


 Royal College of Psychiatrists

Psychiatry-East

The Eastern Division e-Newsletter

Editorial



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Hello! The summer newsletter is here to herald the start of the summer, in case you had not noticed!

Well at the national level we have so much to talk about..Brexit, Brexit and more Brexit; the most pressing conundrum the nation faces currently. Never has the nation been so unified in their desire to have an outcome and divided in what the outcome should be!!

In alignment with the state theme, the focus of this edition is clinical dilemmas and challenges! I am delighted with the number of perfectly themed submissions and the breadth of content received. I hope you enjoy the thought provoking articles on a range of vexing issues, as much as I have. Dr Walker gives an overview for doctors to meander through the complexities of safeguarding world. Dr Swanepoel touches on the issue of one sided bad press for clinicians. Chetan Shah and colleagues expand on the challenge of drug shortages and its impact on services. Dr Sawhney and Professor Zia flag up the ethical dilemma of incapacitated patients not accessing tribunals and urge clinicians to overcome it. Dr Khaja, explores the contentious matter of Section 49 reports. Dr Shardlow looks into the complexity of adhering to Accessible Information Standards in learning disability services.

And as ever, we have our regular features – an update on the Division by the chair Dr Raoof and feedback on the successful Eastern division summer conference. Additionally, in our ‘Conference Watch’ section we have a report on the National Association of Clinical Tutors by Dr Hafizi. Dr Swanepoel gives feedback on the Evolutionary Psychiatry Special Interest Group workshop. Finally, we have

Dr Mukherji reporting on the launch of the RADIANT, a (ReseArch in Developmental NeuropsychiaTry) consortium of NHS service providers and other stakeholders.

Many congratulations to Dr Khaja (ST6) on winning the prize for the best written article in the newsletter where he explores ‘to do or not to do’ the Section 49 reports.

I am no longer flying solo; I am delighted to welcome Dr Shevonne Matheiken (ST4) as my co-pilot in the editorial team.

Many thanks to our contributors and as always we welcome your feedback on how to improve the newsletter. We’re always thinking ahead to the next edition – the theme for the winter newsletter will be: **Work life balance for psychiatrists**. Please send us your thoughts in 800 words or less, with an accompanying picture.

Hey, there is so much more to life despite ‘deal or no deal’ and all the challenges at workplace. Hope you all have a fantastic summer and enjoy the Cricket...keep calm the cup is coming home!



Chair's Column

By Dr Abdul Raoof

Congratulations to Kate King MBE!!

Mrs Kate King, our Service User Representative and Executive member has been awarded MBE in this year's Queens Birthday Honours list

A well-deserved recognition; we all are proud of our Kate. Kate's contribution to Mental Health Act review is well known and recognised nationally. In spite of her busy schedule and multiple commitments, Kate has always made time to support Eastern Division activities and advise the Executive Committee. We are really grateful for her inspirational presence in the committee.

As you would read in this edition, we all agree that we had a very successful Spring Conference this year. Thanks to your support and our Division Coordinator Moinul Mannan and Academic Secretary Kallur Suresh's hard work, our Spring and Autumn Conferences are becoming more and more popular. Thank you all for your feedback and suggestions. Kallur has already managed to line up some great speakers for forthcoming conferences!

The Division Executive committee had a strategy meeting the day before the Spring Conference, there were multiple suggestions to improve membership engagement and to expand our activities to meet members and trainees needs. Details will follow.

In line with the College's commitment to support members and affiliates of all grades throughout their career, we are keen to develop new programmes based on your suggestions. You are already aware of our initiatives to support medical students and Foundation Doctors. Please let me know you have any further ideas.

In response to feedback from trainees and supervisors we will be running ARCP/Portfolio online workshop during the summer. Our next StartWell event for new consultants is in October 2019. Following on from the success of our Section 12 Induction courses, which were very well appreciated by trainees finishing their Core Training in the region, we have submitted a proposal to start our own AC (Approved Clinician) Induction course. Subject to approval, we aim to launch this course in March 2020. This would be of great benefit for trainees approaching CCT and preparing for consultant appointments. We have also contributed to a workshop for SAS doctors on how to apply for AC status through portfolio route.

Needless to say all such activities would not be possible

without selfless contributions from our colleagues. Many senior colleagues who have served in the executive committee are demitting offices completing their term this year. I would like to thank each one of them on your behalf while welcoming the new members to the committee. I am sure these new colleagues would bring fresh ideas and new energy to our work.

Wishing all of you a great summer!



Dr Abdul Raoof, Chair, Eastern Division



Chair's Column

By Dr Abdul Raoof

Eastern Division 2019 New Executive Committee Members

Dr David Middleton

Dr Nita Agarwal

Dr Jennifer Axford

Dr Kapil Bakshi

Eastern Division Spring Conference 2019 Poster Prize Awards

Medical Student Category

1st Prize - Bridget McManamon

2nd Prize - Nicholas Smith

3rd Prize - Owen Crawford

Foundation Year Doctor Category

1st Prize - Dr Thomas Axon, Dr K Ashaye, Dr Jayalath

2nd Prize - Dr Francis WB Sanders, Dr Nitin Gupta, Dr Harry Roberts

3rd Prize - Dr T Rance, Dr C Lazarri, Dr T Rajanna, Dr A Nusair

General Category

1st Prize - Dr Venkata Gudi, Dr Anna Eaton, Dr Petros Tyrakis, Dr Alan Kershaw

2nd Prize - Dr Joby Easow, Dr Parbathy Pillay

3rd Prize - Dr Amit Pancha, Dr Ruchi Maniar, Dr Anna Marowski, Dr Yasmin Hassanin, Dr Aneeba Anwar

Multi Disciplinary Category

1st Prize - Matthew Day, David Oakley

2nd Prize - Kirby Evans, Nadine Bogdan

3rd Prize - Jesse Fayle

The Role of an Adult Safeguarding Lead Doctor in a Mental Health Trust

By Dr Michael Walker

Working in this role, I found that it was a path that you have to find yourself. You have to ask awkward questions, make your own networks and lead your own initiatives.

