Foreword from Dr Chris Rusius, Trent Division Chair

Welcome to the latest edition of the eNewsletter. In it I hope you will find some very interesting articles, so please have a look at the titles and more details of those which take your fancy. If you can't find anything, then please feel free to get in touch with any helpful suggestions and please do consider contributing an article yourself. See also the editorial section for further details. May I add my thanks to Dr Yousuf Zakaria who is stepping down as co-editor due to his promotion to higher training in the West Midlands and congratulations to him.

Unfortunately for us, since the last newsletter, both Nikki and Sue have left our Birmingham office for (allegedly) better things. It's been a very big loss for us but we certainly wish them both the very best for the future. On the plus side, Heather has taken over in Trent Division as Manager, and we are very lucky to have secured her appointment, so we're getting back on track quickly.

Our website continues to evolve. Please take a look at it, but may I draw your attention to three of the areas:

The forthcoming 2016 Annual Conference will be on Wednesday 16 November. Just off junction 24 of the M1, so sometimes fairly easy to get to. Much work has gone into its organisation and we certainly hope it will be as interesting, educational and enjoyable as recent ones, so please consider supporting it. It is also quite cheap at £90 for a full day of varied presentations and CPD points. The agenda and booking forms can now be viewed here.

There will be various vacancies on the Trent Executive Committee coming up over the next few months, so please let us know if you are interested and look on the website / emails for the adverts.

The Trent and West Midlands College backed AC and Section 12 Mental Health Act Training and Refresher Days have been a great success. More dates are set for 2017, so please look on the division page for more details, but you may need to book quite early as they get quite full.

Anyway, back to the newsletter - enjoy

with best wishes

Dr Chris Rusius

Chair of Trent Division

Consultant in Old Age Psychiatry

Sheffield

Editorial from Doctors Yousuf Zakaria and Samuel Tromans

Dear colleagues,

First of all, we would like to give a big thanks to all of you who contributed to the Winter 2015 edition of the newsletter. We hope that it made an enjoyable and stimulating read for all of you.

For our Summer 2016 edition we have an Olympic-sized variety of articles from colleagues throughout the Trent Division. These include medical students discussing their undergraduate experiences of psychiatry, an audit of monitoring of physical health parameters in a rehabilitation setting, details of a Psychiatry Early Experience Programme in Sheffield and many more.

Our e-interview this Edition is with Dr Simon Thacker, a Consultant Psychiatrist in the RAID team based at the Royal Derby Hospital. He talks to us about his interests, influences and hobbies outside of Psychiatry.

If you are interested in contributing to the Winter 2016 edition of our Newsletter, we would love to hear from you. Some suggestions for possible articles are as follows:

· **Interest articles:** This can pertain to some local or national work you are personally involved in and would like to increase awareness of, or a topic in mental health which you yourself find interesting and would like to share with your colleagues.

· **Events:** This could be a review/feedback from conferences or other mental health related events that you have attended. Alternatively, if you are planning an event within the Trent Division that you wish to promote, this would also be welcomed.

· **Opinion pieces/ reflective writing:** Any issues in mental health that you are passionate about and wish to discuss with a wider audience.

· **Cultural contributions:** This could be in the form of artwork, photography or poetry pieces, though we are open to other ideas in a similar vein

· **Research/Audits**: any innovative and interesting projects that you have been involved in and would like to share with a wider audience.

· However, **do not feel constrained by these choices**; if you wish to submit an article that does not neatly fit into one of these headings get in touch with us via e-mail, and we are happy to discuss this further

Please also note that we are happy to provide certificates on request for your professional portfolios for any accepted articles (though the presence of the article itself on the Royal College of Psychiatrists website will also serve as evidence of this).

We want to ensure that this newsletter is valuable to all members of the Trent Division and catering to all interests, so would welcome any feedback to help us continue developing this platform. Please contact Sam Tromans or Heather Waltham regarding any feedback, recommendations or submissions for future editions.

