care (3).

Background

Schwartz Centre Rounds (SCR) provide a structured forum for staff from all disciplines to meet and discuss the difficult emotional and social challenges that arise in caring for patients. SCR were developed in the late 1990s in the USA by a young lawyer named Kenneth Schwartz, who received care for terminal lung cancer. Kenneth was struck by the simple acts of kindness that he experienced in his last few weeks and so before his death, he set up the Schwartz Centre in Boston in order to help develop compassion in healthcare. In 2009, SCR were first replicated in the UK by the Point of Care Programme at The King's Fund and they continue to be implemented by The Point of Care Foundation.

SCR follow a standard model that is replicated across all settings and normally take place once a month for one hour. They consist of a panel of three to four professionals from different backgrounds (clinical and non-clinical) who individually tell their stories for the first 15 to 20 minutes. Following this, there are two trained facilitators who then lead an open discussion, guiding reflection and steering away from problem solving for the remainder of the SCR.

Research into the implementation of SCR has shown that staff who attend report increased insight into the emotional and social aspects of care, greater understanding of the roles of their colleagues, improved team working and decreased feelings of isolation and stress. Goodrich (4) found that SCR were perceived by participants as a source of support and that their benefit may translate into benefits for patients and team working. However, little research has explored the implementation of SCR within forensic settings, and no research has focused solely on the experiences of panel members.

Methods

The research team recruited participants via the following methods: 1) expressions of interests from previous panel members within SCR steering group meetings; and, 2) email invites sent to staff members who had been panel members (names were sourced from a confidential database within the service). Informed consent was obtained from all participants; prior to this participant's had been given all necessary information regarding the research and offered the opportunity to ask questions.

Three focus groups were facilitated with participants who had been a part of an SCR panel within a forensic mental health service. Semi-structured interviews were carried out, audio recorded and subsequently transcribed. The chosen method of data analysis was Interpretive Phenomenological Analysis and this followed the six stages of data analysis set out by Smith, Flowers & Larkin (5).

Results

The qualitative analysis identified four superordinate themes: Feeling Vulnerable, The Importance of Validation, Exposure to Intense Emotional Experiences and Improved Understanding and Connection. Regarding the theme "Feeling Vulnerable", panel members reported feeling apprehensive about sharing their experiences and this apprehension was interpreted as stemming from a fear of saying something that was incongruent with others' beliefs or experiences. An additional sense of vulnerability came from an awareness of senior members of staff who were sometimes present at SCR, and panel members who were not in senior positions in the organization seemed to question whether they deserved to be present at SCR.

The theme entitled 'The Importance of Validation' highlighted the importance of hearing others share similar experiences and this experience was interpreted as a protective factor against feelings of isolation.

The third theme of "Exposure to Intense Emotional Experiences" highlighted that the SCR often triggered intense emotional experiences for participants. For some, connecting to emotions that are usually suppressed was seen as a positive as it is not an experience for which they often have an outlet. However, this exposure to emotions was not necessarily welcomed by panel members as there seemed to be a belief that expressing emotions in front of colleagues is undesired. This may explain and underpin the perceived feelings of vulnerability discussed above. There seemed to be an understanding that SCR were unique in the way that they put people in touch with their emotions whilst in the work environment. It was apparent that there was a shared belief that emotions are often "bottled up" or supressed in some way whilst at work and so connecting with these emotions feels unnerving and potentially exposing.

The final theme "Improved Understanding and Connection" identified that despite the fear of exposing oneself and connecting with their emotions, participants reported how SCR can often foster connection and understanding amongst colleagues. For some, it was an opportunity to share their experiences of their role and improve understanding, as well as gaining a sense of validation that they provide a valuable contribution to the service.

Conclusion

Four key themes were identified within the current research. These themes highlighted a journey that SCR panel members embark upon when they undertake this role. The fear of expressing emotion and vulnerability in front of colleagues was apparent and underpinned intense nervousness and apprehension. However, SCR appear to

Conclusion continued

provide an opportunity to experience validation and therefore overcome the fear of judgement when expressing emotional experiences within the context of work. To conclude, SCR have the potential to increase understanding of others and a chance to connect with colleagues on an emotional level, thus enhancing relationships and team working. Further research is needed into the experiences of attendees, to understand the impact that SCR have on their own emotional well-being and subsequent clinical practice. It is these individual stories and narratives that have the potential to shape and guide the development of future SCR.

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Research in the Northern and Yorkshire Division

Visit www.mood-disorders.co.uk for details of open studies on affective disorders in the region.

Visit www.psychosisresearch.com for details of open studies for psychotic disorders in the region.