Firstly I would like to set out what safeguarding is and what it isn't. Sometimes, I wonder if the term "safeguarding" is misleading. The Care Act 2014 replaced previous guidance about the "vulnerable adult" and adds "neglect" along with "abuse". However, the underlying principle remains that it relates to protection of a named individual who is in some way vulnerable, and has experienced or may experience abuse. It does not apply to a general risk from a service user to others – which would be dealt with by risk assessment and other core psychiatric management. The Care Act 2014 defines those subject to safeguarding procedures as:

- (a) has needs for care and support (whether or not the authority is meeting any of those needs),
- (b) is experiencing, or is at risk of, abuse or neglect, and
- (c) as a result of those needs, is unable to protect himself or herself against the abuse or neglect or the risk of it.

An important principle I apply in adult safeguarding is that our social work colleagues are the real experts, not doctors. My primary desire for a doctor's practice in adult safeguarding is that they can identify abuse/at-risk situations and know where to get help. This is very likely to be a social work colleague in our teams. However, not all teams have social workers, and doctors need to know how to proceed.

The safeguarding landscape can be complex with some teams having delegated responsibility from the local authority. In these teams, social workers will have primary responsibility for safeguarding and are an excellent resource for our doctors for advice and usually for referral. Other teams, either do not have social workers or they do but they only work with some service users. In these cases, the doctor will have to make a referral to the local authority, though it remains my guiding principle that having identified the need, the doctor only needs to ask for help rather than understand the details of what happens next.

This requires the professional who identifies abuse or neglect or a risk of these to:

- 1) Record an incident on the incident reporting system.

- 2) Fill in an adult safeguarding referral form to the local authority.

An important role of the Lead Doctor is to liaise with the safeguarding lead of the CCG. A challenge that the CCG has made to the trust is to evidence safeguarding supervision of doctors. SAS and trainee doctors who have regular clinical supervision are easily covered. Consultants are only appraised annually and not supervised. Safeguarding supervision of consultants is currently informal and includes support from social work colleagues. Some of our social workers organise "safeguarding huddles" where colleagues are supported and supervised in safeguarding practice. In other teams, safeguarding is a standing item on the team meeting agenda and doctors can be supported by bringing up cases, potential cases and questions here.

I heard about some Trusts where safeguarding is on the agenda at Medical Staffing Committee meetings, where doctors across the Trust meet. I also heard that our colleagues in CAMHS cover child safeguarding in their regular medical meetings, but these are on a much smaller scale. So I thought the ideal way would be to replicate the small meetings in appropriate local areas or smaller sub-specialties.

I have started a programme of rolling out Safeguarding Case Based Discussions (CBD) in local medical meetings. We use the CBD form from the Royal College of Psychiatry to record the discussions. This can then form part of the consultant's appraisal. This helps them cover both the CBD requirement of 2 per year and safeguarding elements of their appraisal. I have therefore invited myself to the consultants' regular meetings across the Trust and requested doctors to bring safeguarding cases for a CBD.

I also have meetings with the adult safeguarding leads of other Trusts. I was a little surprised to find some of them are very busy with requests mainly relating to capacity rather than actual or even potential abuse. An adult lacking capacity will meet the Care Act criterion for vulnerability, but for there to be a safeguarding enquiry, there needs to be actual or potential abuse. So use of DOLS for people lacking capacity admitted to general hospital and capacity to consent to medical procedures are both important medicolegal questions. Unless there are further complications, these are not abuse and are not in my opinion primarily safeguarding questions. Any care that significantly deviates from standards could become a safeguarding issue under the premise of neglect.

The Role of an Adult Safeguarding Lead Doctor in a Mental Health Trust

By Dr Michael Walker

Capacity is a complex issue in safeguarding. It is an important principle that an adult with capacity can decline to be the subject of a safeguarding investigation. However, there are important exceptions:

- 1) If other people are at risk – e.g. from a perpetrator of sexual abuse
- 2) If the abuse amounts to a serious crime
- 3) If there is coercion – it is important to interview the service user in private and ideally without the alleged abusers knowledge

So, although the “Empowerment” principle of the Care Act means that we would normally be guided by the decisions of an adult with capacity, it is important NOT to disregard safeguarding procedures just because someone has capacity.

In summary, being a Safeguarding Lead Doctor is an exciting role but you have to make it your own. Expectations and systems of working are very different for medical staff than other professional groups and I have put a lot of work into bridging this gap. Capacity assessment is often important in safeguarding, but is not the primary question. We must retain a focus that safeguarding is about detecting and preventing abuse of vulnerable people.



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Conundrums in the Workplace: Bad Press

By Dr Annie Swanepoel

I don't believe anything I read in the newspapers anymore. Journalists' work is to write articles that are newsworthy. For that, they need to be attention-grabbing and be something out of the ordinary. It is utterly boring from a journalistic point of view, to publish a paper about young people with mental health issues who are helped by services and make good recoveries.

However, it is more interesting to read about patients or relatives with mental health problems who report poor service, particularly if it is extreme or shocking. Whether it is the truth or not is irrelevant, as long as the paper sells.

A young person from our service, who has mild learning disability, told her father with probably similar difficulties, of poor treatment at our service. We know for a fact that this was not true and this was substantiated not only by her rapid recovery but also by CCTV evidence. However, her father went to the papers and gave them a sensationalist account that was duly published. The patient thought it was a funny prank. She was pleased with herself and relished the attention.

It is difficult to stay professional and continue to have positive relationships with patients and parents who sabotage you through their limited understanding and sometimes intentional troublemaking. What makes matters even more difficult is that it is impossible to defend the service as that would lead to a breach of confidentiality for the patient.