Best wishes,
Sam and Yousuf
ST4 Psychiatry Trainees and Editors of the Royal College of Psychiatrists Trent Division Newsletter

Final note: Yousuf will be leaving the Trent Division as of August 2016 to continue his training in the West Midlands. As such, he is standing down as editor of the newsletter following this edition. Yousuf has been a great co-editor and a much valued friend and colleague to many, and I hope you will join me in wishing him all of the very best in his future training and career. – Sam

Psychiatry Early Experience Programme

Improving undergraduate attitudes to psychiatry

What is PEEPS?

The Psychiatry Early Experience Programme Sheffield (PEEPS) is a trainee led initiative that was set up to improve undergraduate access to psychiatry experience.

PEEPS is currently running between the South Yorkshire psychiatry training scheme and the University of Sheffield Medical School. It is about to enter its second year of recruitment following a pilot year. There is one other PEEP programme, now successfully running for four years, which links Kings College medical school and the South London and Maudsley (SLaM) deanery.

PEEPS pairs up first year medical students with core and higher psychiatry trainees and allows them to shadow their trainee mentor for at least 1 day in each training placement. Students will follow their trainee throughout medical school and should get the opportunity to shadow every placement that the trainee works in, allowing access to a wide variety of psychiatry subspecialties over 3-5 years. Shadowing is combined with regular social and educational events which look to cover areas of psychiatry that students don't typically get undergraduate experience of such as CAMHS and forensic psychiatry.

How is it Run?

PEEPS is run by a committee of psychiatry trainees and medical students which has been overseen by a higher trainee. The committee recruits students and trainees, arranges events and manages social media communications.

There is also a research arm of the project looking at the changes in student attitudes to psychiatry throughout their time in PEEPS using the attitudes to psychiatry 30 questionnaire.

The pilot year of PEEPS has been awarded funding by the Royal college of Psychiatrists and Health Education England's trainee recruitment initiative project. Funding has helped to cover the costs of events and research but it would be possible to set up a similar programme with no outside funding.

Why run PEEPS?

Recruitment to psychiatry training is known to be in difficulty in a number of areas of the country. Previous research has shown that many students develop a negative attitude towards psychiatry during their time at medical school with 'psychiatry bashing' being a recently recognized phenomena which significantly impacts on students decisions to become psychiatrists. Positive attitude changes occurring after an undergraduate psychiatry training placements (typically undertaken in 3rd or 4th year) are short lived and have been shown to diminish by the end of medical school.

It is felt that providing earlier psychiatry exposure to students and ensuring this is maintained throughout their time at medical school will have a positive impact on attitudes and reduce the effects of 'bashing' and mental health stigma.

PEEPS was set up to improve medical student experience of psychiatry during undergraduate training. It hopes to widen the variety of sub-specialties that students are exposed to and provide clinical experience of psychiatry from a much earlier point in undergraduate training. This will provide a consistent and diverse exposure which will improve attitudes to psychiatry, increase understanding of mental illness and reduce the stigma associated with mental health. It is hoped that ultimately this will lead to recruitment into the speciality.

Contact us

If you would like more information on the Psychiatry Early Experience Programme or are interested in developing a local scheme please contact us or follow us on twitter

Dr Gaelle Slater, ST6 General adult psychiatry, Sheffield Health and Social care Trust

My Reflections on Mental Health as a Medical Student

When I mention that a career in psychiatry may be a possibility for me in the future, I do not always get a positive response. Some people seem to think it is boring, that people rarely get better and, that I would spend most of my time listening to peoples' problems. Even today with the increased awareness of mental health, I am still amazed that people have these ideas. Since starting clinical placements as part of my medical degree, psychiatry has been the block I have eagerly anticipated the most.

As a graduate entry medical student, I already have a degree in Forensic Investigations and prior to this, I had no exposure or knowledge regarding mental health. During my degree, I learnt about the different reasons for why people commit crimes and that they can sometimes be mentally unwell and not realise the implications of their actions. Instead of being punished, I recognised that these people needed help, support and treatment in order to manage their mental health. This sparked an interest in me, and I was keen to learn more about the types of mental illness. I then began to consider medical school once I graduated to pursue this further.

