

Leadership and training in a time of Covid-19

by

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On the 9th March I met with my consultant supervisor, and we discussed the strategies that were being looked at as a service to prepare for an outbreak of Covid-19. This was three days before the very first televised press conference from the prime minister. The preceding weekend I had travelled to London on the train, attended a large family party, and packed into the crowds at the National Portrait Gallery: all blissfully oblivious to the phrases 'social distancing' and 'lockdown'.

We discussed the complexities of implementing strategies in a secure unit; particularly in the women's service. PPE itself presented a risk-where would it be stored and then doffed? Bins of aprons and gloves would be a clear ligature and choking risk for our patient population. Staff members may have to be in close proximity to each other for a prolonged period of time during a restraint, increasing the risk of transmission.

A multidisciplinary leadership and strategy meeting specific to addressing issues posed by the Covid-19 pandemic was established and the first 'VIPER' meeting was held on the 18th March. Members of the core trainee cohort were invited to attend to provide feedback on patients who had been swabbed, were isolating, or had been transferred to the general hospital; as well as being able to suggest appropriate responses to difficulties arising and have input on the rest of the agenda. Given the situation posed a lot of unknowns and was rapidly evolving, we had a unique opportunity to contribute to ongoing creation of policy and the operational approach.

A junior emergency rota was implemented from the 1st April, in line with the senior medical team, however we were asked to design our working schedule ourselves. We initially designed a 'week on site, week off site rota' to reduce the risk of the whole cohort becoming ill at once and to minimise the impact of self-isolation on staffing levels on the unit. A morning 'huddle' was set up for the medical team to ensure effective handover and allocation of tasks. The weeks 'on site' were high intensity and processes were certainly clunky at the start; doing a swab was an onerous process which required equipment stored in multiple different locations across the site. However, we found our senior leadership team

to be accessible and responsive- we were afforded a 'dry run' when we had an outbreak of a particularly virulent influenza A and throughout these operations were streamlined.

There was an unprecedented increase in workload that was indirectly related to the Covid-19 outbreak. There was increased anxiety, boredom, and frustration amongst the patient population. Wards were treated as households, leave was restricted, visitors were stopped, and shared facilities such as the gym and creative spaces were put out of action. Despite the best efforts of staff in trying to provide reassurance, many patients were unable to access previous coping strategies and support systems. Anecdotally the use of seclusion rooms was high and there was an increase in self-harm incidents even from patients who had previously been stable for some time.

As a core trainee cohort, we had weekly communication meetings with a consultant and a representative from the medical education team, and were able to feedback about our experiences. This feedback led to practical change; an increased workload out of hours was addressed with funding being sourced for a second duty doctor at the weekend.

Despite my visit to a high secure hospital being cancelled, being unable to attend prison clinics, and the move from a forensic focus to more of an on-call type role, the placement has proved invaluable to my learning. It was certainly not what I was expecting from my rotation in forensics, however I gained valuable insights into clinical leadership in a way that could not be replicated.