Clearly, the welfare of the patient is paramount. But should we not also consider the welfare of clinicians, who work so hard in such difficult circumstances?

There are several things that could potentially help. Journalists may agree to not publish one-sided accounts and insist on getting permission from the patient to get the view from the service as well? Or we may want to agree on having CCTV and voice recording of all interactions with patients, so that a balanced account can be gained and proven? I sometimes wish that an investigative journalist would film what we do, as then the truth of our good practice would become known – but on the other hand, it probably would not, as it would not be shocking or sensational and would not be newsworthy.

Such is life.



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Clinical Director CAMHS
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Drug shortages, price increases and market turbulence through the lens of mental health in England

By Chetan Shah, Andrew Smith, Prof Asif Zia and Dr Indermeet Sawhney

Background

Over the past 24 months medicines shortages have become an increasing problem for the National Health Service (NHS) in England. Alongside medicines shortages the prices of medicines has also increased dramatically particularly for generic medicines. The scenarios encountered have been unprecedented and although various reasons have been cited (*raw material shortage due to natural disaster, distribution hold ups, unexpected strikes, refrigerated truck failures, complex supply chains in remote sites, partial removal of manufacturing authorisations from two manufacturing plants and currency fluctuations*) it is unclear why the generic medicines market has become so turbulent.

Due to the prices of certain medicines increasing unexpectedly in 2017, the Department of Health and Social Care (DHSC) conducted an investigation into NHS spending on generic medicines and published their report in 2018¹. The report¹ suggested three main factors (fall in sterling, removal of licences from manufacturers and medicines shortages) that may have caused the price increases but were unable to fully verify or quantify these. Interestingly the report also found unexpected increases in pharmaceutical wholesalers' margins that it could not fully explain.

Understanding medicines reimbursement and shortages
Medicines costs in primary care or when FP10 prescriptions are issued in secondary care are controlled by the DHSC which sets out what pharmacies will be reimbursed for the cost of each medicine they dispense for an NHS prescription in a monthly Drug Tariff.

In situations when there are drug shortages and pharmacies are unable to purchase a medicine at, or under, the Drug Tariff price the Pharmaceutical Services Negotiating Committee (PSNC)² may request that the DHSC grants a concessionary price for that medicine for that month. In 2017-18, the DHSC granted 709 concessionary prices, up from 282 in 2016-17¹.

Financial and clinical impact of medicines shortages in Psychiatry

During April 2016 to 1st November 2018 approximately 11 psychotropic drugs across 40 different strengths were designated a price concession by the DHSC indicating difficulties in obtaining supply of medication. We

undertook a short analysis of the through obtaining the raw data from OpenPrescribing.net data lab³ and PSNC² website. An example of the analysis is depicted in table 1 below.

Drug	Duration of price concession (days)	Drug price before concession (pence)	Average drug price during concession (pence)	% increase in cost
Quetiapine 100mg tablets	210	159	7625	4696%
Olanzapine 20mg tablets	210	155	9542	6056%
Aripiprazole 15mg	210	120	357	198%
Amisulpride 200mg tablets	210	559	1420	154%
Risperidone 2mg tablets	90	130	1575	1112%
Chlorpromazine 100mg tablets	210	165	3331	1919%
Haloperidol 1.5mg tablets	90	113	1066	843%
Venlafaxine 75mg tablets	270	191	519	172%
Mirtazapine 15mg tablets	210	122	485	298%
Citalopram 20mg tablets	150	71	224	215%
Lorazepam 1mg tablets	210	214	601	181%

Table 1: Psychotropic drugs designated a price concession by the Department of Health during 1st April 2016 to 1st November 2018

The analysis revealed:

- Significant number of commonly used psychotropic drugs that have been affected by supply issues and therefore designated a price concession by the DHSC

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By Chetan Shah, Andrew Smith, Prof Asif Zia and Dr Indermeet Sawhney

- Across the 11 psychotropic drugs and 40 different dosage strengths there was a significant increase (mean: 1464% (3 - 6328%) in the cost of psychotropic medicines
- Across the 11 psychotropic drugs and 40 different dosage strengths there was an extended period (mean: 176 days (60 – 300 days) that the supply issue and cost increase was encountered
- A significant issue which is often overlooked is that the medication rarely reverts back to its pre-concession price.

Discussion

Pharmacological treatments in Psychiatry rely on a small pool of medicines which are increasingly more difficult to source and costing larger sums of money.

In order to ensure continuity of medication supply for patients both in the inpatient and community setting and manage the financial impact, most Trusts have had to consider alternative formulations of medications, changing strengths of medication and finally consider alternative treatment options where absolutely necessary. A clinical scenario that occurred in our Trust whereby no other options were available, resulted in a service user having to be supplied with Clomipramine 10 mg capsules and requested to take 15 capsules twice daily. Considering the age, vulnerability, severity, complexity and challenges around medication adherence in mental health Trusts, the above scenario begins to raise concerns regarding the ability of clinicians to maintain service user engagement with treatment plans.

Conclusion

The current situation faced with drug shortages is relatively unprecedented and it must be recognised and acknowledged that dealing with medication supply issues can often be a time consuming challenge for busy clinicians and the pharmacy staff.

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Let's just do it: Tribunal Referral for Incapacitated Patients

By Dr Indermeet Sawhney and Prof Asif Zia

The Mental Health Tribunal is a long established safeguard for patients detained under the Mental Health Act. It gives these patients an effective appeal mechanism to ensure legal protection of their liberty. The right to apply to the tribunal against such detention is underpinned by the right to liberty under Article 5 of the European Convention of Human Rights (ECHR). Article 5 (4) states; 'Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by Court and his release ordered if the detention is not lawful'.

