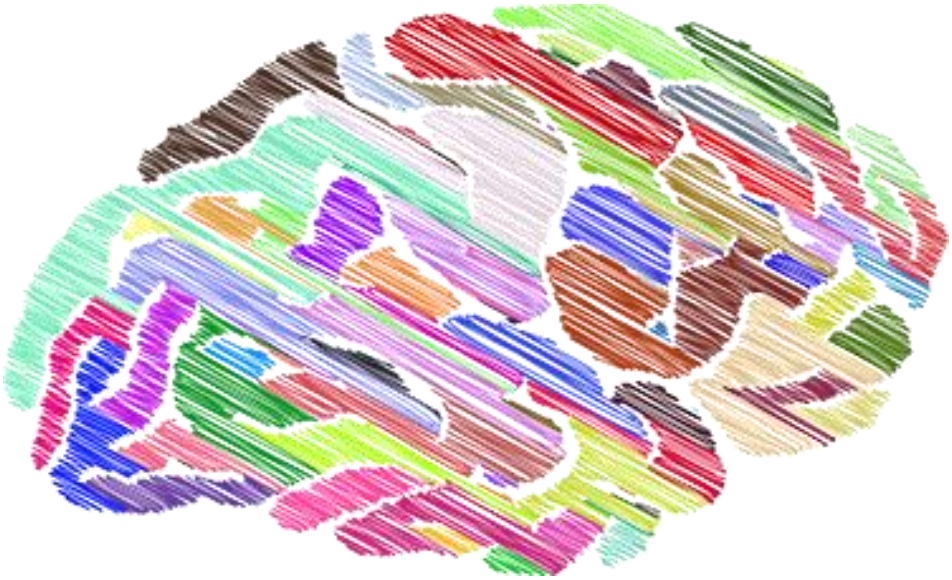
iMind

Newsletter of the
Faculty of
General Adult Psychiatry



iMind General Adult Psychiatry

October 2017

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Executive Summary Blog

by Dr Billy Boland

This is my first newsletter as the newly elected Vice Chair of the faculty, and I'm looking forward to another four years serving the faculty after my time as an elected member comes to a close. One of the things I love about being involved with the faculty is that we get to shape psychiatry now and in the future, and we achieve this through our members. The General Adult Psychiatry (GAP) Faculty has the largest membership of all the faculties in the college. And so, as our President Wendy Burn said to me at our excellent faculty conference in October, we have the potential to have the strongest voice, and influence the evolution of the College as a whole.

Engagement

I made it clear in my election statement that I'm keen to do what I can to help the faculty executive engage with our members, and to ensure our agenda best reflects what is important to you, your lives and the lives of patients and carers that you work with. To do this I think we need to ensure you have full sight of executive business, so I'm pleased to announce that after I raised this, there was an agreement to share our minutes routinely with our members. I'm committed to writing brief highlights of our committee meetings for you, as well as including a link so you can download the minutes in full. Read the first copy of our minutes.

Acute Care Survey

At our meeting in October we were lucky enough to have a sneak preview of the acute care survey; our questionnaire to faculty members about the current state of acute services across the UK. The results, which were subsequently presented at conference, tell a stark story showing psychiatrists working in challenging circumstances, doing their best to help patients. Key findings include:

- 40% reported patients waited more than 4 weeks to be allocated a care coordinator
- 50% reported that waiting times were slightly or much worse compared with 15% who felt they were slightly or much better
- around 50% of patients waited more than 2 weeks to be transferred to community services

This is shocking data and we will be doing more work to analyse these further and publicise them through the college and other routes. See below for more detail on this.

Council Feedback

As our chair, Lenny Cornwall is our representative on the College Council. The lead items

he fed back to the executive from Council in July included:

Quality improvement strategy. The Council had endorsed the strategy.

Redesign of the College's website. This had been delayed by problems with the upgrade of other IT systems.

Recruitment. Recruitment continued to be a problem, with particular issues in the North East and South West.

