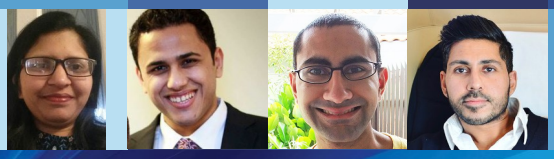



# Mind the GAP

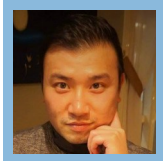
VOLUME 7 | ISSUE 2 | AUGUST 2018
NEWSLETTER BY WEST MIDLANDS HIGHER TRAINEES IN GENERAL ADULT PSYCHIATRY


## Upcoming Events

Annual Medical Education Conference **Sep 2018**

General Adult Psychiatry Faculty Annual Conference **Oct 2018**

West Midlands Division Winter Academic Meeting **Nov 2018**

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# "Letter from the patient" aids resolution of the Neuropsychiatric Conundrum


A Choudry (ST6 Forward Thinking Birmingham)
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***Sir William Osler told his students, "only listen to the patient, and he will tell you the diagnosis" to emphasise the importance of careful and thorough history taking.***

A key skill for Psychiatrists to cultivate throughout their career is the ability to integrate and synthesise all of the information obtained from an interview (Benning and Broadhurst 2007). These skills become the core component of the diagnostic process in the field of Psychiatry.

### Patient presentation and background

Mrs K is a 63 year old divorced Caucasian lady of German origin. Living alone in her flat she was fairly able to manage independently until this period of ill health. She was initially assessed due to deterioration in her mental state. She presented with extreme fear and anxiety symptoms secondary to persecutory beliefs that she had numerous unpaid bills. Following an initial crisis assessment she was followed up by the home treatment team, but she went missing during this period triggering a police search. Mrs K returned home of her own accord after 36 hours, her whereabouts during this period was not known. Following this she was admitted informally to the general adult acute psychiatric ward. At this point she complained of "struggling to cope, feeling horrible, and hearing voices".

Neurovegetative symptoms included poor appetite, low energy levels, poor concentration and lack of motivation. She also complained of fleeting thoughts of self harm.

### Past Psychiatric History

Her initial presentation was with post-natal depression when she was 21 years old. Previously she had two admissions to the acute psychiatric hospital when aged 53 years and 55 years, for treatment of depression and general anxiety disorder. Previous medication included *Trifluoperazine, Paroxetine, Citalopram and Risperidone*. Previous relapses in the community were characterised predominantly with depression and anxiety secondary to stressful life events which included her husband's business becoming bankrupt in 1994 and divorce in 1999.

### Past Medical History

She was diagnosed with hypertension and migraines. On admission she was taking Duloxetine 90mg, Olanzapine 10mg and Propranolol 80mg.

**Family History**

Her sister suffered from depression and had required Electro Convulsive Therapy.

**Personal History**

Mrs K described a difficult childhood and not feeling settled due to moving back and forth from Germany to the UK. Her mother had relocated frequently during her early years due to problems with domestic violence from her husband. She had a period in foster care at the age of 9 and stated she suffered from physical abuse from her mother during her childhood. She left school mid 60's with no qualifications and last worked in 1994 as a shop assistant. She was married for 29 years, but divorced in 1999 due to her husband's dependence to alcohol and added financial stressors due to his business becoming bankrupt. She denied any drug use, did not smoke and only drank alcohol occasionally.

**Progress during admission - Adult Psychiatric Ward**

Following admission physical and neurological examination was unremarkable and initially she was treated for psychotic depression on the basis of pervasive low mood with mood congruent auditory hallucinations. Medication was reviewed and Duloxetine was changed to Mirtazapine and this was slowly increased to 45mg. Olanzapine was also increased to 20mg.

Despite these changes in medication Mrs K continued to clinically deteriorate. She became more withdrawn, less communicative with mute periods. Mini mental state examination was completed and the scores dropped from 18/30 on admission to 8/30 within 4 Weeks. She began to display bizarre behaviours, for example undressing in lounge areas, vacant staring episodes and maintaining postures for long periods of time. During this period she also developed urinary incontinence.

An urgent MRI head was requested which revealed mild vascular changes. All routine blood investigations ruled out any underlying organic basis for the deterioration. Antipsychotic medication was changed to Risperidone by 3rd week due to the lack of improvement and antidepressant medication was changed to Escitalopram 10mg. Within weeks of medication change she had a collapse episode. Psychotropics were stopped and she was transferred to a medical ward in a district general hospital.

**Progress on Medical Ward-General hospital**

On medical review she was found to have a complete collapse of the right lung with aspiration pneumonia and further she developed type 2 respiratory failure requiring ITU care. Following recovery from pneumonia and respiratory failure her clinical state was reviewed by the neurology team who raised differential diagnoses that ranged amongst Neuroleptic malignant syndrome, autoimmune encephalopathy and spongiform encephalopathy. Due to fluctuating increased tone when examined she was commenced on Co-Careldopa for drug induced Parkinsonian type symptoms. However further investigations including lumbar puncture and CSF examination were normal and EEG showed no epileptiform activity.

Clinically at this point following recovery from the pneumonia she presented as predominantly withdrawn, uncommunicative, and fully dependent for all her care needs. Subsequently on basis of extensive nursing need to maintain her care following a pre-discharge meeting, she was discharged to a nursing home from the general hospital medical ward and followed up in the community.

However the placement did not last and within one month Mrs K was re-admitted to a medical ward at the general hospital due to poor oral intake, dehydration and poor compliance with medication. She was uncommunicative and more resistive to care by the nursing staff. During this readmission to a medical ward another neurology review was sought and following a review of all the investigation results it was felt that her presentation was that of rapidly progressive dementia.

