Articles
RCPsych award winners; EFPT exchange programme; Changing out of hours arrangements; plus more!

Opinion
The #Juniorcontract and Mental Health Act Assessments

Training Update
Taking a look at the neuroscience future of Core Psychiatry Training
Welcome

Happy New Year to you all! We are delighted to present this quarter’s edition of the Registrar. My name is Priya and I am the current editor of this magazine, representing psychiatry trainees of all levels nationwide. Consider this a platform to share thoughts, opinions, reflections and innovations in written form. We are always looking for contributors and if you have an idea for a future article or would just like to get involved then please do contact us at ptcsupport@rcpsych.ac.uk or tweet us at @RCPsychtrainees - we would love to hear from you!

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Disclaimer: The opinions expressed in this magazine are those of individual authors and do not necessarily represent the views of the Royal College of Psychiatrists.
MEDFEST 2017
AN INTERNATIONAL MEDICAL FILM FESTIVAL

EROS & THANATOS
: MATTERS OF LIFE AND DEATH

PALLIATIVE CARE. EUTHANASIA. A GOOD DEATH. IMMORTALITY. TRANSHUMANISM. AI.

Image courtesy of Sally Bramley
Welcome to the January 2017 edition of The Registrar. My name is Kate Milward and I’m the Psychiatric Trainees’ Committee (PTC) Chair for 2016 – 2017. I’m an ST5 in Old Age Psychiatry in the West Midlands, currently working Less Than Full Time.

I’m sure you will find this edition of The Registrar full with thought provoking and interesting articles. This includes a reflection on the EFPT exchange programme, an opinion piece on the new Junior Doctor Contract and the winning entry for the PTC’s 2016 Canada Competition. All opinions expressed are those of the authors and do not reflect the official position of the PTC or Royal College of Psychiatrists.

The PTC is composed of pre and post membership trainees from across the UK. Our primary role is to represent you within the College. The PTC advises the College on matters affecting training and trainees. A PTC representative sits on and contributes to virtually all College committees. We don’t just observe the work of College committees; we have an active role influencing its work and policy. As well as contributing to committees, the PTC conducts project work with the central aim of improving training in psychiatry.

The last 18 months have been exceptionally difficult for trainees. The Junior Doctor Contract dispute has highlighted wider concerns about the morale of doctors in training. The PTC is committed to doing what it can to improve the wellbeing of trainees in psychiatry. We are therefore undertaking “Supported and Valued,” a national review of psychiatric trainee morale. We want to identify the factors that positively impact on your morale, to enable us to promote and encourage these. We also want to identify the areas that you feel would improve your work-life balance and training, so we might be able to address these. Regional events have been held across the country and we are in the process of analyzing the results.

The work of the PTC is directed by the feedback that we receive from trainees. A frequently raised area of concern is the perceived variability in the ARCP process nationally, therefore the PTC has conducted a survey looking at perceptions of the ARCP. I would like to thank all trainees who completed the survey. The results are also being analysed and will be communicated back to the College in due course.

Another priority for the PTC has been retention and concerns about trainees leaving psychiatry between CT3 and ST4. We conducted a survey to explore the push and pull factors for remaining in Psychiatric Training. Furthermore, the PTC held its first conference ‘Return to Practice’ in November. The results of the survey and the feedback from the conference will contribute to the development of a new College strategy addressing retention.

Recruitment and promotion of psychiatry as a career has always been a focus of PTC work. We recognise the huge amounts of work that trainees across the country do to promote psychiatry, for example, engaging with Medical School PsychSocs and local Buddy Schemes. This also includes our interactions with Foundation Doctors and Medical Students on Psychiatry placements to ensure that they get a fantastic training experience. On behalf of the PTC, thank you for this vital work.

Finally, the PTC wants to be able to represent you fairly within the College. To do this, we need your feedback on any aspect of Psychiatric Training. You can contact us via email on ptcsupport@rcpsych.ac.uk or via Twitter @RCPsychtrainees.