With that interest in mind, and with the determination to get into medical school, I began working as a Health Care Assistant and spent the majority of my time on elderly care wards looking after people with dementia. This was my first experience of caring for people with mental illness. Initially, it was hard to believe what I was experiencing. People were seeing things that were not there, they did not know what year it was or where they were and, were saying things that did not make sense. I found it really upsetting to see people and their loved ones go through the cruel nature of dementia. Over time, I learnt that there was more to a person than their mental illness. Each person had their own story to tell, and it was evident that they were loved and cared for by their family and friends.

Many people told me not to work with patients with dementia, as they can be 'aggressive and difficult.' I soon learnt that this was an unfair thing to say, and realised that these 'aggressive patients' were instead often confused, disoriented and unwell and, as all patients do, required the highest standards of care. I learnt that providing a consistent level of support can make a huge difference to the patient's life as well as to their loved ones.

During my time at medical school, I particularly looked forward to starting the Mental Health rotation. I spent my first two weeks in the community attending General Adult Psychiatry clinics, followed by two weeks in Old Age Psychiatry. My final two weeks have been based on an inpatient ward for adults with severe and enduring mental illnesses.

Before this block, I spent 7 weeks on general medicine and in these outpatient clinics, patients were allocated 5-10 minute appointments. I was surprised when I came to psychiatry, as patients were allocated 30 minute to 1 hour appointments instead. I recognised quickly that there were vast differences between medicine and psychiatry.

I learnt that a psychiatric history is structured slightly differently to a medical one and that in psychiatry, it is important to really get to know the patients on a deeper level. Not only are the presenting symptoms discussed, but the patient's entire life story from the moment they were born up until the present day is also elicited – this I found was a great way of truly understanding the patient. Additionally, it helped highlight the reasons why someone is presenting, as I learnt that often, patients have experienced particular life events in the past which have lead to their current state. Working out a full patient's history is greatly beneficial, as it allows doctors to make the right diagnosis and establish an appropriate management plan.

One of the things I have enjoyed the most in psychiatry was that it was more possible to know the patients on an individual level. Staff members could really get to know the patients over time, and this allowed the patients to trust and engage with them more. I believe that a career where it would be possible to spend more time with the patient and get to know them well would be greatly suited for me.

Many of my colleagues were not particularly interested in mental health but have ended up really enjoying their rotations, and some on the other hand have decided that it is not for them. My advice for other students starting their mental health block would be to be open-minded, to ignore the opinions of others and to see for themselves what psychiatry entails. It is not for everyone, however, no matter what specialty you choose, there is no escaping mental illness and there are important skills to learn that are transferable to every specialty. My experiences have shown me that a career in psychiatry is something I will certainly consider in the future.

Amy Kitchener, 3rd Year Medical Student, University of Leicester Medical School

Psychiatry: A Foundation Doctor's Perspective

It is no small secret that the NHS has a recruitment crisis[1]. Difficulties in recruitment affect all specialties, including psychiatry, and at present this crisis does not appear to be abating. In recent years there has been an increasing emphasis on the recruitment crisis within psychiatry, and as such the number of foundation training posts has increased.

In 2011 only 78% of CT1 posts were filled within psychiatry, but far from being a contemporary crisis reports of a recruitment crisis within psychiatry can be found within the literature from the 1970s[2]. Alongside this growing concern of falling recruitment the Royal College of Psychiatrists released guidance in 2011 outlining a recruitment strategy, the primary aim of which was to increase recruitment of junior doctors into psychiatry with an aim to have a 95% fill rate of CT1 posts by 2016[2]. The guidance highlighted three time periods that were important in forwarding psychiatry as a career option: pre-medical school; during medical school; during foundation training, this area shall be the focus of our discussion from our recent experiences.

One of the key areas highlighted within the foundation segment of the 2011 report was to increase the number of foundation posts in psychiatry to 7.5% in FY1 and 7.5% in FY2, this has since been increased to 22.5% of FY1s and 22.5% of FY2s[2,3]. A study by Kelley et al in 2013 substantiated this proposal further, it found that those who experience psychiatry placements are significantly more likely to pursue a career within the specialty; 14.9% applied to psychiatry in the cohort who had undertaken a psychiatry rotation during the foundation programme compared to 1.8% in those who had not[4]. Although there is an argument that positive selection could have contributed to a false dichotomy in the cohort studied, the striking difference would indicate that placements are likely to benefit recruitment. However, beyond the opportunity for recruitment, the opportunity of a psychiatry rotation in developing a more rounded and informed doctor, better able to apply knowledge garnered from psychiatry to all clinical specialties, is a vital attribute that should not be understated.