**Second Opinion Assessment - Old Age Psychiatry Input**

A referral was made at this point to the old age Psychiatry team. When reviewed mental state examination revealed a frail thin lady lying in the foetal position horizontally across the bed, uncommunicative, following people with her eyes and not interacting with staff. She was able to follow simple commands. She remained mute and lay still in one position with evidence of posturing. There was evidence of rigidity, negativism and ambitendence. Mood objectively appeared low and subjectively there was no response. Any further assessment was limited by lack of cooperation.

During this assessment a detailed letter written by the patient following the period of care when she was in ITU was found in the notes. The letter had been written by Mrs K prior to her discharge to the nursing home, written at the time of her pre - discharge meeting. This letter addressed by her to the clinician treating her at the time gave an account of her understanding of her own presentation at that point and her wishes of future care. A summary of the letter appears on the next page.

Following this assessment a working diagnosis of Catatonia was made on the basis

### Mrs K's letter

The following transcript highlights some of the key points raised by her in the letter. It was corroborated by her daughter that this letter was written by Mrs K herself.

**Transcript:**

- "I used to work for social services which I enjoyed"
- "I had to go to bay 17, I was very ill"
- "I was in bed 2-3 weeks sometimes I would speak to R (Her Daughter) other times stare into space"
- "my family have been crying in despair"
- "I hope to go back to my home if my legs will carry me, if not I will have to go to a home"
- "I hope to be independent in the flat, watch TV, listen to radio and fetch little bits of grocery"
- "worried about climbing the stairs"

of her clinical presentation and evidence based on the letter of her having apparent awareness of surrounding and her existing circumstances. Subsequently she was transferred to the old age psychiatry ward. Whilst on the ward she was noted to have mute episodes and remained uncommunicative and was dependant for all activities of daily living and self care. Bush Francis Catatonia Rating Scale highlighted the presence of 9 Catatonic Signs.

As the assessment progressed she was commenced on Lorazepam on a as required basis to which she had a marked clinical response with periods when she would appear brighter and become quite communicative but then regress back to a catatonic state. She was then commenced on regular oral Lorazepam which had a striking impact. Mrs K became more animated having spontaneous conversations with staff and residents. As the assessment progressed Duloxetine and Aripiprazole was started and Co-careldopa was stopped. It was felt as opposed to Parkinson's disease, the observed rigidity likely attributed to catatonia. She continued to require ongoing prompting to eat and drink and assistance with self-care and remained incontinent of urine.

On the basis of a presentation of catatonia, Mrs K was assessed under the mental health act for ECT. However she agreed to have ECT as informal patient.

Over the next few weeks there was a marked improvement in the mental state which stabilised following the 5th ECT treatment. Diet and medication compliance improved, and she began engaging in her self care as well as spontaneous conversation with peers and staff. Her MMSE scores improved from 14/30 at commencement of ECT to 29/30 over a period of 6 weeks.

By the 10$^{th}$ ECT, there was a remarkable improvement noted. She now presented alert with no cognitive problems. She was euthymic in mood with no objective evidence of psychosis and had good Insight. She became independent of all activities of daily living. She maintained this progress and made a full recovery. Following this she was discharged to a residential unit in community for further rehabilitation input with a view to moving her subsequently to sheltered supported housing accommodation.

**Discussion**

During the psychiatric reassessment a careful review of the medical notes at the general hospital revealed the finding of a hand written letter from the patient which had been filed in the notes. This letter was written by her addressed to the then treating clinician at the time when a pre-discharge meeting had taken place at the hospital prior to her discharge to the nursing home. Contents of the letter as highlighted above clearly gave us an insight into her understanding of orientation to the place, understanding and awareness of her ill state and her own views related to future care options. Her insight and awareness reflected in the letter enabled us to move the working impression of rapidly progressive dementia down the list of differential diagnosis. Following our clinical assessment alongside the benefit of having a comprehensive organic evaluation, the history of typical presentation of severe depression with psychotic features at the onset of her Illness helped us to point towards the diagnosis of catatonia secondary to severe depression with psychotic symptoms.

This handwritten letter by her was what we considered the key to her recovery process and one that she provided us. If this letter had not been there we consider it would have been very difficult to make judgment on her cognitive function in

her mute and withdrawn clinical condition. The letter that she herself wrote in this clinical state gave us insight into her cognitive function and enabled us to challenge the diagnosis of rapidly progressive dementia that was kept at that time. With that insight comprehensive psychiatric assessment revealed more catatonic signs. Once this diagnosis was arrived at appropriate treatment could be initiated which led her to have full recovery.

**Importance of history taking as a skill**

History taking remains the most important tool for assessment and diagnosis across the field of medicine. In Psychiatry the importance of History taking is further amplified as this science is limited by lack of confirmatory investigations.

Essential value of history taking is further enhanced when it is ensured information from all sources is obtained. Primarily in Psychiatry this includes taking a history from the patients and obtaining collateral history from the next of kin or carer who know the patient well. Moreover information from all other professionals involved in patient care and equally from the patients all clinical notes are important sources of valuable information. As this clinical case highlights it was the information found in her medical ward notes that became the key to making the diagnosis.

Core skill of history taking forms an integral part of long case assessments in Psychiatry. Only by practicing this skill repeatedly can one master it and can this be deeply embedded in one's clinical practice.