Dr Kate Milward @katemilward
NEWS
RCPsych Award Winners 2016
The Registrar 5

COMPETITION
Winning entry
Dr Anna Mead-Robson 6-8

UPCOMING
Conferences and Prizes
The Registrar 9-10

OPINION
The Junior Doctor Contract and Mental Health Act
Dr Kaanthan Jawahar 11-13

TRAINEE EXPERIENCE
European Exchange Programme for Trainees
Dr Anna Rebowska 14-15

TRAINING UPDATE
Updating Neuroscience in Psychiatry
Dr Gareth Cuttle 16-17

INNOVATION
Changing Junior Medical Cover Out-of-Hours
Dr Alexander Hartley, Dr Abigail Swift & Dr Susan Howson 18-22

REFLECTION
Collaboration with a Recovery College
Dr Anna Ludvigsen 23-25
Core Psychiatric Trainee of the Year

Dr Karen Cocksedge, Cornwall Partnership NHS Foundation Trust

Dr Karen Cocksedge completed a degree and PhD in Physics before medicine, then worked as a Royal Society Research Fellow in Astrophysics, publishing around 40 papers on starburst galaxies. She trained in medicine in Sheffield and was awarded the Alan Johnston Prize Medal for achieving the highest score in medical school exams and a Foulkes Foundation Fellowship for her medical research. She completed Core Training in Psychiatry in Cornwall, where she published five peer-reviewed psychiatry papers and was awarded the RCPsych Laughlin Prize for her MRCPsych results.

The judges said: “Dr Karen Cocksedge achieved the highest score in the MRCPsych exams. She has an interest in personality disorder and practices Dialectical Behaviour Therapy. Karen has gained experience in community forensic psychiatry and published on the subject. As a trustee of her local branch of Mind she developed a befriending scheme and undertook a project to promote mental health awareness”

Higher Psychiatric Trainee of the Year

Dr John Tully, South London and Maudsley NHS Trust

Dr John Tully led research on a seclusion reduction strategy at Broadmoor Hospital during his Academic Clinical Fellowship in forensic psychiatry and was awarded a Wellcome fellowship to pursue a PhD in the neurobiology of antisocial personality disorder. He authored an examination textbook for medical students, engaged in teaching in multiple settings, and authored an RCPsych blog on music and mental health.

The judges said, “Dr John Tully has made significant contributions to research, education and quality improvement. He has investigated neurobiology, Schizophrenia and use of technology in Forensic Psychiatry. He has co-lead a project to reduce the use of seclusion as well as publishing his book for medical students and supporting a Psychiatry Summer School.”
We sat facing each other in A&E. Holding his head in his hands, avoiding all eye contact, he could not articulate what lay behind his suicidal ideation. Clutching his notes, anxiously, I attempted to engage him in conversation while dwelling on the fact our local wards were all full should this man need admission to hospital.

“What’s the plan?” asks the A&E sister. “He’ll be breaching in 20 minutes.”

“I don’t know yet,” I admit.

I didn’t know yet. The on-call Consultant hadn’t returned my call while the Crisis Team would not be able to visit for two days. Could I take the risk?

“I need more time,” I say, angered by the pressure the “system” put us all under.

“Why did it take you three hours to get here in the first place?” she asks, demandingly.

I was busy assessing a demented elderly woman with a suspected hip fracture, admitting a psychotic patient to the acute ward and tolerating the swearing of an aggressive man in the 136 suite, I think to myself.

Returning home at the end of that shift, I could not crack on with much needed exam revision. I could not reflect on my time management skills on my e-portfolio. All I could do was worry.

The pressures facing doctors are numerous. Firstly, perhaps most obviously, there is the problem of death: from dissecting cadavers and examining the deceased through to breaking the bad news to relatives that their loved ones are dying, we are exposed to mortality in a way most professions are not. As psychiatrists we have the added pressure of managing those individuals who no longer want to be alive and the sadness and anxiety this often creates in us.

In the UK we are also challenged currently by the pressures of working for a struggling public healthcare system, changes to which feel beyond our control as individuals. I am dismayed by the limited number of psychiatric beds in my part of the country, I am angered by cuts to children’s mental health services, but what can I do about it? I feel powerless.

Patient expectations, the so-called “complaints culture” and rise in referrals to the General Medical Council also fuel anxiety, depression and even suicidal ideation among medical professionals and can lead to defensive practice (1).