Spotlight Study

Optimizing response to lithium treatment through personalised and multimodal evaluation of individuals with bipolar I disorder (the R-LiNK study)

Lithium is a gold-standard maintenance treatment for bipolar disorder but not everyone responds, and we lack the ability to predict response.

The R-LiNK study (rlink.eu.com) will combine clinical, digital, imaging and biological assessments with routine practice over a two-year period to determine which patients with bipolar I disorder are most eligible for long-term lithium treatment. Crucially, in this study, the decision to start lithium is made by the patient and their usual clinician. Study enrolment begins once that decision has been made, but before treatment is started. The R-LiNK team can provide advice on the indication of lithium, assist with reminders for blood monitoring and support patients with a detailed, regular follow-up throughout their participation.

There are 16 recruiting sites across eight European countries. Dr David Cousins, Hon. Consultant Psychiatrist for RADS Inpatients and Newcastle Magnetic Resonance Centre Director, is leading the UK's North East site from Newcastle University, working closely with Cumbria, Northumberland, Tyne and Wear Foundation Trust and Tees, Esk and Wear Valley NHS Foundation Trust.

We are aiming to recruit 20 people with bipolar I disorder to the study over the next 12 months. Patients can be in any mood state, and outpatients and inpatients are eligible alike.

Additional eligibility criteria include:

- Aged between 18 and 70 years old
- Eligible for blood tests and MRI scans (for example, not have metal implants or fragments in their body)
- No current thoughts of self-harm and/or behaviours
- Individuals must not be pregnant, currently breast-feeding, or planning on getting pregnant in the near future

For more information or to refer a patient, please contact:
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If you are involved in a research study and would like to publicise it through the newsletter, then please submit a piece similar to the above (Max 1000 words).

Trainee led teaching

Authors: Dr Sadie Kitson, Dr Lachlan Fotheringham, Dr Caroline Hayes, Dr Nicole Edwards

Trainee-Led Teaching began life in wave 1 of the pandemic, amidst re-deployments, cancelling of research time, study leave and formal teaching. With so much of our practice changing, it felt like the perfect time for learning and adapting. A small group of interested trainees decided to grab the initiative.

At first, this focused on virtually hosting colleagues from the local acute trust to tell us all about how to cope with physical health challenges in the psychiatric inpatient wards. It soon became clear however that there was an opportunity to bring in speakers on whatever we wanted to learn about. The positive feedback from fellow trainees for these initial sessions emboldened us to continue seeking out prominent experts in fields we felt were important to us, but neglected in the mainstream curriculum. In picking out topics and planning our sessions, we drew heavily on feedback from attendees on what they wanted to learn about and how. This enabled us to find a niche and sustain interest and relevance, even when more established streams eventually adapted to online formats.

Some highlights so far include:

- Author Tim Lott on Storytelling
- Psychiatrist and Professor Navneet Kapur on Suicide Prevention and COVID-19
- Psychologist Professor Jason Ellis on CBTi
- Dr Mourad Wahba on Psychiatry's Psychedelic Future
- Solicitor Phillip Lea on Medical Negligence
- Microbiologist Dr Ali Robb on IPC, PPE and General Psych-rodiology
- Palliative Care Consultant Dr Jennifer Vidrine on End of Life Care
- Barrister Simon Garlick on Capacity and Court of Protection
- Neurologist and Professor Jon Stone on Functional Neurological Disorder
- Community gynecologist Dr. Diana Mansour on Psychosexual Counselling

Relationship with CNTW and HEENE

Trainee-Led Teaching is run by doctors working in Cumbria, Northumbria, Tyne and Wear NHS Foundation Trust (CNTW).
Our local medical education department have given us a platform to promote our work and we are now supported with some funding from Health Education England North East. Those within these organizations with a more formal role in local and regional medical education have been able to draw on our evolving experience in helping them to adapt to online learning environments. Our initiative remains independent however, and we value our independence in continuing to evolve in a direction dictated by our own values and priorities.

What we have learnt:

This experience has taught us that, as learners, we are capable of organising our own professional development, and in doing so, we have become more aware of how our specialty interacts with other disciplines and society on a wider level. Both speakers and learners alike have shown enthusiasm and flexibility in contributing to sessions at all times of day, and in adapting to the models of delivery that others in our trainee community have called for. Drawing on learner feedback, our guest speakers have tended to appreciate the novel modes of interaction and engagement that we have encouraged; before, during and after the session, to create an involved - if physically distant - online learning environment.

We are still to discover how sustainable we can be. We may have created a new strand of learning within our trainee community which will continue to involve and engage existing and future trainees. It is possible however that what we have achieved has relied on a transient high water mark of good will, and that this will fade with the pandemic.