Communication

We reviewed our methods of communicating with each other (currently an online system called Basecamp) and our work streams (acute care, student mental health and Quality improvement). We also support a number of special interest forums. The faculty has representatives on a range of college committees such as the Psychopharmacology, Workforce and Quality Assurance committees, and the executive

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meeting is an important place to share learning and input to these. Furthermore we also share the work of the faculty in each of the four nations, with reports given to the executive from our representatives.

I hope you've enjoyed this and found the information useful. Please if you have any questions or comments on what I've written about here, or what you see in the minutes, don't hesitate to get in touch with me at billy.boland@hpft.nhs.uk. The more support we have from you the more impact we will have.

Survey on Acute Care Forum

by Dr Asif Bachlani /Dr Jonathan Scott

Over the last year we as a faculty took forward a big piece of work engaging with members in order to provide college input to the Commission on Acute Adult Psychiatric Care.

We would like to thank you all for taking the time to complete the acute care survey; we had a total of 737 respondents with 86% from England, 8% of Scotland and 3% from Wales and Northern Ireland respectively. The Faculty were able to present preliminary results at the recent GAF Conference in Newcastle, which showed 52% of respondents stating there have been significant changes to acute and community services in the last two years. The themes coming out from the survey are that specialist services such as crisis services being the main beneficiaries whereas the core services such as CMHT having difficulties with high caseloads for CPNs and limited numbers of allied staff. The plan over the next few months is to analyse this data thematically and provide individualised data for each of the local UK divisions to support colleagues in local areas with information to present to Trusts and Commissioners.

Small project grants

A chance to get some funding to kickstart your project!

by Dr Safi Afghan

The Faculty is able to support up to 12 projects for up to £2000 each for 2018. These would include a minimum of 2 and maximum of 3 projects that clearly relate to promoting the recruitment, retention and development of the psychiatric workforce. Proposals need to be received by Sunday 28 January 2018. If you would like to apply for the 2018 funding round, please contact Stephanie Whitehead (stephanie.whitehead@rcpsych.ac.uk) for an application form or visit the Faculty webpage for more information.

Wellbeing and Mental Health in the university student population

How can we ensure better care for our student population?

by Dr Michael Doherty

This theme is increasingly recognised as being in need of development and a more joined up whole university approach. Similarly the interface with the NHS including GP services, IAPT and secondary care mental health services, needs to be improved and more consistent across the UK. Universities UK (UUK) has established a Mental Health in Higher Education programme to develop a framework for universities to improve student mental health by:

1) Developing a whole university approach to well-being and mental health; supported by an enhanced evidence base

2) Spreading good practice via implementation activities and pilots

3) Developing guidance for commissioners of statutory mental health services for students and a good practice framework for professionals in statutory and university support services, across the UK.

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A Higher Education Working Group has been established with representation from RCPsych, NUS, Student Health Association, NHS England, Public Health England and other student support organisations. In September 2017 the Stepchange Framework for student mental health, which is aimed at Higher education leadership, was published.

The Institute for Public Policy Research (IPPR), has produced an independent report with recommendations: Not by degrees: Improving student mental health (Thorley 2017).

The majority of students are at the age group where maturing personalities and emerging mental health conditions are important. Mental health services need to respond to the needs of this population of young people who are mobile, often living away from home and in a pressured academic environment, with term times of 8 to 10 weeks. They also need to link in with primary care and university student support services. Young people's mental health is also emphasised in the NHS England's Five Year Forward Plan and we need to remember that 50% of school leavers go to university with the majority living away from home. There are challenges for timely assessment, treatment and continuity of care for those students who develop a mental health disorder either before or during their university course. In addition, there is also a lack of local data for planning purposes for student populations, which can be very diverse from university to university. A UUK Task Group on student Mental Health Good Practice Frameworks has now been established. The purpose is to look at frameworks for commissioning services, professional frameworks and partnerships between university and statutory services. In addition, Dr John Callender, who chaired the group that produced the influential RCPsych report CR166: Mental Health of Students in Higher Education (2011), is leading on the production of an updated report which will be ready next year.

The Medical Student Essay Prize in General Adult Psychiatry

'Is diagnosis dead? Discuss.

The General Adult Faculty would like to invite interested medical students to apply for the Medical Student Essay Prize.

