iMind

Newsletter of the
Faculty of
General Adult Psychiatry

iMind General Adult Psychiatry

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Summary of GAP Faculty Executive Meeting February 2018

by Dr Lenny Cornwall: Chair, GAP Executive

This month's General Adult Faculty executive was a very stimulating meeting for my viewpoint as the Chair. The main focus was on 3 strands of work relating to the whole field of service delivery in general adult psychiatry: our survey of our own members; the NCCMH community mental health care pathway; and our plans to provide guidance on service models in adult psychiatry.

Jonathan Scott and Asif Bachlani updated the committee on the analysis of the acute care survey which 750 of our members participated in last year. We are in the process of looking at the themes from the qualitative comments. It is clear that there is wide variation in how services are functioning around the country, but members are reporting deterioration in the delivery of our core services in community mental health teams, mainly because of financial pressures.

We heard from Tom Ayers and Lade Smith from NCCMH who are developing guidance on a community mental health care pathway on behalf of NHS England. This is of crucial importance for us as it will be the means to get commissioners to fund and implement improvement at a local level. If you would like to see the draft work to date, please contact our Faculty administrator, Stephanie who will sign you up to the Basecamp discussion forum. Tom and Lade aim to complete this work by July 2018 and would appreciate comments soon.

Finally we discussed a new project in development to provide College guidance on the key ingredients for service models in adult psychiatry. Since we last wrote a report in this area (in 2014), service delivery models have continued to diversify and this has been a significant concern to members.

Our other key work streams are progressing: today we are launching a report showcasing QI work (see below) around the faculty and there will be a new prize for best QI poster at our October conference. The student mental health work stream is progressing well and will be reported on at a at a workshop at the GAP RCPsych Conference in October.

We are now planning ahead for 2018-19. We have a strategy day in June and the progress of the review of the Mental Health Act will be discussed then. We are very interested in what members' priorities for our work should be. There are 2 easy ways to join in – you can contact me direct; or if you want to engage more actively you can access the executive discussion forums through our online platform, Basecamp.

Minutes of the GAP Executive meeting, February 2018

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Quality Improvement – New GAP Faculty Guide and new GAP Prizes

by Dr Billy Boland

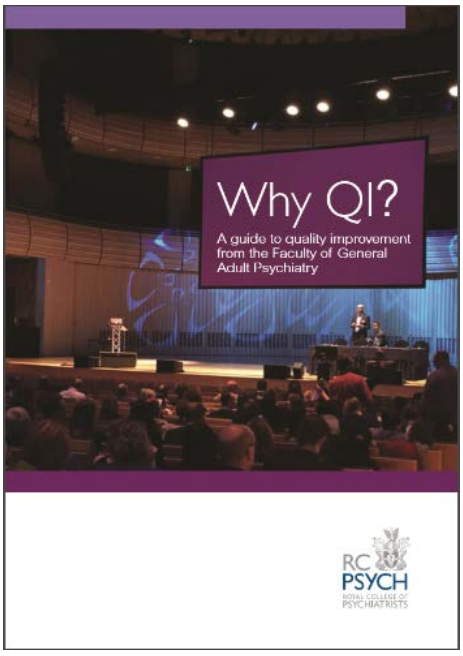
Quality Improvement (QI) has been a significant part of our GAP strategy this past year. The Acute Care Commission saw QI as a key approach to improving the quality of acute services, and so we as the General Adult Faculty have made it a core part of our mission to do what we can to enable that. We contributed to the creation of the College's new QI Strategy, and have been collaborating with other faculties on other emerging QI initiatives.

We've also been driving forward some unique projects specifically for faculty members. We are delighted to launch our new QI Faculty Guide in this edition of the newsletter.

The first publication of its kind in the faculty, we have brought together stories of member's experiences with QI to give you food for thought on where to take your own QI journey. We're grateful to everyone shared their perspectives with us. We hope you find it inspiring and would be delighted to hear your comments. Don't hesitate to email me to let us know what you think.

We're also pleased to announce our new QI prizes. This is a new category of prize for our conference that we hope will stimulate further efforts and interest in QI. There will be two prizes, one for consultant and SAS doctors and one for trainees. The submission will be as a poster, so should be straight forward. Entrants will simply indicate at the time of their poster submission whether they want to submit it for the QI prize.