For a trainee, training is guided by the assessment process at the end of training period. As highlighted in a personal view (NC Teoh ,FJ Bowden BMJ May 2008) in which author's share experience of teaching at a University where final year students are not required to do long case assessments. They report after completing their summative long case assessments in the third year, many students stopped seeing patients and spent most of their time studying for written assessments. And they further make the observation that the student's clinical skills in the final year deteriorated.

With the advent of current examination system of OSCE's and thereby the unfortunate demise of long case assessments, there is growing need to ensure that through the training period for trainees every attempt is made for on-going emphasis on developing and mastering the skill of history taking.

# Harm minimisation and recovery strategies - a reflection

Richard Carr
Final Year Medical Student, University of Birmingham Medical School

***A reflection on how harm minimisation and recovery strategies are integrated in rehabilitation services***

In addiction psychiatry, the strategies used to treat patients can generally be grouped into two clusters: harm reduction and recovery. Harm reduction is the practice of trying to minimise a user's risk to themselves through unsafe drug-taking habits. Services available here might include opioid substitution therapy (OST), needle exchanges, and encouraging patients to switch from IV drug use to lower-risk routes of administration such as smoking or insufflation. Recovery, meanwhile, aims to help people detoxify and remain clean from substance use indefinitely. This might include Narcotics Anonymous meetings and other self-help groups, psychological interventions such as motivational interviewing, and sponsorship programmes. I recently spent my elective period at the iHEAR partnership in Hounslow and was able to observe how these strategies are integrated in modern addiction services, providing a holistic and tailored package of care to each individual patient.

I had a conversation with one of the doctors about how practice had changed over the past decades, and as she remembered it, the landscape of addiction medicine has generally favoured one or the other strategy. The HIV/AIDS epidemic in the 1980's ushered in heavy promotion of harm reduction (as well as a great deal of support for addiction services), with the focus being to reduce a patient's exposure to blood-borne viruses through the introduction of needle exchanges, virus testing, and even injectables clinics where patients with severe IV opioid habits could receive a special preparation of IV methadone. Crime reduction was another aim here. Since the focus was society's benefit rather than the patient's, and society benefited as much from patients continuing treatment programmes as completing them, thousands of people were en-

couraged onto OST while little was done to help them detox from it, and they remained on the programmes indefinitely.

Following this, practitioners started to consider how patients could be helped to quit their habits for good, and the focus shifted to recovery. Maintenance, previously the accepted standard treatment for service users, became a “dirty word”. At the same time, some of the harm reduction practices, such as the injectables clinics, started to fall by the wayside (only 2 patients in the practice were still using IV methadone). The shift was dramatic and led to an obsession with getting patients off drugs, often too quickly. Since then practice has found a happy medium, which has been reinforced by the release of guidelines promoting the benefits of both approaches [1].

It is possible to see how some people might, in the past, have viewed these two strategies as contradictory: you either put your resources into getting people onto OST or off it. However, this caused problems. When the focus was on harm reduction, patients on OST were often left to their own devices; if they wanted to become fully clean it was largely up to them, but the lack of recovery-oriented treatments meant they were often unsuccessful. Likewise, when the focus was on recovery, the needs of heavily dependent patients were overlooked, and people may have been rushed into detoxing too fast, increasing the risk of relapse [2]. This has changed in the past two decades. In my time at iHEAR I saw both recovery and harm reduction strategies being applied, not as individual opposing schools of thought but as integrated treatments that complemented each other.

For example, OST is primarily a harm reduction strategy that for many people still forms the central pillar of their treatment, moving them onto a controllable and stable drug regimen that minimises the risk from, for example, inconsistent strengths of street heroin or adulterated drugs. However, it is also a tool that can be used to promote recovery: stabilising on a steady dose of medication with a long half-life is far easier than with a short acting drug such as heroin. Once stable, a detox can be initiated if the time is right. This replace and reduce strategy, controlled by a trained practitioner, tailored to the needs of the patient and complemented by other recovery-focused interventions aimed at keeping the patient off drugs, is a far more effective way of quitting drugs altogether than either OST alone or a cold turkey withdrawal and is the prime example of how harm reduction and recovery can work synergistically [3].

However, one thing that struck me about modern services is the degree of flexibility with which the doctors approached patients’ treatment. This, to me, represents an important departure from the more rigid practices of the past, and recognises that there is no one-size-fits-all treatment for addiction. One patient I saw had a long history of spotty interaction with iHEAR, a number of stop-start attempts at quitting drugs, a complex psychiatric history and was on 55ml of methadone at the time of the consultation. The plan that was developed for him did not include a view to quitting methadone at all, with the doctor explicitly stating he could well be taking it for life. The view was that for this patient, the risk of relapse bought on by detoxing (and the subsequent, inevitable loss to follow-up) was greater than the indefinite methadone, at least for the time being. This consultation showed me that individual interventions available in addiction are, more than anything else, tools in a toolbelt, and that flexibility was more valuable than trying to argue for or against the value of harm reduction or recovery as the central aim of the service. The individual patient circumstances will dictate what treatments are most suitable.

My time at iHEAR was an eye-opening insight into an area of medicine that is barely, if at all, covered in the medical school programme. Addiction is increasingly underfunded; at iHEAR each new contract is delivering less and less to the services, meaning volunteers are being relied upon to fill many of the positions that previously may have been run by salaried staff. As the debate reopens about how to allocate what funds are available and even what the goals of addiction services are, it is imperative that doctors do not themselves relapse into the rigid thinking of the past, inescapably at the expense of their patients.

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**1.** Strang J. et al. Medications in recovery: re-orientating drug dependence treatment. National Treatment Agency for Substance Misuse, 2012.