Prize: A cheque for £250 plus two days' free registration at the Faculty conference, one night at conference hotel, and standard advance rail travel within the UK (receipts required).

Two runners-up (awarded at judges' discretion): two days' free registration, one night at conference hotel, and standard advance rail travel. The conference prize package is for the year in which the prize is awarded and cannot be carried over.

Marking will be based on content, presentation and scientific merit. Criteria for judging will include clarity of expression, understanding of the literature and evidence, cogency of argument and overall ability to convey enthusiasm and originality within a 3000 word limit.

Submissions to Faculty Manager: stephanie.whitehead@rcpsych.ac.uk

Closing date: Wednesday 28 February 2018.

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Reflections on Coproduction

by Dr Helen Crimlisk

The GAP Faculty is lucky to have engaged members representing service user and carer voices – supported by the Patient and Carer Committee. A big theme for them is coproduction.

On World Mental Health Day this year, I felt it was timely to reflect on how mental health services are changing. A conversation with members of the Health Foundation Alumni Mental Health Group (a supportive group of Health Foundation Fellows working in mental health) made me reflect on my experiences with a subject that seems to be on everyone's lips… co-production.

Co-production has become a buzzword among those commissioning, designing and improving quality in mental health services. And mental health services are ahead of the field in this. With its roots in the civil rights movement, co-production is advocated or supported by commissioners, charities, institutes and government departments. But it should also be at the heart of what doctors do in day-to-day clinical practice. Reflecting on this helps me to remember the radical nature of the concept and keep a critical eye on how 'co-productive' I really am.

As a doctor, I am familiar with the power of stories. I use the word 'story' to indicate the dialogue I have with my patient as we try to make sense of the issues being discussed. When teaching, I advocate the use of open rather than closed questions. I encourage students to use their own words rather than jargon, and to check the meaning behind the words their patients use.

The clinical experience should be an act of active co-production: an opportunity for patients, service users and health care professionals to make sense of the words used and bridge the gaps between their thinking. This collaborative effort can help them reach a joint understanding and creates appreciation on both sides for possible or desirable future action – a co-produced care plan.

But how much do I really listen in practice? How collaborative is my approach under pressure? As a psychiatrist, I am in a position of power through my professional status and responsibilities under the Mental Health and Mental Capacity Acts. Yet when pushed for time, there is a temptation to cut the collaborative process short, to retreat to the familiar position of being the expert who 'knows' what is best.

Active listening, a lynchpin of health coaching, requires the suspension of action – not moving too quickly to a problem-solving approach. This allows people to come up with their own ideas about how to move forward (or not…), ensuring plans are collaborative and co-produced. It also means recognising the shared nature of expertise. My expertise comes from my professional background, whereas people are

experts in themselves, their strengths, history, culture and communities. Co-production requires me to rein in my position of power, and acknowledge and respect the patient or service user's own expertise. This is challenging when, for millennia, doctors have been placed in positions of power.

I have found the recent focus on hearing people's stories helpful in understanding the meaning of quality from a patient's perspective. Working in a team with patients, service users and peer workers is a powerful reminder of the value of lived experience – I am not the only expert in this process. A service user colleague challenged me recently: 'How much are you really prepared to change your view? Because if you're not, then there's really little point in continuing.'

Both in the clinical environment and the wider system, professionals behave as if co-production can be 'added' – an addendum to satisfy patient groups, grant-giving bodies, commissioners, managers and boards. But in true co-production we should anticipate

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an element of surprise – shifts of power that can be personally and professionally challenging. If it is too easy, we should question whether we're doing co-production, or simply playing at it.

Although my approach to co-production will not be revolutionary and is inevitably flawed, I will carry on. My actions are not worthless or insignificant. An increased interest in co-production provides a real opportunity to change the way we do things. The health service was designed at a time when the world was different, and the next generation of health care professionals will undoubtedly have to do things differently again. Co-production is a great way to start to think about the future in exciting new ways.

General Adult Faculty Survey

In each newsletter, we include a survey on a theme relevant to our work. This time it's a research item on the philosophical understanding of the diagnosis of schizophrenia.

Take the survey

If you'd like to have your survey here please contact Stephanie.Whitehead@rcpsych.ac.uk

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