Throughout our time at medical school (and now beyond) buzzwords which are ever present include the much clichéd “patient centred care” and “holistic approach”. Psychiatry, more so than most specialties, are key advocates and practitioners of truly holistic care. The emphasis on communication and fully understanding the formulation of the patient has provided a new approach, aspects of which that are definitely transferable to future rotations. One key example came on an on-call shift where we had to perform a risk assessment for a young lady on the surgical ward, who had initially presented with non-specific abdominal pain, but was now voicing suicidal ideation. Having managed many patients in whom no physical cause could be identified for abdominal pain whilst on general surgery rotations, performing the risk assessment on this lady and taking a thorough psychiatric history I gained a much stronger appreciation just how intrinsically linked physical and psychological health are (especially in this patient cohort) then in four months of general surgical placement. This “holistic” approach is definitely one that has been enhanced in psychiatry and one that will prove indispensable in the future.

Psychiatry is forever being stigmatised from multiple facets. The profession itself suffers from stigma, both from the general public and from other medical professionals. One pertinent, if slightly humorous, statistic is that 26% of medical students and 47% of the public said they would feel uncomfortable sitting next to a psychiatrist at a party. Far from being ‘party poopers’ I have found the healthcare professionals I have worked with at my ward to be very engaging and passionate about their specialist area within psychiatry, and for the record would be more than happy to invite them to a party! In having 45% of foundation doctors rotate through a psychiatry placement, the capacity for challenging and hopefully removing stigma is immense. The increasing appreciation of the role that psychiatry can play in complimenting general practice and hospital medicine has been helped through the varied placement we have had, with time spent both in the community, in liaison and at our base inpatient ward. Through this varied experience our preconceived notions around psychiatry have been challenged, and we have a much more positive view on both psychiatrists and mental health services.

The foreword from Sir Simon Wessely in “A guide to psychiatry in the foundation programme”, clearly mentions the benefits of foundation rotations to recruitment, but he also eloquently emphasises the importance of rotations in providing an opportunity in creating a medic who is able to meet the challenges of the future NHS. Psychiatry patients disproportionately suffer physical health complaints, thus regardless of future specialties the knowledge and skills garnered on this rotation will no doubt prove immeasurable[6]. Despite the enjoyment we have both had in these posts neither of us are currently considering applying for psychiatry training posts; BUT, although we don’t want to do it we are definitely better for it.

Daniel Pennells (Foundation Year 2 Doctor) and Jonathan Bunn (Foundation Year 1 Doctor), both working in Older Adult Psychiatry, Sheffield Health and Social Care.

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Reflections on My Experiences in Psychiatry

Prior to my medical studies, I developed a keen interest in memory and learning behaviours whilst undertaking my medical physiology degree. There were many questions from this that I wanted to know more about; how does a person's life experiences and upbringing shape their personality, and does it affect their thought processes and mental health? Therefore, I was particularly looking forward to the mental health block at medical school so these questions could hopefully be answered.

My first exposure to psychiatry was after graduating from my first degree, when I was working as a healthcare assistant. In this job I cared for several patients with schizophrenia. At the time, I knew nothing about mental health let alone a complex disorder like schizophrenia. I found them presenting with symptoms such as auditory hallucinations and frequently becoming scared or agitated as a result of such experiences. Sometimes the voices were derogatory in tone, telling them that they were worthless. Over a period of 6 months, I became more accustomed to working with patients with these symptoms. The hallucinations and delusions no longer worried me and I realised that my initial beliefs about schizophrenia were absolutely wrong and I realised that there was much more to patients than their diagnoses. Many of them were caring and thoughtful people, willing to disclose to me their deepest troubles from their past, including previous abuses and self-harming. I could not imagine what it would be like to live with such a condition and the things that some of the patients I cared for had been through.