**2.** Stimmel B, Goldberg J Cohen M. Rotkopf E. Detoxification from methadone maintenance: risk factors for relapse to narcotic use. Annals of the New York Academy of Sciences, 1978, Vol.311, pp.173-80

**3.** Amato L, Davoli M, Minozzi S, Ferroni E, Ali R, Ferri M. Methadone at tapered doses for the management of opioid withdrawal. Cochrane Database of Systematic Reviews 2013, Issue 2.

# Analysis of self-inflicted abdominal trauma at Queen Elizabeth Hospital Birmingham 2016-2018

Mr G Kerans (CT Surgery), Dr Y Zakaria (ST5 General Adult Psychiatry), Mr T Ismail (Consultant Surgeon), Mr B Tan (Consultant Surgeon)

## Introduction

Deliberate self-harm is a common presentation to A&E in the UK. Abdominal self-harm may suggest a higher degree of intent to harm given the higher forces required to penetrate deeper tissue layers.

Abdominal trauma from self-inflicted injuries and he patient pathway is a poorly understood area which poses a significant burden to both surgical and psychiatric services.

## Aim of Study

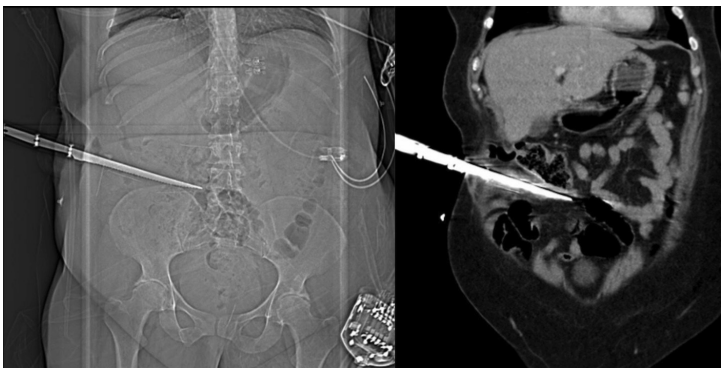
The aim of this study was to characterise the epidemiology and outcomes of patients with self-inflicted abdominal injuries in order to improve understanding and clinical management relevant to both surgical and psychiatric teams.

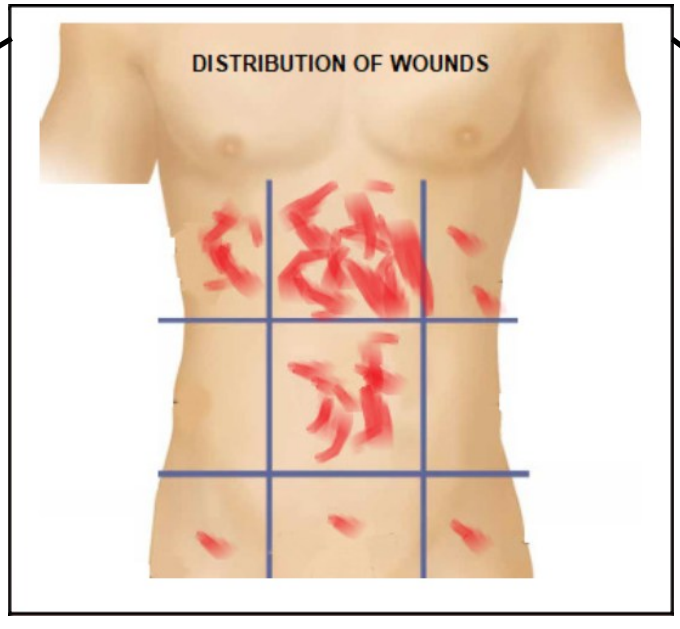
## Methods

The clinical registry of patients admitted through A&E at the QEHB and the web-based electronic care record system for mental health patients, RiO, were utilised to identify all patients with a self-inflicted abdominal injury from 2016-18. Demographic data, injury characteristics, surgical interventions and outcomes were analysed.

## Results

- 20 patients presented to QEHB with self-inflicted abdominal injuries.
- Most were male (75%), with a mean age of 38 years (range 20-68).
- 75% of patients had a previous psychiatric history.
- The most commonly used instrument was a kitchen knife (75%).
- 50% of patients required a laparotomy; only one laparoscopy.
- 20% were transferred to a psychiatric hospital with a mean length on the surgical service of 5 days.






37% of patients were in their 20s

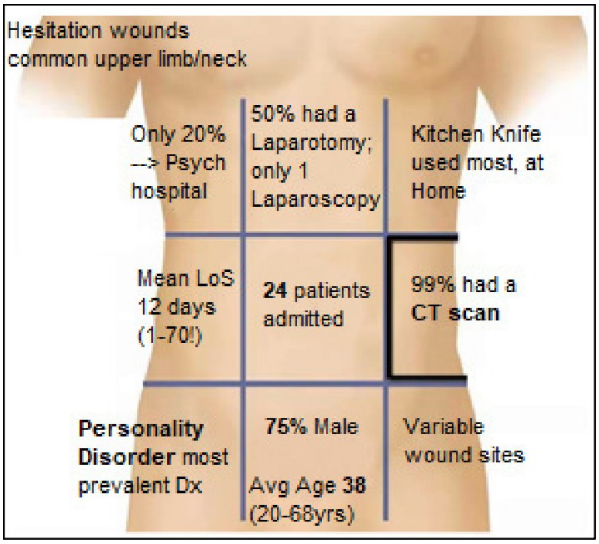
No deaths occurred in hospital

Upper abdominal wounds at laparotomy revealed significant intra -abdominal injury

Most common site of injury was the epigastric region

RUQ and umbilical the second most common

Four patients required a blood transfusion




### Conclusion

Self-inflicted abdominal trauma can induce significant abdominal, retroperitoneal and intrathoracic injuries although the mortality rate caused is relatively low. These presentations represent a unique opportunity for secondary prevention through psychiatric intervention. These interventions may not only preserve life but also improve resource utilisation.