We are not just expected to survive these feelings of anxiety, anger and powerlessness, but to thrive in spite of them. As juniors we are faced with the additional burden of exam revision, numerous workplace based assessments and ARCP preparation. While these are arguably necessities they can hardly be described as “fun”. Furthermore many of us have character traits, such as perfectionism, that can predispose to burn out or mental illness.

It is no wonder doctors’ wellbeing is under threat.

Continues overleaf…
Recently the importance of “resilience” among doctors in the face of such pressures has emerged as an area of interest. Indeed the College recently held a conference on the subject, and the General Medical Council has gone so far as to recommend medical students be trained in resilience (2). Research in to the impact of mindfulness, reflection, self awareness exercises and shared experience has found such training can lead to modest and consistent benefits, though the methodology of these studies has arguably been low (3).

I am not immune to this subject. My working life has been peppered by periods of sick leave due to mental illness. Frequently I become the painfully visible gap in the on-call rota. The trainee who really can’t hack being a psychiatrist. The trainee who failed to look after their own wellbeing. Do I really lack “resilience”? Or am I just unlucky?

It would seem to me there is a language problem here. The very word “resilient”, to most, is akin to being “tough”, with the saddening consequence that those of us who drop out of medicine are left feeling weak, which in itself can have a profound psychological impact.

In my experience the greatest challenge of all is looking after yourself when you are no longer part of “the game”. When sick notes are piling up on your desk: You are not fit to work. While friends and colleagues continue to see patients, continue to sit exams, continue to socialise after work, there you are rotting in bed. Hopeless, defeated.

What keeps me going in these moments? What magic ingredient has dragged me back to work each time? It's not therapy, medication or good sleep hygiene, although these factors are clearly important. No. It’s my colleagues. Other doctors and nurses, who may or may not have experienced depression themselves, welcome me back to the work place. They have held me through my anxiety, reassured me I am not alone and supported me to be the best doctor I can be in a speciality that deep down I love.

Perhaps the greatest tool we all have to stay in the game is one another.

References


3 Balme E, Gerada C and Page L. “Doctors need to be supported, not trained in resilience”. Available at: http://careers.bmj.com/careers/advice/Doctors_need_to_be_supported,_not_trained_in_resilience
After winning 2016’s “Canada Competition” I was fortunate to travel with former PTC chair Dr Matt Tovey to Canada for the Canadian Psychiatric Association’s annual conference.

This year the conference was held in Toronto and we took the opportunity to arrive early for a bit of sight-seeing. We began by visiting the CN tower where we indulged in a three course meal at the famous rotating “360 restaurant” which overlooks the city. Subsequently we took a trip to the Niagara region where we went wine tasting and visited Niagara Falls.

At the start of the conference we met with a group of Canadian psychiatry residents (trainees) and were able to share experiences of training and healthcare systems.

The conference itself had a broad range of talks and debates. Of particular interest to me was a lively debate on the use of Community Treatment Orders internationally and a talk on how to reduce stigma against patients with Emotionally Unstable Personality Disorder, a problem which is as prominent in Canada as it is in the UK.

On the final day of the conference we were given the chance to present a talk on the topic of this year’s competition: Staying in the game - how can doctors look after their own wellbeing? This topic, as I hope I made clear in my essay, has always interested me, and it was great to get the chance to talk to our Canadian counterparts about issues that surround doctors' wellbeing. It was clear that they struggle with similar stressors to us.

Just as I entered this competition, Canadian residents can also enter a writing competition for a place at the College’s International Congress.

Having the opportunity to visit Canada and present at a conference was an honour and benefitted me personally. It was a wonderful experience and I look forward to meeting some of the Canadian residents at the Royal College Congress in Edinburgh later this year!