A part II patient may apply to the Tribunal, or their case may be referred to the Tribunal. An application can be made to the Tribunal by a patient or his nearest relative under Section 66 of the MHA. The only way a patient detained under Section 2 can have access to the Tribunal is by a direct referral made by the patient, within the first fourteen days of detention with no provision for relatives to apply to the Tribunal. There is no provision for a managers hearing for a Section 2 patient. Essentially, an incapacitated patient can be detained without any safeguard and mechanism to review the detention for 28 days. For patients detained under Section 3, there is a provision for relatives to apply to a tribunal in the first six months of detention. However, an incapacitated patient who does not have any family member involved in their care will have no recourse to the tribunal for this period of detention.

We need to be mindful that patients who lack capacity in reality are unable to challenge their detention and, in such cases, these safeguards can be tokenistic. Perhaps unsurprisingly, a study revealed that patients who do not appeal under Section 2 have greater difficulty in understanding their rights under the Act (Bradley, Marshall and Gath, 1995). Studies that have looked into the association between capacity to request a tribunal and frequency of completed tribunal hearings found that patients with capacity received more completed hearings per year than those without, both overall, and by patient application (Galappathie, et al. 2013).

In the case of "MH v UK", the European Court of Human Rights upheld that MH's Article 5(4) rights were violated in relation to the initial 28 days of detention. MH was a woman with Downs Syndrome who lacked capacity to apply to a Tribunal and was admitted to hospital under Section 2 of the Mental Health Act. The Court upheld that "special safeguards" need to be in place in order to protect the rights of persons who lack capacity to challenge the lawfulness of their detention under the Mental Health Act. The judgement is significant, and

ensures equality of access of safeguards for patients who are deemed to be incapacitated and puts their rights at par with those with capacity. It has reiterated the obligation of the State to place patients without capacity to consent in the same place as those patients with capacity; thus protecting their rights under Article 5 (4).

How does the current statute lend itself to address the violation identified in the judgment? To protect persons lacking capacity, the Government has made amendments to the statutory guidance in the revised Code of Practice which came into force in April 2015. The role of an Independent Mental Health Advocate (IMHA) was established to help patients understand the legal provisions to which they are subject to, under the MHA (MHA, 1983), and the rights and safeguards which they are entitled to. The IMHA will assist patients to exercise their rights by helping them to make applications to the tribunal. However, the cohort of patients with moderate and severe learning disabilities who cannot appreciate that they are being detained, might 'slip through the net', and miss a crucial opportunity to access the tribunal.

Additionally, the Revised Code of Practice (Para 37.45) states: 'Hospital Managers should consider asking the Secretary of State to make a reference in respect of any patients whose rights under the Article 5 (4) of the ECHR might otherwise be at risk of being violated because they are unable (for whatever reason) to have their cases considered by the Tribunal speedily following their initial detention or at reasonable intervals thereafter'. Any departure from this should be well documented and included stating the reasons for the same. The Code of Practice also dictates that this reference should be normally be sought in any case where the patient lacks capacity to request a reference (Para 37.46). Section 67 of the MHA enables the Secretary of State to refer a patient to the Tribunal.

An audit of our services was undertaken to ascertain if detained patients without capacity admitted to our Assessment and Treatment unit, were referred by the Secretary of State to the Tribunal. The data was collected for a year from August 2015 to August 2016. Out of the six admissions, five were deemed not to have capacity to apply to a tribunal at the time of admission and a referral to the Tribunal was not done for any of the five patients.

Since this audit, a process has been set up to change practise in this context in our local service, whereby, every patient is assessed by the Responsible Clinician

Let's just do it: Tribunal Referral for Incapacitated Patients

By Dr Indermeet Sawhney and Prof Asif Zia

(RC) for their the capacity to apply to a tribunal at the outset of admission. The hospital managers are alerted for patients who lack capacity by the RC and a referral is triggered to the Secretary of State requesting for a tribunal.

We need to be mindful that for incapacitated patients, detention does not become a default position as a consequence of their inability to challenge their detention. Any departure from the guidance in the Code of Practice is not justified. There may be exceptional circumstances in clinical practice that need careful consideration with legal advice. Needless to say, routine procedures will have cost and resource implications but this should not be a deterrent to deny these patients of their basic human rights. It is ironic that the most vulnerable and marginalised patients, who need maximum protection of their rights are unable to exercise the same. As psychiatrists we need to champion and advocate for the rights of this vulnerable cohort of patient to ensure that they get a timely hearing. If we don't who will? So, let's just do it!



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MCA Section 49 Reports

By Dr Jaleel Khaja

If the House of Commons' written questions and answers (31st of January 2019)(1), are anything to go by, the government does not have data on the number of requests to the NHS bodies for section 49 reports. Neither do they have information about which NHS bodies have received these requests in the last five years. I presume that local data collection processes and impact assessments are afoot in various mental health Trusts including the one(2) mounting the 10-point challenge in RS v LCC & Ors [2015] EWCOP 56 case. There are increasing instances of consultants having to dedicate days or often a whole working week to complete the reports. This means clinical appointments are being rescheduled, probably adding significantly to patient waiting times. Conversely, there are many of us out there who still aren't aware of what the section 49 of MCA stipulates, let alone having ever been asked to produce a report. Those working in intellectual disability and old age psychiatry are more aware and indeed more likely to be asked to produce a report, as the issue of mental capacity features more commonly in the context of a learning disability or dementia than in any other mental or developmental condition.

Section 49 Reports is increasingly becoming an area of contention. Even in work places where there is scant demand to produce them, discussions abound and I often get the sense that we, as it were, are under no obligation to do this work. The fact that we have no knowledge of or clinical contact with the person, costs, pressure on time and resources and lack of medico-legal expertise would support this stance. However, these arguments (along with a few more) were dismissed in RS v LCC & Ors [2015] EWCOP 56 case and in doing so the judge provided more clarity as to the meaning of the Section 49 of the MCA and the guidance provided in the Practice Direction.