# An Audit on Care Pathway in Recovery Services: A Case of 'Inverse Care Law'

Vrinda Chandrachoodan (Consultant Psychiatrist, BSMHFT), Andrew Leonard (FY1), Sudheer Lankappa

### Introduction

The Care Programme Approach (CPA) provides a framework for the effective management of individuals with severe mental health needs. It is reported that the City Recovery Services (CRS), adult services for chronic mental disorders, Nottingham City, had significantly more patients on Care Pathway than CPA Pathway compared to national standards.

### Aims

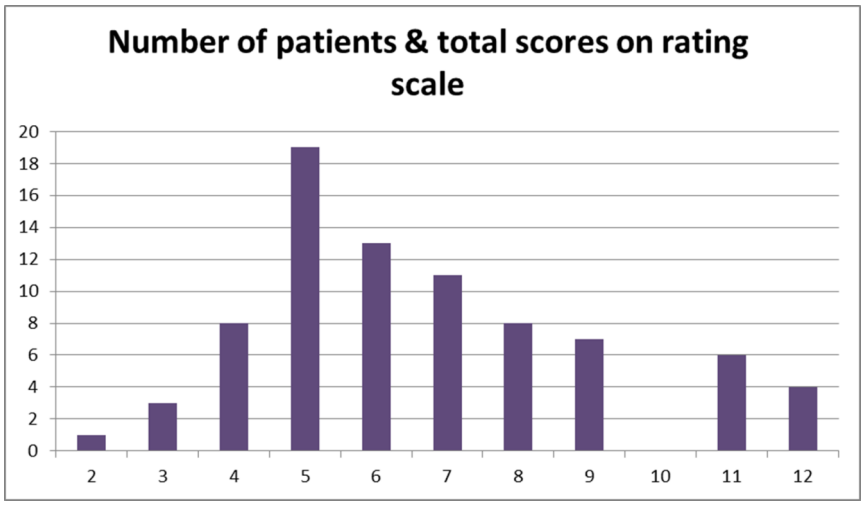
This audit reviewed patients on Care Pathway and rated the complexities of their needs using national CPA eligibility criteria with objective of identifying if these patients needs are best met on a CPA pathway.

### Method

Data relating to patients socio-demographics, psychiatric and medical illness, substance use, risk, cognitive and functional abilities etc. were obtained from clinical letters for CRS patients. These items were rated on a scale (below) based on presence or absence for each domains and the total score indicated severity of their needs.

### Locally developed rating scale (1 point for each domain)

- Complex mental illness (> 2 conditions)
- Physical comorbidity
- Intellectual disability
- Substance misuse
- Alcohol misuse
- Complex psychotropic medications
- Accommodation difficulty
- Other agencies
- Criminal Justice System involvement
- Carers involvement
- Recent admission/Crisis Resolution Home Treatment
- Problem in functioning
- Cognitive problems
- Parenting responsibility
- Risk assessment (one point for mod-high risk)

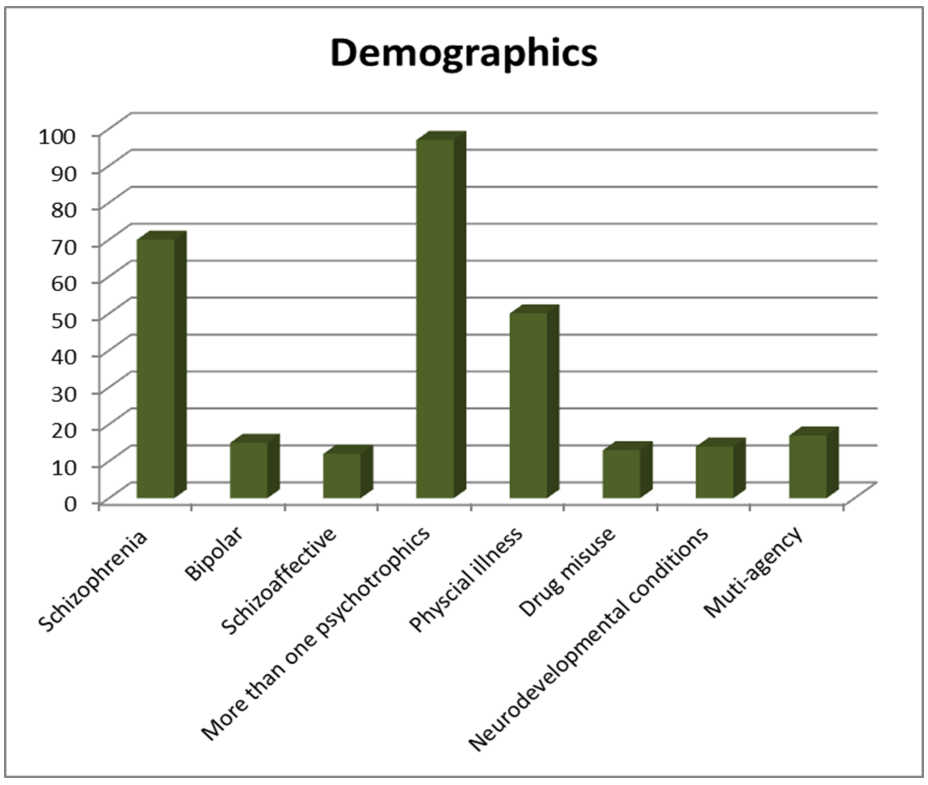



Based on CPA eligibility standards, all categories were scored and total sum was computed for each patient. The lowest total score was 2 and the highest was 12 (higher the score indicates more complex the needs).