We're looking forward to receiving your submissions! Best of luck with the prizes and enjoy the QI publication. I hope to see you at what is shaping up to be an excellent conference for the faculty in London in October.



Quality Improvement guide

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Mental Health Act Review: a view from the inside

by Ms Kate King, Service user representative on MHA working group, GA and Eastern RCPsych Committees

When services are under pressure, it's often the people with the least power who suffer the most. A disproportionate rise in BAME detentions, extreme ill treatment of people with intellectual disabilities, patients assessed to be in need of formal detention but left in the community or sent hundreds of miles from home for treatment; this is all done under the auspices of our Mental Health Act. Paul Farmer (CEO Mind) describes the Mental Health Act (MHA) as "a 1950's house with a 1980 extension and a 2007 conservatory".

With the opening up of the asylums, it was an Act written to ensure that formal detention was only used when absolutely necessary. It provides rights and safeguards, for example: to second medical opinions, to an independent appeal, to funded care after S3 detention and a limited right to refuse ECT. It provides for regular review of detention and a requirement for treatment, albeit modified over time. However, it was written in an era when patients were more often not seen and not heard, when decision making rested firmly in the hands of doctors. Today, in society and in medicine, people have realised the importance of working collaboratively, that decisions made together are more likely to be followed through. Psychiatrists work in teams, your teams work with patients.

Our health services and the MHA should acknowledge that people have capacity to make real choices for themselves about their lives wherever that is possible, they should have the ability to say what treatment does or doesn't help, which family member or carer they wish to be involved in their care, and to know that their views will be listened to.

The independent review chaired by Sir Simon Wessely gives a chance to really interrogate how the Act functions today, in a climate of

Simon Wessely

austerity, but also with a spirit of pragmatic optimism about what might be achieved in mental health services in the future.

Being detained can be a terrifying experience: you may be held down, handcuffed and transported rattling around on the hardboard seat in the cage of a police van; but being in hospital under Section can also see a stripping away of rights and dignity, a loss of contact with family and friends, assault and verbal abuse. Coercion is felt by those who are sectioned and those who are not, but fear they might be.

As a patient you may feel that you have to put up with mistreatment: being mocked, being told that you are a useless mother and that you can't have much of a family, being assaulted, signing careplans you have had never even seen before, even having your hair straightened despite not wanting it. You listen passively to a doctor who accuses your husband of slipping illicit medication into your coffee, accept being drug tested, alcohol tested – even if it makes you laugh because your idea of a heavy night is sharing a bottle of beer, and laugh because they've just cleaned the mouthpiece with an alcohol wipe.

You laugh, but you fear you will lose your leave. You bear these things because to be seen as non-compliant is far worse and also because deep down you blame yourself: your illness is always the harshest critic, it learns the insults and repeats them back to you. You think you deserve whatever you get, you think you are, as a nursing assistant once jovially said, a f***ing nightmare.

But of course, this is not the whole picture: there are doctors and nurses who continue to help you, who hold the faith that recovery is possible, who believe that you can return to a life and a family, who hold doors open rather that erect hurdles. Staff who, like their patients, just keep on trying. When I was given the opportunity to be on

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the working group for the MHA review, I remembered those people as well as all the patients and friends I have met on my journey. A better functioning Mental Health Act will help everyone, and protect the vulnerable more effectively.

We are currently in the first stage of the review where we have been picking apart the Act, seeing for example where there are anomalies, problems or gaps (eg the lack of a temporary holding power in A&E, nearest relative provision) as well as how human rights law and recent court cases, including those on MCA and DoLs, impact or reflect on the Act. We've begun hearing from experts in all fields and from service users and carers about their experiences and concerns so that we can help the review identify problems and opportunities that can then be addressed in the later part of the process. The RCPsych has submitted a report to the review which you may have contributed to or already seen.

Why don't you read it, and we can go on this journey together?

The Personality Disorder Consensus Statement and the College's response

On 11th January Norman Lamb MP along with Sue Sibbald led the parliamentary launch of the Personality disorder Consensus Statement.

Ms Sue Sibbald

It brought together people with Lived Experience and the full range of professionals which make up our multi-disciplinary teams. The statement was led by the chairs and Dr Alex Stirzaker, Clinical Psychologist. A wide range of contributors gave their time for free over a three year period. As you might well imagine, reaching a consensus in such a complex area was challenging and required tenacity and patience, but the end result was worthwhile.