The judge clarified that no specific medico-legal expertise is required, if the format of a report as clarified by the Rules and the Practice Direction is followed. Also, there is no provision under section 49 in relation to fee or expenses incurred but the judge states that the court will "carefully consider resources and listen to any argument from the Trust particularly in relation to the time for compliance and the scope of the work to be undertaken". The judge acknowledged the cost to any Trust or NHS body and the burden upon it to comply with the direction while maintaining the provision of its service to existing patients. The judge added that such difficult questions may ultimately have to be considered elsewhere.

Practice Direction 14E(3) provides detail on how to respond to requests for section 49 reports. Based on this, many NHS bodies and Trusts have developed their

own Section 49 Reports 'standard operating procedures' and policy documents(4) to provide further clarity.

Finally, the legal experts(5) say that the direction to produce a section 49 report can be challenged and indeed this has been done successfully in cases where it was established that the NHS Trust was not the correct statutory body. In some such cases, the order was completely revoked and in some others the scope of the report was reduced. The Practice Direction ensures the Trusts have adequate time to decide whether they are the correct statutory body or not, or else to negotiate the scope of the report.

It is hugely desirable that the issue of resources and costs including fees is looked into but until that happens, the section 49 reports have to be completed regardless, because that is how the statute stands. It is vital that we gather evidence as to how this additional demand is impacting on the resources and our day to day clinical work. The evidence will help steer the will of the legislators to make provisions recognised in the case mentioned above. Making provision for payments will almost certainly attract independent assessors, thereby reducing the recurring need for rescheduling clinical appointments to free up time for doctors to be able to complete section 49 reports.

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Accessible Information Standard and the Challenges it brings to Intellectual Disability Services

By Dr Sophie Shardlow

On the 1 August 2016 it was made law (Section 50 of the health and social care act 2012) that all organisations that provide NHS care or adult social care must follow the accessible information standard. The standard was set out with the aim to ensure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need from health and social care services. However, 3 years on, are we doing well in implementing this standard and what are the challenges we face within Intellectual disability services? Given that our whole service is designed for those with a disability, we should be leading the way with this law and its implementation.

What does the standard tell organisations to do?

1. Ask people if they have any information or communication needs and find out how to meet these needs.
2. Record those needs clearly.
3. Highlight or flag up the person's file or notes to make it clear that they have communication needs and how to meet those needs.
4. Share information about people's communication needs with other providers of NHS and adult social care, when they have consent or permission to do so.
5. Take steps to ensure that people receive information which they can access and understand, and facilitate communication support if they need it.

What does the standard include?

The standard says that patients, service users, carers and parents with a disability, impairment or sensory loss should:

1. Be able to contact, and be contacted by services in accessible ways, for example via email or text messages.
2. Receive information and correspondence in formats they can read and understand, for example in audio, braille, easy read or large print.
3. Be supported by a communication professional at appointments if this is needed to support conversation, for example a British Sign language interpreter.
4. Get support from Health and care staff and

organisations to communicate, for example to lip-read or use a hearing aid.

Despite the existence of legislation, from the equality act 2010 and the care act 2014, many service users continued to receive information in formats they could not understand, so this led to the development of the accessible information standard.

The standard also specifically supports the response to Winterbourne View Hospital, where patient and carer voices were not heard, and they were not always involved in decisions about care, with serious consequences. However, recent similar events at Whorlton Hall might suggest that it has been a challenge to fully implement these standards in services for people with a learning disability.

We have many challenges within our services but these standards embedded in the law and should be the basis to all our information sharing and communication. But where do we start and how do we ensure we are addressing these needs? This may be more difficult than we think in learning disability services since we have such a wide range of abilities and communication needs to address. Standard practice to improve our communication has probably been in place for some time, for example use of easy read leaflets and letters, but this only targets a certain percentage of our patients and is not usually individualised. Others may need verbal information only, pictures, pecs, social stories, BSL, Makaton, their own signs or a combination of these. Communication with some of our patients can be very limited indeed and so we also need to ensure we communicate effectively with family members or carers, and take on board any issues they may have with the way they receive information. As community services, one of our main ways of working is through clinics, so one of the biggest challenges we may face is designing information, appointment invites and outcomes to meet the needs of each individual patient. Services tend to have a standard letter to invite a patient to clinic, which may also be in easy read format, but this will not suffice for everyone. Telephone calls may add to this but texts and emails may be less helpful for our patient group. As Doctors we tend to write to the patients GP outlining their appointment but the real challenge is to ensure that the GP receives the correct medical information but also that our patients have understood as much as possible about the meeting, and that this is followed up



Accessible Information Standard and the Challenges it brings to Intellectual Disability Services

By Dr Sophie Shardlow

and shared with them, as well as the GP, in a way that they will understand, and often for their carers/family to understand as well. Building a personalised and clearly highlighted record that all professionals can easily access, requires a system in place and should apply to our electronic records as well. Alert systems are in place on our Trust's electronic records, however it does not appear to be regularly used, awareness of its presence is limited, and ensuring this is completed and kept up to date requires additional resources. Perhaps the biggest challenge in achieving a high standard of accessible information for everyone is the time and resources that are needed to bring it all up to standard.

I recently joined hands with our local county council and set up some workshops for patients and carers on mental health awareness, looking at basic signs and symptoms of mental illness and learning disabilities. This proved to be a very helpful forum to discuss and share really important information and the feedback from both groups was very positive. This project did however involve commitment and time, as well as money, but it was very well received. This is just one way that we can improve our communication and sharing of information to help improve the lives of those with a learning disability but we really need to be doing more and getting creative within our everyday clinical practice. It's the law after all!