**84% patients scored more than 5 points indicating their needs are best met under CPA rather than care pathway.**

## Results

- A total of 81 patients were audited, mean age 51 years with 53 (65%) males.
- 44% were ethnic minorities.
- 70% had primary diagnosis of schizophrenia, 12% schizoaffective, 15% bipolar disorder
- 7% had neurodevelopmental disorders including ID (intellectual disability)
- 17% of patients had comorbid psychiatric conditions.
- 97% had more than one psychotropic medication.
- 50% had physical illness, 13% had drug and alcohol dependence.
- 93% of patients were unemployed and 87% in receipt of benefits.
- Multi-professional agencies were involved in 17% of the cases.




## Conclusion

It is acknowledged that 'inverse care law', the availability of good care tends to vary inversely with the need for the population served, still exists for mental health. Our findings indicate that patients with chronic mental illness with complex needs are less supported from services.

Possible reason for patients with residual symptoms and functional impairment receive less support in resource constrained services is they are classed as minimally challenging and less risky. Our findings highlight the need for services to make relevant organisational changes to address this dissonance. By providing optimal care aligned to national standards will enhance mental health and general well-being and help achieve recovery of our patients.

# Advising Patients on Fitness to Drive: Re-Audit

A. Kumar (ST6), M. Hossain (Associate Specialist), E Kearns (FY1), Y.Zakaria(ST6), D.Pang(ST6)
N. Kennedy (Consultant Psychiatrist) - Birmingham and Solihull Mental Health Foundation Trust

## Introduction

An original audit in the Leicester Partnership Trust in 2016 gave recommendation as follows:

- To disseminate findings of the original audit within the team.
- Team presentation of Audit results to clinicians.
- To include the question of whether the patient drives into the Core MH form on RIO.
- Stress on importance of asking whether patients are driving in local junior doctor induction.

After implementation of the above recommendations, we undertook the task of re-auditing in Birmingham and Solihull Mental Health Foundation Trust. This looked at whether clinicians were recording key questions on whether patients were driving.

## Aims

- To determine the number of Service Users that drive and may have had a reduced ability to drive, and see the number of those affected who have been identified during their inpatient stay
- To determine whether patients have an impaired fitness to drive and the number that have been advised to abstain from driving upon discharge and to notify the DVLA, and whether this has been documented
- Where there is evidence that the Service User informed the DVLA, and if not, the number of Service Users where their clinician has informed the DVLA directly
- To design and implement an action plan to increase compliance with best practice

| Criteria | Standard | Evidence base |
|---|---|---|
| Where patients are identified as having an impaired fitness to drive, the Risk Assessment Template should be completed (on admission) with details and information source key. | 100% | Assessing Fitness to Drive Guidance from DVLA |
| For patients who were driving prior to the onset of their current episode of illness, (inpatient episode): | | |
| They are advised not to drive upon discharge. | 100% | |
| They should be advised to notify the DVLA of their condition. | 100% | |
| They should be advised that it may be necessary for their clinician to notify the DVLA of their condition. | 100% | |
| There is evidence that the patient is monitored and encouraged to ensure they have notified the DVLA. | 100% | |
| If the patient has not informed the DVLA the clinician is to inform the DVLA. | 100% | |

## Data Sample and Source

All patients who were admitted to an acute inpatient psychiatric ward in Birmingham and Solihull Mental Health Foundation Trust during a 6 month period between August 2017 and February 2018.

The total number of patients included in the re-audit were 147 that were randomly selected using Microsoft Excel from a total sample size of 1582.

We conducted a comprehensive audit of not only the initial clerking documentation, but also went through Rio (our electronic records system) progress notes to identify whether patient's pre-admission driving status had been documented.

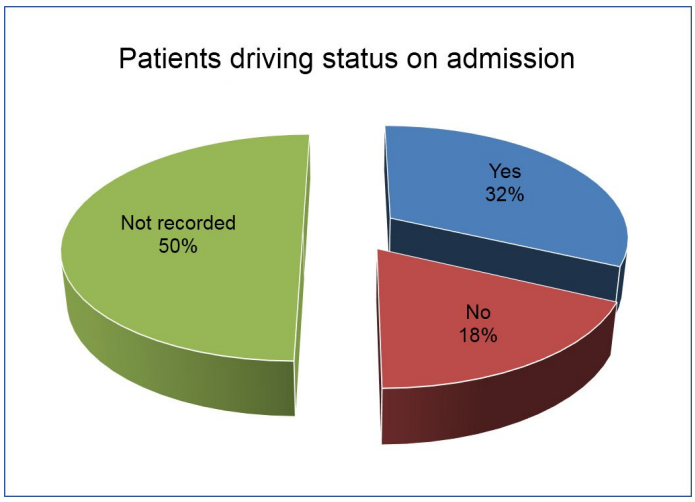
## Findings

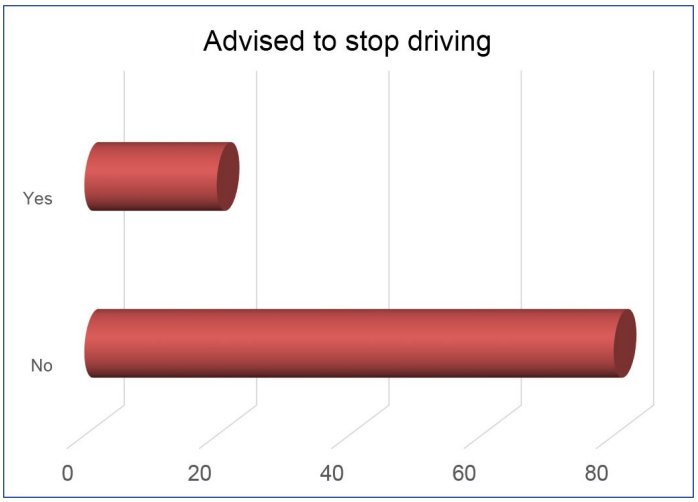
Out of the 47 patients who were identified as driving pre-admission, we then audited the number of patients who were advised to stop driving. *(Results in the chart below)*

20% of patients were advised to stop driving out of those patients who recorded to be driving prior to admission.