As a result of these earlier experiences, I particularly looked forward to the mental health rotation during my time as a medical student. During the first few weeks I was placed in an inpatient ward, and came into contact with patients with episodes of severe depressive illness, some of whom had previously attempted suicide. Even though I have read about depression and known friends with the condition, this was the first time I had witnessed, first-hand, how severe the condition can be. I began to realise how much these people need time and support, and it was really reassuring that the level of care delivered to these patients was often exceptional. The multidisciplinary team (MDT) on the ward really knew the patients, not only on a medical basis, but also on a personal level; their favourite TV programmes, their families, their favourite foods. Despite some of the patients lacking insight into their condition, the care-team always endeavoured to do what was best for them.

Many of my colleagues, friends, and even the doctors I have met, are very surprised when I mention that a career in psychiatry could be a possibility in the future. They say things like "It's boring, all you will do is spend your time listening to someone else's problems". Compared to some medical fields, I find that the time element is greatly beneficial as it gives doctors a better insight in to a patient's past and current medical history, enabling a more holistic approach to their care.

In conclusion, the mental health block has given me an excellent foundation to build on in the future, and has taught me that psychiatry is a much wider speciality than what meets the eye. As mental health problems are so common in the general population, and with almost all specialities coming into contact with mental health issues on a daily basis, I think it would be greatly beneficial for medical schools to make it a larger proportion of the curriculum. The mental health block has encouraged me to pursue a career in mental health and I look forward to the next few weeks on old age psychiatry.

Michael Lam, 3rd Year Medical Student, University of Leicester Medical School

An Audit of Physical Health Monitoring of Inpatients in a Rehabilitation Setting

Background

Patients with severe mental illness have increased rates of physical health problems and reduced life expectancy.

Physical health of patients on long stay psychiatric units is reported to be suboptimal, with high rates of obesity, smoking and significant weight gain following admission to these units (Cormac et al 2005).

The National institute of guidelines for bipolar disorder and schizophrenia (NICE 2014) recommend regular physical health monitoring and advice for patients with severe mental illness.

In secondary care improving physical health care to reduce premature mortality in people with severe mental illness is one of the commissioning for quality and innovation (CQUIN) mental health goals of 2015.

Aim

The aim of the audit was to assess the standards of monitoring of physical health problems in in-patients with severe mental illness at Cambian Ansel clinic, an independent sector rehabilitation unit measured against standards recommended by the NICE and Royal college of Psychiatrists.

Method

The audit sample included all inpatients (n=24) in the unit during the period May to June 2015. The data were collected from electronic individual case records using a structured collection tool derived from the guidelines of physical health monitoring from Lester UK adaptation of positive cardio-metabolic health source tool (National audit of schizophrenia resources 2014).

The Royal College of Psychiatrists recommends the use of the Lester UK adaptive version tool kit to improve the physical health monitoring and care of inpatients with severe mental illness.

The tool provides guidance for clinicians relating to assessment and monitoring of cardio metabolic parameters as recommended by NICE guidelines for psychoses and schizophrenia in adults. It supports implementation of physical health CQUIN which aims to improve collaborative and effective physical health care monitoring of patients experiencing severe mental illness focusing on antipsychotic medication.

It recommends as a minimum those prescribed a new antipsychotic at baseline and at lease once after 3 months supervised and monitored for weight, waist circumference, fasting blood sugar, lipid profile, blood pressure, life style status and family and personal history of cardiovascular disease. Weight should be assessed weekly in the first six weeks of taking a new antipsychotic, as rapid early weight gain may predict severe weight gain in the longer term.

It further recommends where there are concerns medication should be considered as a possible causative factor, and if so, whether alternatives could be offered weighing the clinical benefits, patient preference and side effects. It is advised that any side effects as well as the rationale for continuing, changing or stopping medication is clearly recorded and communicated with the patient

- The audit assessed six parameters of physical health which include body mass index (BMI), smoking, life style or levels of activity, blood pressure, fasting blood glucose and lipids profile.
- For each cardio metabolic parameter whether assessment was documented at baseline and annually
- Patients who were at need for intervention whether they were offered further referral or treatment as appropriate
- Patients who were on antipsychotics (either when a first agent is prescribed or when changed to a different antipsychotic) whether the monitoring was completed at baseline and at three months, including measurement of weight every week for first six weeks.