The headlines from the Statement are that the label is considered by many to be controversial and inherently blaming. Whilst the call for change here is increasing, there was the recognition that patients continue to be excluded from services and that simply changing the label was not going to address systemic shortfalls.

It is evident, sadly, that the way in which mainstream services are structured and staffed can compound an individual's problems and that there remains ongoing institutional stigma. It was a unanimous view that more must be done and that without effective services people are at best being neglected and at worst being subjected to poor practice.

The statement chimed with other efforts such as making services more informed by trauma, formulation and reflective practice. Those contributing to the statement cited a range of evidence based interventions and NICE guidance which would bring quality

Dr Oliver Dale

improvements. It is also increasingly clear that these improvements can also deliver considerable cost savings through reducing crisis presentation and demands on inpatient care, acute hospitals and primary care as well as more effective use of statutory services. That one in ten die by suicide and

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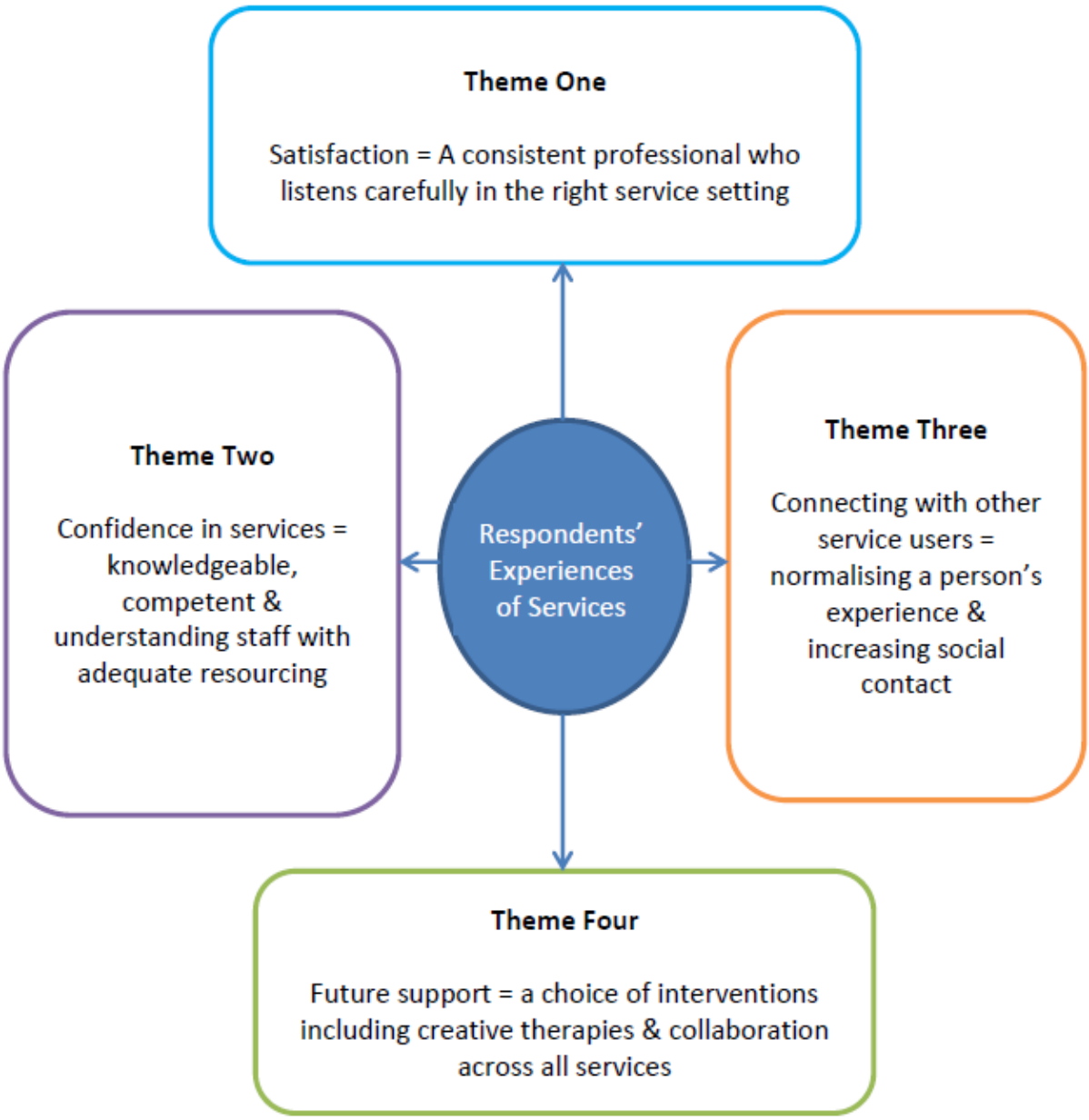
women die 19 years and males 18 years earlier than the average and that without treatment such outcomes remain poor, gave those involved a real impetus. During the launch there was a sense of shared purpose and passion.