Out of the 47 patients who were identified as driving pre-admission, 7 patients were advised to inform the DVLA.

Out of the 47 patients identified as driving pre-admission, the clinician was documented to have informed the DVLA for 3 patients.




## Discussion

Driving was not discussed with patients unless they were admitted with a driving offence or if dangerous driving was as a result of their mental illness, e.g. BPAD

Five patients were admitted with some driving related incidence and a discussion about stopping driving or informing the DVLA never occurred throughout their admission

Two patients where pharmacy or student pharmacist discussed concerns regarding medication and the impact on driving. Advised to discuss in MDT however this never happened.

## Comparison of Results with Initial Audit

On analysing the results, we are able to observe that compared to results in 2016 where 75.6% of patients driving status was not documented on admission, on re-auditing the sample in 2017 we noted that 49.6% of patients driving status had not been documented on admission.

This is a considerable decrease compared to our initial audit, however further work needs to be carried out to ensure that we can meet our standard criteria.

From the initial audit in 2016 – we note that in 11% of cases, the clinician advised the patient to contact the DVLA.

In comparison to the results of the re-audit in 2017, we note that in 14% of cases the clinician advised the patient to contact the DVLA.

We note that this is not a considerable change compared to the initial audit results and are acutely aware that measures need to be taken to ensure these results are improved upon in the future. These measures have been outlined in the recommendations.

### Recommendations

Disseminate findings within the trust

Present results at team meeting

Include Audit findings and stress on importance of documentation of driving status and local junior doctor induction forums.

Integrate questions on driving status as part of clerking assessment document.

Re-Audit in 2019

# The use of Video-Consultation within Secondary Psychiatry Services: a Scoping Exercise and Pilot Study

Dr Laura Stevenson, ST5 dual OA and GA psychiatry, North Staffordshire Combined Healthcare NHS Trust.
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## Background

North Staffordshire Combined Healthcare NHS Trust (NSCHT) Serves over 470,000 people of all ages across the Stoke-on-Trent and North Staffordshire areas. It was identified that on the whole, technology is used in a somewhat limited way to engage patients and that there was scope for development in line with what other healthcare providers offer. This included the use of video-consultation. Skype; one of the most widely used software applications for video communication has over 30 million online users at peak times and over 600 million users worldwide [1].It is therefore unsurprising given its extensive general use that avenues are being explored for expansion of this within the healthcare setting. Video-consultation over recent years has gained in popularity as a means of patients accessing healthcare professionals and a variety of services are currently available. It is recognised that some patients may prefer this method of communication for a number of reasons including convenience, time and financial costs, as well as being able to conduct a consultation in the comfort of their own home. There are also potentially a number of benefits to the organisation, including increased accessibility, a potential reduction in the rate of patients who fail to attend for face to face appointments in person, and travel time and costs when otherwise patients would have been visited at home. One of the challenges for service providers is the determination of which patients may be suitable to consult with using this method. This involves an assessment of risks and benefits, ensuring that aspects such as safety, security, information governance and medical indemnity have all been considered and accounted for [2]. Within the setting of secondary mental health services there are aspects to a clinical consultation such as the assessment of mental state and risks to self and others that are especially important, but there are areas of psychiatric care which could be very amenable to the use of video-consultation . Our aims were to determine patient interest in using video-consultation as a means of accessing mental health professionals; to identify any barriers to its widespread use; to complete a pilot study using video-consultation with patients already open to the service rather than attending for an appointment in person, with evaluation focussing on its acceptability, advantages and disadvantages to guide future service development.

## Method

Prior to commencing any work with patients the relevant trust documents were reviewed and updated in line with the clinical governance framework. The decision was made to conduct the pilot study within the neuropsychiatry and old age psychiatry directorate as clinicians within these areas had expressed an interest. A standard operating procedure and clinical guideline were produced clearly indicating the groups of patients identified as suitable participants. It was deemed appropriate to only offer follow up appointments via this method. The use of video-consultation was promoted to patients and carers as well as staff, and a patient infor-

mation sheet and consent form were distributed. A specific weekly medical out-patient clinic was established with the expectation that members of the nursing team visiting patients at home or in a care environment would support them to consult with the doctor for review in this way. Patients involved with the Vascular Wellbeing Team (part of the neuropsychiatry service) were also invited to participate by a lead nurse colleague for 1:1 video-consultation. This patient cohort tended to be younger and suffer with memory impairment plus vascular risk factors often combined with a mood component. The pilot ran from September 2017 for a period of 3 months. Qualitative evaluation was sought from staff, patients and carers in the form of a short survey and 1:1 focussed discussion.