Results

There was 100% compliance of the documentation of data on all individual parameters on admission and once every twelve months. Body mass index, fasting or random blood glucose, lipid profiles, blood pressure, smoking status and life style such as amount of exercise every week were documented for all patients.

Of 24 inpatients 17 (70%) had unhealthy BMI with 30% being obese.

64% were offered advice on weight management or referred to the life style management program as recommended by the NICE guidelines for obesity.

22 (90%) were smokers of those 3 (1%) were initiated on nicotine replacement therapy.

5(2%) patients had high blood pressure, 6(2.5%) had dyslipidemia and 6(2.5%) had high blood sugar levels. These patients were offered treatment or referred to the specialist clinic as per the current clinical guidelines

Physical health parameter	Patients where a need for intervention	Patients offered at-least one intervention
BMI	17	11 (64%)
Glucose	6	6
At High Risk of Diabetes	2	2
Diabetes	4	4
Cholesterol	6	6
High blood pressure	5	5
Smoking	22	3
Sedentary life style	7	4

The audit recorded that all of 24 inpatients were prescribed either an antipsychotic or mood stabilizer. Of those, 14 were changed or initiated on a different antipsychotic medication during their admission. The audit found that there was 100% compliance on the monitoring of physical health parameters at base line, at 12 weeks and annually but weight was not recorded weekly for first six weeks. Further there was only 80% of documentation of assessment for side effects of the medication but when medication changed for one patient because of the side effects there was documentation of the rational for change.

Conclusions

While current practice at Cambian Ansel clinic appear to be in line with current standards for physical health monitoring of patients with severe mental illness. The audit results revealed smoking, overweight and lifestyle factors such as exercise need to be addressed collaboratively and vigorously with the patients.

The audit highlights need for range of health promotion strategies include smoking caseation, dietary and physical activity advice and management to be adapted as an integral part of the patient's assessment and treatment plan.

Recommendations

1. To update current admission assessment and discharge summary template to include details of all the parameters in physical health section.
2. To develop a local protocol outlining standards in relation to the assessment and treatment of individual physical health parameter.
3. To update current physical health review template to include weight monitoring once every weekly for six weeks when patients are initiated on newer antipsychotic medication
4. To repeat the audit in 12 months

Dr. F. S. Sophia Senthil, MBBS, MRCPsych Specialty Doctor in General adult psychiatry

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2. NICE guidelines for schizophrenia and psychoses in adults (CG178)

3. Royal college of Psychiatrists; National audit of schizophrenia resources Lester UK adaptation of positive cardio-metabolic health source (CMH resource,2014 update)

The Psychiatry - Clinical, Leadership, Academic, Personal (PSY-CLAP)

A Proposed Self-Assessment Tool for Psychiatrists in Training

Description

The **PSY-CLAP** self-assessment tool (click here to access the tool) allows psychiatrists in training to review their performance across multiple domains, including Clinical, Leadership, Academic and Personal skills. It was developed through reviewing the Royal College of Psychiatrists' curriculum for psychiatry core training (Royal College of Psychiatrists, 2015), as well as the CanMEDS Physician Competency Framework (Frank, Snell, & Sherbino, 2015), which formed a basis for the development of the curriculum.
The main purposes of the PSY-CLAP tool are:

- Self-appraisal of current performance
- Identification of future learning goals
- Development of reflective skills

Merits

The PSY-CLAP tool was designed such that Likert-scale based scores need to be evidenced by the trainee and reflected on, as this can help establish future learning goals and foster self-regulated learning (Eva & Regehr, 2005; White, Gruppen, & Fatone, 2014). This will also encourage trainees' to reflect on significant events, as well as bringing such issues to supervision, where feedback from self-assessment could be provided (Kilminster, Cottrell, Grant, & Jolly, 2007).

As the PSY-CLAP tool covers all of the CanMEDS components (professional, communicator, collaborator, manager, advocate and scholar) it provides a holistic view in how the trainee is progressing in terms of meeting society's needs of a modern doctor (Frank et al., 2015).