End of life care in a secure hospital setting

Dr Owen Obasohan, Old Age Psychiatry, Senior Registrar, TEWV, Dr Deepak Tokas, Consultant Forensic Psychiatrist, TEWV, Dr Mamta Kumari, Forensic Psychiatry Senior Registrar, TEWV

To measure the standard of care provided to patients who had a natural and expected death whilst in secure care, at Roseberry Park Hospital, Marton road, Middlesbrough.
Mallard Ward is a low secure psychiatric ward for older age men suffering from cognitive difficulties and significant physical comorbidity, in addition to a severe and enduring mental illness. The patient population is such that it would remain the most appropriate placement for some until their death. It is therefore important that the staff members on Mallard ward, and indeed in all parts of the Trust, need to be aware of the priorities for care of the dying person and ensure that care is provided in accordance with these priorities.

The Leadership Alliance for the Care of Dying People (LACDP), a coalition of 21 national organisations, published *One Chance to Get it Right – Improving people's experience of care in the last few days and hours of life* in June 2014. This document laid out five priorities for care of the dying person focussing on sensitive communication, involvement of the person and relevant others in decisions, and compassionately delivering an individualised care plan.

The data collection tool was adapted from *End of Life Care Audit: Dying in Hospital,* a national clinical audit commissioned by Healthcare Quality Improvement Partnership (HQIP) and run by the Royal College of Physicians. Data was collected from both electronic and paper records. There were three natural and expected deaths in the last two years.
The patient referral process for the audit was based on the number of patients who had died whilst on Mallard ward in the last two years.

- All three patients were resident on Mallard ward
- All patients were above 70 years of age and there was documented evidence that they were likely to die in the coming hours or days.
- End of life care discussion was held with the nominated persons and not with the patients as they lacked mental capacity.
- Two patients died from cancer whilst on the ward and one patient died from heart failure on a medical ward following transfer to an acute trust hospital.
- The needs of both the patient and the nominated persons were explored in all three cases.
- All patients had an individualised care plan which was followed; their religious, cultural and social needs were explored with the nominated persons.
- In all three patients, the palliative care team provided advice to the ward staff on palliative care medications for the management of their symptoms and the use of syringe drivers for the administration of the medications.

The level of care was largely consistent with the priorities listed.

The national audit compares performance of only acute NHS Trusts with no data to reflect the performance of mental health hospitals. It is imperative that mental health services work in collaboration with physical health and palliative care services so they are able to continue providing a high level of care to this patient group. Clinicians and staff involved in the care of dying patients also need to be adequately trained.

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Dr Owen Obasohan

COVID-19-My patients and me

How COVID-19 is changing the face of Inpatient Psychiatry in one Northern England Unit

Introduction

The COVID-19 pandemic has changed the face of our society. It has had a huge impact on the NHS, its workers and the patients that access its services.
COVID-19 poses the constant threat of serious illness to individuals and their loved ones, the risk of losing income, and distancing and lockdown measures have meant more people are isolated from their support network. Studies have highlighted increased risk of psychosis with increased levels of social isolation, therefore it is not surprising that there have been an increasing number of presentations of COVID-19-related mood disorders and psychosis, first noted in China at the start of the outbreak[2].
This article presents case summaries of **three** patients admitted to an Adult Psychiatric Inpatient Unit in Leeds during April/May 2020, written by doctors at different training levels, each showcasing how the pandemic has affected patient presentation and themselves in turn.
This article is based on observations and not patient interview. Patient identifiable information is not included. Ethical approval and patient consent criteria were not met and therefore not sought.

Case 1: Foundation Trainee

As an FY1, COVID-19 changed the first year of my career. Health Education England suspended rotations; therefore I worked in psychiatry for eight months instead of four, meaning I experienced how COVID-19 changed inpatient psychiatry. More patients presented acutely with many not fitting the classifications we were taught.

One that stands out is Mr X, a 44 year old gentleman, previously unknown to services who presented acutely agitated. He believed he had done 'something terrible' to his family and was better off dead.

He bit his wrists substantially in order to end his life, despite close monitoring, and required surgical intervention. He improved rapidly with medication and at discharge had no evidence of psychosis. He was the model patient.
Prior to admission, Mr X functioned actively in his community but the extreme distress drove him to acute psychosis.