Dr Sophie Shardlow
Consultant Psychiatrist in Intellectual Disabilities
Hertfordshire University Partnership University NHS Foundation Trust

Celebrating 50 Years: Report of the National Association of Clinical Tutors (UK) Spring Meeting 15 and 16 May 2019

By Dr Sepehr Hafizi

The National Association of Clinical Tutors (NACT-UK) Spring Meeting 2019 took place on two sunny days at the Moller Centre, Churchill College, Cambridge. This year marked the 50th anniversary of NACT (UK).

Day 1 began with an introduction by Prof. Irish of Health Education England (HEE) describing the 'reluctant leader' in the medical education field. He suggested that being passionate about one's area of interest and having solution-focused thinking could help educators to develop as effective leaders.

Session 1 was on NACT (UK) in its 'early decades'. Dr Matheson began with the Goodenough Committee Report (1944) and went through the developments in the following decades that led to the inception of NACT (UK). Dr Jackson described the 'Nuts and Bolts' course of the 1990s and gave the audience an exercise with a series of delegation statements. In his talk Dr Whitehouse narrated his personal story and explained how a learning-needs assessment within an educational encounter is essential for engaging learners. He advocated the use of tools for measuring quality. Prof. Grant challenged establishment thinking and described medical education as a practice that is still growing in its evidence base. She encouraged the profession to be skeptical and to take back control. Dr Long described the damaging effects of the previous Medical Training Application Service (MTAS) and asked all to aspire to excellence.

Session 2 was titled 'Moving Forward'. Dame Carol Black suggested 'stewardship contribution' to help women in medicine. Prof. Melville of the GMC advocated mentorship and Prof. Hughes of HEE described her career development. The Q&A discussion included mention of upcoming GMC reports (e.g. on making investigations fairer) and an autumn conference on medical student selection. Lunch intervened before Dr Thomson gave his talk on working together and multi-professional frameworks.

Session 3 which was titled 'Where are We Now?' began with Dr Frankel. He described the tension between the role of the Responsible Officer and the need to support trainees. He cited exception reporting as a powerful tool and role modelling as essential. Dr Read (ST5 in geriatrics) advocated better consideration for those not in career grades. Prof. MacLeod emphasised how staff well-being initiatives, digital advances and flexible training pathways could all help with future recruitment.

Session 4 titled 'What Next?' was a debate between Prof. Hughes (for the motion of a better postgraduate medical education in 2029) and Dr Spencer (against the motion). Though both were convincing, fortunately the motion was passed. The Q&A suggested better integration of the NHS and HEE.

Day 2 of the meeting began with talks on SAS doctors and LEDs (Locally Employed Doctors). Dr Malin advocated the need for an hospital-based LED tutor role. Dr Takwoingi cited the SAS Charter and the SAS Development Guide (Feb 2017) in support of creating more opportunities for SAS doctors to act as supervisors and independent practitioners. Dr Fields from USA described the evolution of sophisticated interdisciplinary campuses in North Carolina, including the ECHO project where technologies such as Zoom are used for distance supervision. Ms Stuttard of PwC explained the human need for purpose and the obligation for the future workplace to adapt. She categorised the work sector into 4 groups: Yellow (Humans Come First), Red (Innovation Rules), Green (Companies Care) and Blue (Corporate is King) with the first 3 groups expected to become more prominent in the future. The Q&A discussed the need for DMEs to take charge of the education of LEDs and the need for peer mentor training.

Dr Malin (travelling fellow) compared medical education in UK and USA. He described the Severn Professional Support Unit and compared it to the SOM Wellness Initiative in North Carolina. Reference was made to the NACT (UK) document 'Supporting Trainees: A Guide for Supervisors' (May 2018). Survey results have shown trainees do not want to be seen as weak and that they worry about confidentiality and stigma. He suggested prevention work including buddying schemes, peer mentoring, support for those returning to training and faculty development. Dr Hale from USA compared and contrasted the practice of geriatrics in the 2 countries. Dr Kelsall spoke on the amazing work of the East of England Global Health Fellows in South Africa.

The presentations were followed by workshops in the afternoon. 'Supporting the Educators' workshop suggested the following: in-house CPD, thorough job planning and educational appraisals, formal induction into role, formal feedback from trainees and Educational Programmed Activities (EPA) to replace SPAs, and that trainers in difficulty could be picked up



Celebrating 50 Years: Report of the National Association of Clinical Tutors (UK) Spring Meeting 15 and 16 May 2019

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through trainee and ARCP feedback. The Professional Support Unit could then help remediate with an action plan. THE NACT (UK) website contains a number of scenarios helpful for DMEs to go through. In the 'Emotional Intelligence' workshop attendees were given a number of tools including the Johari's Window Self-Assessment Questionnaire, a Values Exercise and a tool for assessing and enhancing your own emotional intelligence. I did not attend the finance workshop, but references were made to a useful Department of Health document published in 2019.

Overall, it was a great conference with the recurrent theme of mentorship. Next year's meeting is planned for Bangor.



Dr Sepehr Hafizi
Clinical Tutor in Cambridge
Cambridgeshire & Peterborough NHS Foundation Trust



EPSIG: Workshop on Suicide 31st 2019

By Dr Annie Swanepoel

The Evolutionary Psychiatry Special Interest Group (EPSIG) of the RCPsych hosted a thought-provoking workshop on suicide on 31st May 2019.

The first speaker, Dr Mohammed Abbas from Leicestershire, spoke about how suicide is not the end, but rather the means to an end. He highlighted that as psychiatrists we tend to be good at asking questions about why people want to die and thinking about the things that happened in the past or present which contribute to that decision.

We tend to not be so good at asking about the future by considering what people think will happen after they die. This is where we miss a trick. People want to die for different reasons. Some think that their suffering will stop. Others think that they will cease to be a burden on their family. Occasionally they think it will make others sorry for what they have done. We might get important information that we can use clinically by asking young people what they think would happen after they die. Suicide is a means to an end. That end may conceivably be reached through other ways that do not necessitate dying.