Potential Problems

The PSY-CLAP tool assumes that the trainee has accurate perceptions pertaining to what represents good performance, how this compares to their own performance and appropriate strategies to close any performance gaps (Sadler, 1989). However, a systematic review by Davis et al (2006) found that many doctors 'have a limited ability to accurately self-assess.' Nevertheless, such self-assessment skills can be taught (Gordon, 1992), and appropriate training to accompany the PSY-CLAP tool could increase its usefulness for trainee development. Indeed, such training could have wider benefits, as trainees who can effectively self-regulate their learning demonstrate increased resilience, resourcefulness, motivation and capacity to reflect (Wood, 2014; Zimmerman & Schunk, 2004).

As PSY-CLAP has only just been developed, it has yet to undergo robust scientific investigation for validity and reliability; such research is essential prior to widespread use (Holmboe, Sherbino, Long, Swing, & Frank, 2010). Additionally, due to much of the information generated from PSY-CLAP being qualitative in nature, analysis of trainee data beyond an individual level would be resource-intensive and time-consuming (Pope, Ziebland, & Mays, 2000).

Mechanism for Feedback

Upon completing the tool, the trainee would meet with their educational supervisor, the professional most familiar with their development (Royal College of Psychiatrists, 2015). The self-assessment results would be discussed, with the supervisor providing additional insights in the context of other forms of feedback (e.g. multi-source feedback). Any discrepancies between the trainees' perceptions and that of the supervisor or colleagues would be reviewed in further detail.

Future performance could be worked towards by agreement of the goals in each domain as well as set dates for review of progress towards these goals. It is essential that any goals are 'SMART' in quality, in that they are Specific, Measurable, Achievable, Relevant and Timed, so that subsequent attainment (or non-attainment) of the goal is clear for both trainee and supervisor alike (Connor & Pokora, 2009).

Samuel Tromans, ST4 Psychiatrist, Leicestershire Partnership Trust

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E-interview with Dr Simon Thacker

Simon Thacker is a Consultant Liaison Psychiatrist at Royal Derby, Clinical Director for Dementia Research and Associate Clinical Director at Derbyshire Healthcare. He is Strategic Clinical Advisor for Delirium at the East Midlands Patient Safety Collaborative. He was brought near Uttoxeter. He trained at Birmingham University and on the Oxford and Nottingham Psychiatric rotations. His special interests include Dementia, Delirium and being enthusiastic about Psychiatry in potentially hostile settings.

1. Tell us something about yourself that most people don't know.

I do not have a Liaison endorsement but have learnt to love personality disorder work – I am not fibbing.

2. What trait do you deplore in others?

The failure to look at the beam in one's own eye before deploring the behaviour of others.

3. Tell us about either a film or a book that left an impression on you?

Schwarzenegger's Total Recall is rollicking stuff. I will never be tempted to diagnose a Schizoid Embolism!

4. When not being a psychiatrist, what do you enjoy?

Bashing the piano, trying to keep up with my wife when she goes out on a run, attempting to hit the stumps with a softball in the back garden, trying to understand mathematical physics, working with the YMCA as a trustee.

5. Which people have influenced you the most?

Keith Waters deserves a special mention. He was nurse lead for the Mental Health Liaison Team in Derby before it adopted (thanks to his well-argued business case) the multidisciplinary RAID model. He had already set up a formidable research engine generating data for the Multicentre Monitoring Study into Self-harm and producing numerous papers over the years. He combines clinical leadership, person-centred care and research skill. Dennis Gath, one of the original authors of the Oxford Textbook, was my first consultant. I liked his warm, urbane interview style and he wrote like a dream. Increasingly I am influenced by new consultants who now occupy a bureaucratised world and fear-driven healthcare system. I am optimistic that we older folk can improve on this legacy.

6. If you were not a psychiatrist what other profession would you chose?

Physicist or electrical engineer.

7. How would you like to be remembered?

Yikes, that's tough. I would like to seek Biblical advice and refer the reader to Ecclesiastes chapter 1, vv 1-11 (… vanity of vanities! All is vanity…..)