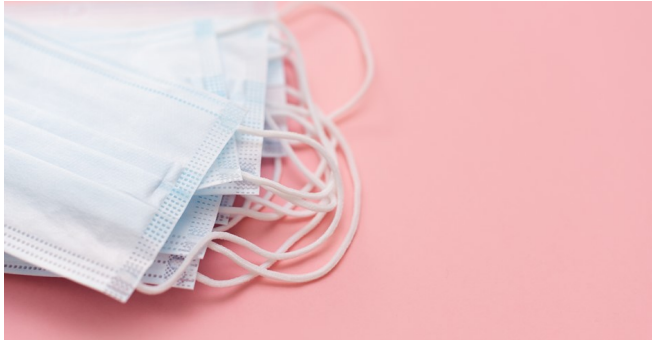
I found him interesting because he presented acutely unwell though had no previous involvement with the service, reinforcing that with the 'right' circumstances, mental illness can happen to anyone. I attended to his injury and to see him recover was very satisfying. I will take this case with me for the rest of my career to demonstrate the presentation and potential for recovery in acute psychosis.

Case 2: Core Psychiatry Trainee

I have seen an increased number of first time admissions in middle-aged individuals since the onset of the COVID-19 pandemic.
Mr Y, a 62 year old male presented with a brief, first psychotic episode. Due to the restrictions, he lost his job and was unable to get financial relief from the government. He subsequently developed poor sleep, drank more alcohol to cope, and his only human contact was his 84 year old mother.

During one of his visits, he physically assaulted her. He had a morbid fear of the COVID-19 virus, connected everything she did to the virus, and believed she had been possessed by a demon. His actions caused her shoulder dislocation and forearm fracture. He was reported to have premorbidly "worshipped" her.
The same night as the assault, Mr Y developed a right forearm tremor. Further examination and investigation revealed no significant finding and he progressively improved.

This case made me appreciate how much everyone needs routine and constant human relationship. The mental distress following disruption caused by the pandemic is enormous, with many struggling to cope, several tipped over the edge, and the effect continues to unravel.



Case 3: Speciality Doctor

The COVID-19 pandemic has instilled anxiety in degrees I have never seen in my NHS career. This has been reflected in the nature of the presentations to mental health services.
Mr Z, a 46 year old gentleman known to services with a history of depression, presented with acute psychosis and overwhelming anxiety after becoming 'obsessed with the news around coronavirus'. He ruminated constantly, felt 'clouded with information', had suicidal thoughts, and used more alcohol.
He developed COVID-19 symptoms however tested negative, became elated, increasingly paranoid, fixated on social distancing without adhering to it himself, and was distressed by the use of Personal Protective Equipment by staff.
His presentation fluctuated with periods of anxiety, elation and agitation followed by reclusiveness. He improved with medication and was discharged after 4 weeks.

I am struck by the rapid deterioration in his mental state and how being overwhelmed by negative news led to psychosis. The sense of uncertainty and 'information overload' generated by COVID-19 have been reflected broadly. I learned a lot about the impact of a health crisis on services and service users, and will draw upon these experiences in my career moving forward.

Discussion/Conclusion:

The on-going Coronavirus pandemic has caused significant distress and led to notable increases in varied COVID-19-related presentations to the mental health service.
We have seen how threat to personal safety and to those of loved ones, as well as change in routine and isolation from others led to changes in thoughts and behaviour.
We anticipate more cases of Covid-19-related mental disorders presenting to the mental health services throughout the UK while the pandemic endures and even long after.

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An example of reflexivity

Authors: Dr Shumaila Shahbaz CT3, Yorkshire and Humber Deanery
Dr Michael Lacey, Consultant Liaison Psychiatrist

Case Synopsis

An interesting case of a young mother of three children with no previous significant psychiatric or medical history, other than occasional migraines, who developed bizarre symptoms and agitation requiring admission to acute trust. She was very difficult to manage in the acute trust due to verbal and physical aggression and disinhibited behaviour. She did not engage in basic physical health monitoring at the acute trust (vital signs, physical examination, and blood tests). Due to her bizarre presentation, she had a Mental Health Act Assessment and she was transferred from an acute hospital to a psychiatric hospital under Section 2. In the mental health inpatient unit, where staff have more skills to look after mentally unwell patients, her engagement was better. We were able to do basic physical health check-ups which revealed very high blood pressure and she was again transferred to an acute hospital. She was treated for high blood pressure and her MRI-identified occlusion of the left middle cerebral artery. Her working diagnosis was "hypertensive encephalopathy".

This is a very good example of thorough history taking, a stepwise approach, and focusing on a holistic approach for diagnosis and management of patients.
It also highlights the importance of "thinking outside the box" and the importance of reflexive listening skills which is discussed in the reflection.