For updates regarding future competitions follow us on Twitter @RCPsychtrainees
Abstract Deadline 1\textsuperscript{st} February 2017 3pm
Upcoming

Faculty and Section Conferences

February 2017

Faculties of Child & Adolescent and Perinatal Psychiatry Winter Institute
Date: Tues 7 Feb | Location: RCPsych, London

Providing integrated care for older substance misusers: CPD update on best practice
Date: Thurs 23 - Fri 24 Feb | Location: London

March 2017

Forensic Faculty Annual Conference
Date: Wed 1 March - Fri 3 March | Location: Madrid

Adolescent Forensic Psychiatry SIG (AFPSIG) Conference
Date: Mon 20 March | Location: RCPsych, London

Old Age Psychiatry Faculty Annual Conference
Date: Wed 22 March - Fri 24 March | Location: Bristol

April 2017

Medical Psychotherapy Faculty Annual Conference
Date: Wed 5 April - Fri 7 April | Location: London

Spirituality and Psychiatry Special Interest Group Conference
Date: Fri 21 April | Location: RCPsych, London

Addictions Faculty Annual Conference
Date: Thurs 27 April - Fri 28 April | Location: London

Prizes

Volunteering and International Psychiatry Essay Prize
Eligible: Medical students, foundation trainees, psychiatry trainees, SAS and speciality doctors.
Prize: Trophy and certificate.
Closing date: Monday 30 January 2017.

Faculty of Addictions Psychiatry 2016 Lecture Prize
Eligible: All psychiatric trainees (CT1-ST6 and equivalent), staff grades and associate specialist psychiatrists.
Prize: A cheque for £300.
Closing date: 4 March 2016.

History of Psychiatry Special Interest Group Newsletter Prize
Eligible: Medical students, psychiatry trainees
Prize: A cheque for £100
Closing date: 31st January 2017

CALL FOR ABSTRACTS

Annual RCPsych Medical Education Conference 2017 is accepting poster, lecture and workshop submissions now. For more information please contact emma.george@rcpsych.ac.uk or nikki.cochrane@rcpsych.ac.uk
#PsychMedEd
responsibilities that belie their clinical experience.

Though I feel imposition is bullying in all but name, I do feel the new contract’s terms and conditions are a relative improvement on what we have now. Whether or not it works in practice is a different matter; it’s a policy experiment after all, but one which I’ve made no secret of advocating trying.

There are however two areas that will directly impact the specialty of psychiatry that I wish to focus on here – non-resident on call (NROC) remuneration and Mental Health Act assessment fees.

NROC in psychiatry is mainly carried out by doctors at ST4 level and above. NROC by its very nature is unpredictable and can be very busy. Currently we are paid an annual base salary with a banding salary multiplier dependent on the level and intensity of ‘antisocial’ hours worked (e.g. 20%, 40% etc.). But actually, even if you picked a senior registrar on current T&Cs at the top of the pay scale on a 40% rota (the example I’ve used is that
of a colleague’s, who is on a 1 in 6 with the out of hours commitments being solely NROC), calculating the hourly rate for an NROC 24 hour shift is upsetting to say the least; circa £10/hour\(^4\).

A substantial part of the work during an NROC shift comprises of Mental Health Act (MHA) assessments at the request of Approved Mental Health Practitioners (AMHPs). Typically between one and three hours of work, these assessments are fee paying, attracting circa £180 each. It is also important to note that MHA assessments are integral to training for higher trainees.

**Unintended Consequences**

As with several other specialties, psychiatry suffers from its own recruitment and retention issues. Together with emergency medicine and GP training, psychiatry trainees will receive a flexible pay premia to aide recruitment and retention within the specialty. Whilst base salaries are higher earlier on the new contract, the on call supplement has decreased to an 8% salary multiplier and banding in its current form will no longer exist (20%, 40%, 50% etc.). In a simplistic way, and with the absence of fully formed rotas to make accurate direct comparisons, one can assume from this that the calculated hourly rate on an NROC shift will be less on the new contract than it is on current T&Cs. I must stress though that this is a simplistic view. As new T&Cs prospectively pay for hours worked (the true prevailing hourly rate – not the calculated figures I’ve mentioned thus far), and exception reporting will compensate where this is insufficient, doctors in theory will be paid for all work done.

The difficulty arises where pay for all work done on the new contract does not correspond to current levels of pay. The effect on individuals will be very different (e.g. a neurosurgical registrar perhaps will be paid more than the psychiatry registrar, who will be paid more than the haematology registrar). An analogy I would use for current T&Cs is sending a letter to the next town and the other side of the country – both cost the same. To make this possible, someone is gaining and someone simultaneously losing. New T&Cs would pay for each mile travelled, unravelling an uncomfortable truth that some do more ‘work’ (measured in time) than others.