For the scoping exercise, questionnaires were devised and distributed to all wards at the Harplands Hospital, Stoke on Trent, and staff were asked to encourage all patients deemed suitable to participate. A slightly different version (reflecting the differences between inpatient and outpatient care) was distributed to four community mental health centres (general and older adult) over the course of one week and placed in the reception area or with reception staff. Scoping questions included whether patients had access to the internet, were aware of video-consultation and how to use it, whether they would be willing to use it to see a mental health professional and the reasons underlying this. One of the questions asked patients about their use of other technology enabled communication or social media.

## Results

Only a small cohort of patients and carers were recruited into the pilot study, for a number of reasons. Qualitative evaluation and summarisation produced the feedback depicted below and overall this was generally very encouraging. It was however clear that technical issues with the video-consultation reduced overall satisfaction on occasions.

N=129 completed questionnaires were received (24 from hospital inpatients, 105 from community patients). There were some notable differences between patient groups for example 81% of patients surveyed in the community had access to the internet compared to only 62.5% of inpatients. Figure 1 depicts the average percentage of patients who responded “yes” to questions across all groups. 71.3% overall knew what video-consultation/ video-calling was, 44.3% knew how to use it but only 36.6% reported that they actually use it day-to-day. 38.2% would be willing to see a mental health professional via this method. Of those not familiar with the technology, 18.2% indicated that they would be keen to learn. There were some notable differences between the responses when comparing those outpatient questionnaires returned from the older and general adult services. Out of the total responses, 22 of the 105 were from the older adult service. Of these, only 63.6% reported having access to the internet at home compared to 85.5% within the general adult population. Whilst 72.2% of the general adult population were aware of what video-consultation is, only 40.9% of the older adult population were. Only 9.1% of older adult patients knew how to use video-consultation and the same percentage responded that they would be willing to sometimes see a health professional via this method. This compares to 34.9% of the general adult population who said the same. Figure 2 depicts the percentage of patients overall who responded that they used other forms of technology / social media.

**Figure 1**

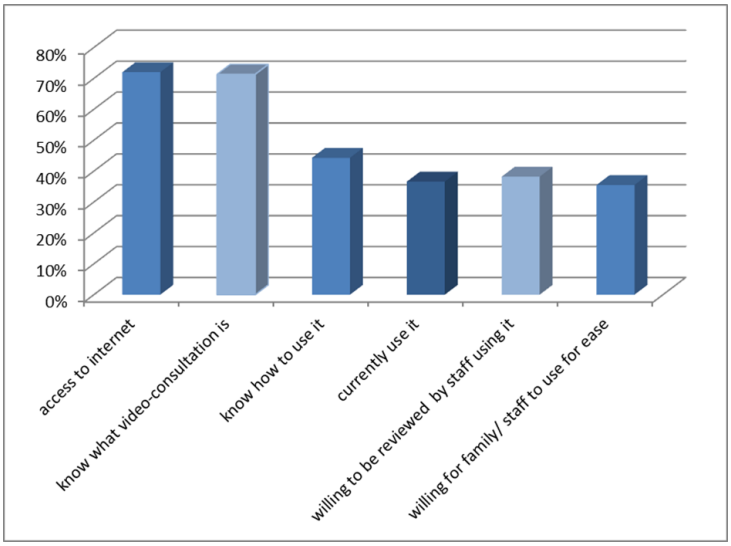
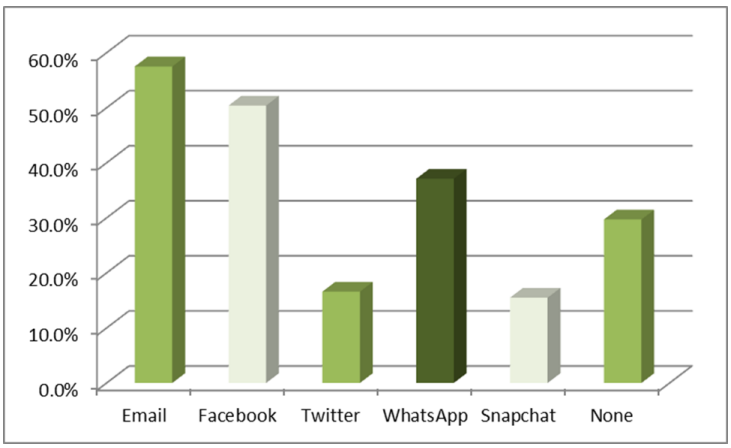



**Figure 2**



**Conclusion**

Overall there is evidence that some patients under the care of NSCHT would like to access mental health professionals using video-consultation and as such we should look to develop and expand this service as well potentially the use of the other technology. A limitation of this work is the small scale of the pilot study and the recognition that biases may exist with regards to those patients who chose to complete the scoping questionnaire. It is a challenge to determine whether they represent the true views of the population as a whole. Those supportive of the technology's use cited convenience and ease of access as reasons for this, however others reflected that they preferred to see mental health professionals in person. This was due to the sensitive nature of the discussions that take place and the perception that "in person" contact is more therapeutic. For expanded use to be feasible technical issues need to be addressed and resources targeted appropriately for instance by making training available to both staff, patients and carers. On reflection, future studies may be better aimed at the general adult, or potentially the child and adolescent population to increase participation, however, no patient group should be excluded as there are situations, for instance within a care home setting where the use of video-consultation may prove to be particularly effective in maintaining open communication.

**References**

1. Bloomberg Business Week. Microsoft Said Negotiating Skype. Available at: http://www.businessweek.com/technology/content/may2011/tc20110510_963865.htm
2. Uniquest Pty Ltd. Telehealth Business Case, Advice and Options. Final Report. Available at: http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/6E3646F307A5E938CA257CD20004A3A8/$File/UniQuest%20Telehealth%20Business%20Case%20Advice%20and%20Options.pdf



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