Patient's narrative of her journey from home to psychiatric hospital due to psychosis

It was bonfire night again. I wanted to make it fantastic for my children, like other years. We planned to buy all the junk food from the corner shop so we could munch while looking at the fireworks. We all lay on the trampoline to see it. I felt as if I had a firework inside my head and I felt as though there was a movie reel in my mind and all of it was as fresh as when I was a child. I remembered different men coming to our house and mum used to introduce us to our new dad. I remembered playing cheeky games with my brother and sisters and enjoying mealtimes, although we did not have enough food. School learning was also fun, although I was not a bright student. I loved my school and school friends.

My life struggles started in my teenage years, horrible times of my life when I met with my first husband and I felt that life was colourful and bright but he left me and my daughter. I remembered the way he wanted to control every part of my life. I felt a sense of ease when he went out of my life. I was over the moon when I met my second husband and we treasured every moment we spent together and had two lovely children.
I could not ask for more and every day was cheerful and lovely. I just fell from the sky when I found out that he was gay and he cheated me.

I was holding my two year old son on my lap and feeling "emotionally numb". I was unable to think anything. These headaches were becoming worse. I remembered when I could not speak for an hour and I felt weakness and numbness in my left arm. All this improved by itself and I promised myself that I would give my children a very good life. They would be my universe and I would do anything to protect them and to love them.

Coming back to the fireworks, we all enjoyed them together and played games in the cold weather. The children noticed that I was not well. They asked me to go to bed and have some rest. I took a relaxing bath, had a hot drink, and snuggled with my book, and then drifted to sleep. The next morning, I did not feel better at all. I started to do weird things like feeding meat to the birds, giving a bath to the pet cat and giggling inappropriately. I threw my mobile phone at the wall and broke it. I felt there was a roller coaster whizzing in my head and it would blast and explode my skull. I was not sure why I was hearing strange voices inside my head, telling me nasty things. It was too much to bear and I asked my daughter to call for an ambulance. My three children were holding each other's hands and standing with my friend and waving me goodbye while seeing blue flashing lights.

The hospital was another world that was full of strangers, unwell patients, anxious relatives, and busy staff. I felt an alien there. My agitation and restlessness started to escalate. I felt that only one nurse was kind to me and the rest of the people were very busy writing something on a piece of paper while taking to me. I felt so uneasy and I took off my top and started to giggle to feel better. I was astonished when I saw my ex-husband on the side of my bed. I screamed in anger and revenge. I told the nurse about him.

She was nice to me, she told me that I am in a safe place and he is another patient, not my ex-husband. She did not finish there, she called some doctors and nurses. They reassured me and told me that I was not mentally well and they called for an ambulance to send me to the mental hospital. I was sitting in the ambulance and looking at the blue flashing lights and bonfire fireworks, which were now merged together.
After a few minutes, she stopped talking and began to weep.

Reflection on Reflexivity

Reflexivity is an emerging part of the therapeutic practice which is reciprocal, like two-way traffic (1). Reflexivity is a stance of being able to locate oneself in the picture, to appreciate how one's self-perspective influences the whole image. It allows a clinician to focus close attention upon one's actions, thoughts, feelings, values, identity, and their effect upon others, situations, and professional and social structures. To be reflexive involves thinking from within experiences. It provides a compassionate listening environment and offers a deeper level of patient engagement and increases empathy.

Reflexivity is potentially more complex than being reflective and has more potential for understanding the "two-way traffic" between the clinician and the patient.
The above patient's narrative is a good example of a journey from active listening skills to reflexive listening skills, which is very important for doctors, particularly psychiatrists. The reflexive listening skills helped us to develop a greater therapeutic alliance with the patient who was physically unwell in a busy medical ward. She felt at ease and reassured that she was telling her story to a listening ear. As she did not have previous psychiatric history, we were able to gather more information from her instead of bombarding her with series of questions and giving her mental exhaustion while answering these questions when she was going through a very stressful situation in her life due to her health.

As I was paying attention to her story as well as thinking (using reflexivity skills instead of a set pattern of reflective listening skills) in my mind, I was able to make links in her story to complete the jig-saw puzzle to understand her problem which initially manifested into psychiatric symptoms.

It ultimately helped us to develop a holistic care plan using biopsychosocial model of care which resulted in good patient outcomes. We avoided prescribing her psychotropic medications which come with their undesirable side effect profile and it would be very risky for a young patient with a history of stroke.

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Sources of Information

The article is written by using patient medical and psychiatric notes and our clinical encounter with the patient. The patient's narrative is paraphrased.

Authors Biography

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We would like to thank all members for their contributions towards Division activity throughout the year.
If you would like an article to be considered for our Autumn Newsletter, please submit your articles to **northernandyorkshire@rcpsych.ac.uk**
The deadline for submissions is 30th July 2021.