The second speaker, Dr Cas Soper from Portugal, presented his thesis about the “Evolution of Suicide”. He made a very interesting point that suicide is an unfortunate by-product of the human condition. The ability to kill oneself requires a certain level of cognitive functioning. This is why young children and other animals do not die from suicide. Billions of people have got the required level of cognitive functioning to be able to think of and execute their own death as a way out of suffering.

Therefore, an interesting question arises: with so much suffering - why are there not more suicides? Cas presented a framework of “anti-suicide devices” which have evolved. It is feasible that symptoms like low motivation, alexithymia, loss of energy and reduced cognitive ability, may be a last-ditch attempt of the brain to protect us against ending our lives.

We may therefore need a conceptual shift where some mental illnesses are not the cause of suicide, but perhaps rather a biological defence mechanism against suicide. I wondered if this might explain why 50% of people who die from suicide had no diagnosed mental illness. It may also explain the potential increased risk of suicide with antidepressant treatment.



*Dr Annie Swanepoel
Clinical Director CAMHS
Elysium Healthcare*

RADiANT Inauguration Event

By Dr Kamalika Mukherji



On the 13th June 2019, Hertfordshire Partnership University NHS Foundation Trust (HPFT) organised the eagerly awaited inauguration of RADiANT at The Colonnades Learning and Development Centre in Hatfield.

RADiANT is hosted by HPFT and stands for ReseArch in Developmental NeuroPsychiaTry.

It is a consortium of NHS providers working in collaboration with academics in a number of universities. The RADiANT advisory board includes service users, patients, families, charities, community leaders and a range of statutory bodies and organisations. It focuses on mental health issues associated with five developmental conditions - Intellectual Disability (ID), Autistic Spectrum Disorders (ASD), Attention Deficit Hyperactivity Disorder (ADHD), Epilepsy (EPI) and Acquired Brain Injury (ABI).

Tom Cahill, Chief Executive and Professor Asif Zia, Medical Director at HPFT welcomed over 80 attendees

including service users, patients, carers, representatives from National and local charities, members of NIHR, and professionals to the inaugural programme .

First Speakers included Dr Regi Alexander (Convenor), Prof Sabyasachi Bhaumik (OBE Honorary Professor, University of Leicester) and Dr Jean O' Hara (National Clinical Director of Learning Disabilities at NHSEi). They spoke about the importance of a research active NHS and called upon engaging frontline clinicians, service users and carers to work together to define research priorities.

Viv Cooper (OBE from the Challenging Behaviour Foundation) gave an inspiring family carer perspective and spoke about: Outcomes that matter: "Can we do better? We can ... and we must".

We heard from Dr Rajesh Mohan (Chair of the Rehab Faculty at the Royal College of Psychiatrists) and Dr Venu Harilal (Medical Director from NCHC) about models in other services (Mental Health and Acquired Brain



RADIANT Inauguration Event

By Dr Kamalika Mukherji



Injury) where coproduction in a research informed manner have actively improved outcomes. Dr Harilal spoke with passion about his drive to introduce the bio psychosocial model in ABI rehab models.

After a networking lunch, poster viewing and some photo opportunities, the audience was pleased to hear an erudite presentation on the challenges of conducting randomised controlled trials and possible solutions delivered by Prof Angela Hassiotis from UCL, London. The audience debated this extensively.

The next session was ably led by Mr Tadghh Lane (Expert by Experience) and Miss Verity Chester (PhD Student at the University of East Anglia). They jointly spoke about a recent Quality Improvement study to consider "Patient and family perspectives of experience, and outcome of care and treatment with patient rated outcomes that really matter".

The final session of the day was delivered by Mr Jonathan Spiers of Autistica. It was inspiring to hear about the journey of Autistica, the only research charity for Autism, who have been pivotal in creating a network for charity funded research into neurodevelopmental conditions.

An active and engaged audience throughout the day ensured particular contributions from service users, families, pastors/vicars, teachers, paid carers,

professionals and academics.

They reinforced the key messages:

- Well executed and meaningful coproduction is powerful.
- Research priorities need to be jointly defined.
- Prevailing gaps in early assessment and intervention need scoping and clearer definition.

RADIANT is the creation of Dr Regi Alexander, Convenor, Consultant Psychiatrist and Associate Dean at the Royal College of Psychiatrists. A unifying force of service users, carers, charities, NHS providers and Academics, we hope to see RADIANT as described by one of the Tom Cahill, Chief Executive at HPFT "Radiant is a great example of clinicians coming together and really listening to service users and families about what works and doesn't work. Bringing families together and seeing our service users within the research initiatives as the boss."

The energy throughout the day was powerful and the audience hungry for more. We look forward to a thriving RADIANT with focus on Public education and awareness as well as driving forward research initiatives.

*Kamalika Mukherji,
Clinical Director, Hertfordshire Partnership University
NHS Foundation Trust*

Eastern Division Spring Conference 2019 'The Inflamed Mind'

Conference Report. By Dr Abu Abraham



"There were 27 posters in total; 3 posters each from the Medical students, Foundation doctors and General category "

The 2019 Spring conference 'The Inflamed Mind' was held on the 6th of June 2019 at our regular venue, Wellcome Genome campus, Cambridge. The keynote address was by Professor Ed Bullmore, who gave a fascinating talk on the association between depression and inflammation of the brain. His initial interests in this area grew from the limitations of current treatment for depression. He discussed current evidence relating to increased inflammatory markers and depression and inflammation in population cohorts with the increased risk of depression several years later. The talk explored which risk factors for depression could have inflammatory effects and whether anti-inflammatory interventions could help treat depression in the future. There were interesting questions around why steroids (known to be anti-inflammatory) cause depression and whether antidepressants itself have anti-inflammatory effects.