The Psychotherapy Faculty established the Cross Faculty Working Group on Personality Disorder in order to help the RCPsych to respond effectively to initiatives such as the Personality Disorder Consensus Statement. This group is organising the development of a strategy that will ensure we can effectively meet our responsibilities to this particular group of patients. We hope you will hear more about this in the coming weeks and months.



PD Consensus diagram

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Models of Care Update

By Dr Russell Razzaque, North East London NHS Foundation Trust

The College originally produced a document around Models of Care in January 2014. The purpose was to outline the current picture and key considerations in relation to different models of care across the country. The document was drafted, however, when functional ways of working were relatively new and, in many Trusts across the country, still bedding in. Since then there has been considerable experience of a range of variants and, as a result, an update is now due that can capture the perspectives and lessons learned to date, and potentially draw conclusions about future directions.

Executive members were asked to provide some feedback and thoughts around their own experience, and this was combined with information from the websites of mental health Trusts across the country to gain an overview of current service structures. The feedback received to date has been mixed around the functional model itself. There are certainly adherents to it, but many people who responded to the Acute Care Survey, that the General Adult Faculty ran last year, seemed to express a number of concerns. Nevertheless, this remains the most common model currently utilised across the country, though there are, of course, several exceptions. Suggestions have arisen around factors that might mitigate some of the issues of concern with functional splits, namely:

1. In-reach between teams could be helpful both as demand management and also a way of improving continuity of care, as well as skilling up staff to work across a wider range of acuity and presentation.

2. Joint working, whether combined with in-reach or offered as a stand-alone aspect of provision, can improve relations between teams, help provide support for those who do not fit obviously into a particular team, and also improve continuity of care.

3. An agreed measure for capacity can help establish safe baselines and support teams who struggle to meet demand. While some guidelines around this exist already, they are by no means comprehensive or universally agreed.

Going forward, the decision at the executive was thus to conduct a Delphi survey on a cross section of professionals, carers and service uses to add more detail to the picture and develop a deeper understanding of the issues that exist and the possible guidance that the updated document might include. An additional work stream has also been set up – within this initiative – around capacity issues, in order to gain clarity around the needs of different teams in terms of caseload and resource, regardless of team or model. Results of these strands of work are expected around Spring/Summer 2018.

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The Future of the Care Programme Approach

by Viral Kantaria, Senior Programme Manager, NHS England

The NHSE England Adult Mental Health Team (AMH Team) have in recent months heard numerous reports that the Care Programme Approach (CPA) framework is not conducive to the provision of high-quality community mental health services due to several factors.

It is of note that the CQC's Community Mental Health Survey of patients found '…enormous variation in the proportion of people on the CPA between trusts' ranging 'from a low of 3% respondents on the CPA to a high of 73%' (CQC, 2016), 'which suggests that there are systematic differences in how trusts individually interpret and apply the CPA policy' (CQC, 2017).

We have therefore been undertaking an informal scoping exercise to gather evidence on effective models of delivering the CPA and to gather professionals' views on challenges and potential solutions that will help to optimise care and maximise efficient use of staff time.

Evidence sought includes views on what, if anything, may need to change with regards to the framework itself, national guidance around the framework, or the way it is applied.

This exercise forms part of a wider policy focus on community-based mental health services.

If you would like to contribute with your views, please email.

Your chance to give your views about Physician Associates

Dr Sarah Jones, Acting Consultant
Sheffield Health and Social Care NHS Foundation Trust

Dr Reem Abed, Consultant
Physiatrist and Clinical Tutor, Sheffield Health and Social Care NHS Foundation Trust

There is a major investment in training Physician Associates which was explored in the last GPA newsletter and we are now undertaking a survey of attitudes.

We would value your views about this, which you can express by following the survey link above.

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