The conference commenced with an address by the chair of the Eastern division Dr Abdul Raoof who gave an update on developments within the Eastern division and future plans.

Dr Kate Lovett, Dean of the Royal College of Psychiatrists spoke on the future of psychiatry training in the UK. Her talk focused on themes pertaining to prevention, leadership skills for quality improvement, inter-professional training and political influences shaping future training. All this will require some review of the curriculum, which is currently being addressed by Dr John

Russell at the college. The review has just completed its initial submission to the GMC and is expected to be completed by 2020. She also touched on 'Credentialing' and the work of UK medical education reference group.

No talk by the Dean would be complete without mentioning the biggest challenge facing not only psychiatry but also doctors in general; Recruitment and



Prof Ed Bullmore, Keynote Speaker 'The Inflamed Mind'

Eastern Division Spring Conference 2019 'The Inflamed Mind'

Conference Report. By Dr Abu Abraham

retention. Recent data show very encouraging results with core training, while senior training leaves much room for improvement. The College has also made determined efforts to address differential attainment in exams and worth mentioning is the work of Dr Subodh Dave, (Associate Dean) for immigrant doctors.

There was a fascinating talk by Dr Cathy Davis on the medicinal use of cannabis. Initial trials have shown promising results in the treatment of schizophrenia similar to antipsychotics. Larger trials are required to prove efficacy and safety.



Delegates with poster displays in the breakout area

The lunch break also offered networking opportunities to the delegates followed by poster presentations in 3 categories. There were 27 posters in total; 3 posters each from the Medical students, Foundation doctors and General category were shortlisted for an Oral presentation from whom the 3 prizes were selected.

Dr Hugh Selsick, Lead clinician at the Insomnia clinic, Royal London Hospital gave the audience some insights into sleep disorders and psychiatry and practical tips on managing them. It was very clinically focused and had useful applications for everyday practice.

Following the coffee break, Professor David Veale spoke about the treatment of depression and mania through chronotherapy. He explained the concept of triple chronotherapy, consisting of resetting the circadian rhythm through total sleep deprivation, manipulating the phase of sleep and adding bright light therapy in the



Breakout area for delegates, Wellcome Genome Campus Conference Centre

morning. If it proves to be successful it could have a significant impact on how we treat mood disorders through a relatively simple intervention.

Our next Autumn conference will be held at the same venue of Wellcome Genome Campus on Friday 22nd November 2019. Look out for publicity on Twitter and by email and of course on the homepage of the Eastern Division website.

Dr Abu Abraham, Finance Officer, Eastern Division

Please follow the official twitter handle of the Eastern Division @rcpsychEastern for latest updates.

Dates for your diary:

**Autumn Conference:
Friday 22nd November 2019**

**Spring Conference:
Thursday 4th June 2020**

Royal College of Psychiatrists

Thursday 24th October 2019

Eastern Division StartWell Event

Hughes Hall, Cambridge



StartWell is a Consultant led Initiative for Psychiatrists in their first five years as a Consultant or Locum Consultant

StartWell focusses on 6 elements to support Psychiatrists in their first consultant role with the intention to establish good habits for their careers



**3 CPD points
(subject to peer group approval)**

**For further information and to register please visit: <http://bit.ly/2c4B0Ue>
or contact: moinul.mannan@rcpsych.ac.uk Tel: 0203 701 2590**



Royal College of Psychiatrists

Friday 22nd November 2019
Eastern Division Autumn Conference
'Mind, Body and Brain'
Wellcome Genome Campus, Cambridge



FREE Entry for Foundation Year and Medical Students through 'Enhancing Foundation Experience in Psychiatry' initiative of HEEoE School of Psychiatry



Lectures on various topics including a keynote presentation, poster exhibitions, prizes and networking sessions

6 CPD points
(subject to peer group approval)

**For further information and to register please visit: <http://bit.ly/2c4BOUe>
or contact: moinul.mannan@rcpsych.ac.uk Tel: 0203 701 2590**

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The Royal College of Psychiatrists is the professional body responsible for education and training, and setting and raising standards in psychiatry.

The Eastern Division is made up of members from Essex, Hertfordshire, Cambridgeshire, Bedfordshire, Norfolk and Suffolk.

We'd like to thank all members for their contributions towards Eastern Division activities throughout the year.

Eastern Division Medical Student Essay Prize Autumn

The Eastern Division has established this prize in order to raise the profile of the Division and to encourage medical students to pursue further study and professional training in Psychiatry.

Prize: £200

Eligibility: All medical students training in Medical Schools located within the Eastern Division.

Where Presented: Eastern Division Autumn Conference, 22nd Nov 2019 at the Wellcome Genome Campus, Cambridge

Regulations:

1. Eligible students are invited to submit an original essay of up to 5000 words on any aspect of psychiatry. The essay should be illustrated by a clinical example from medical or psychiatric practice relevant to mental health and should discuss how the student's training and awareness has been influenced as a result. The essay should demonstrate an understanding of the Mental Health issues pertinent to the clinical problem and should include a discussion of the effects and consequences of the condition for the individual, their family and the wider healthcare system.
2. The essay should be supported by a review of relevant literature and should be the candidate's own work.
3. The Eastern Division Executive Committee will appoint three examiners to judge the entries. Criteria for judging merit will include: clarity of expression, understanding of the literature and evidence, cogency of argument and the overall ability to convey enthusiasm and originality. The Division reserves the right not to award the prize if no entry reaching the agreed minimum standard is received.

Closing date: Friday 1st November 2019

Submissions should be made to:

Moinul Mannan
Eastern Division Coordinator
moinul.mannan@rcpsych.ac.uk

Deadline for next edition

Submit your articles for Winter 2019 edition by 1st Nov 2019 at psychiatry.east@rcpsych.ac.uk

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The opinions expressed in this newsletter are those of individual authors and do not necessarily represent the views of the Royal College of Psychiatrists