In addition, the new contract, in Schedule 7\(^5\), states states that a ‘doctor must not be paid twice for the same period of time’, and later explains how fees gained during salaried time should be either

\[\begin{align*}
  &i) \text{ remitted to the employer; or} \\
  &ii) \text{ should incur a salary reduction equal to the time taken for the fee paying work to be carried out at the prevailing hourly rate; or} \\
  &iii) \text{ should owe clinical time to the employer equal to the time taken for the fee paying work to be carried out}
\end{align*}\]

MHA assessment fees would come under this definition of fee-paying work.

I sense that this whole contract schedule really existed to eliminate misuse of the system by those that routinely carried out fee-paying/private work during NHS time. This is rare in my experience. However it has the potential to adversely affect higher training in psychiatry. This is because one interpretation will combine possible lower hourly rates of NROC pay and the need to remit MHA assessment fees back to the employer. For those with caring responsibilities, NROC is already a logistical struggle (e.g. arranging childcare for a weekend on call). Add in the interpretation above and the financial ramifications become significant. The worst case scenario is that higher training recruitment and retention worsens as it becomes financially unworkable for some. What follows from this are AMHPs struggling to obtain doctors, meaning vulnerable patients waiting longer for their MHA assessment.

**Work Around**

The key here is that this is only one interpretation. One could argue that NROC shifts are not salaried time; that you are being paid prospectively for a calculated set number of hours and an availability supplement. Granted the set number of hours calculated will have to not include MHA assessments, but the combination of an availability allowance and MHA assessment fees does not technically constitute being paid twice for the same time. A doctor could then retain the fee, going some way to making NROC financially viable, as well as retain training opportunities and, perhaps, mitigate the risk of worsening recruitment and retention.

It sounds good on paper, but will an employer go for it? Absolutely – my employer has already agreed to the above. What’s more, they have also agreed to keeping fees during a normal working day as long as the doctor makes up their time in lieu. What I found in my previous role at NHS Improvement is that the vast majority of employers are not out to exploit the junior doctor workforce. They want to be desirable places to work, attracting junior doctors now as they will inevitably be hiring them as consultants in the future.

**Final remarks**

I go back to my earlier point that this new contract
is a relative improvement on our current T&Cs. But this will only be a reality if the contract is implemented in the spirit to which it was intended. At present, the avenue to do this is via the employer’s Local Negotiating Committee (LNC) and the formation of Junior Doctor Fora – a contractually obligated group under the new T&Cs to advise the Guardian of Safe Working Hours.

But is this form of engagement with implementation implicitly resigning ourselves to imposition? I do not know the answer to that. I worry that many of my colleagues feel powerless in this bitter dispute, waiting with baited breath whilst the central figures tussle with each other across the media. For me, holding employers to account on our terms and conditions of service is something we, as junior doctors, should have been doing for years. Doing it now gives me some solace and it does make me wonder whether if we had been more engaged and politically astute over the years, would we be in the position we find ourselves now? That raises a whole other debate that I clash with colleagues on frequently. I personally believe we are where we are as a profession by our own doing. Doctors have clout that we fail to use. Instead we seek to preserve the status quo for individual gain. I for one have had enough of this attitude.

Key Points

• The new junior doctor contract poses potential risks to recruitment and retention when non-resident on call and Mental Health Act assessment fees are considered

• Local negotiation can mitigate many of these risks but requires engagement of junior doctors

• Local Negotiating Committees (LNCs) and Junior Doctor Forums (contractually obliged groups that advise the Guardian of Safe Working Hours) are the current avenues for local negotiation

References


3Jawahar K. The junior doctor contract: we now need leadership at all levels. BMJ 2016;354:i3859

4This is calculated by taking the 40% banding total annually and dividing by the number of hours that are not classified as ‘normal working day’. I must stress that currently banding for NROC shifts serves to ‘compensate’ doctors for their time – it is not a true hourly rate, but rather akin to the availability supplement described in the new contract.


6Dr Kaanthan Jawahar, Faculty of Medical Leadership and Management. https://www.fmlm.ac.uk/kaanthan-jawahar
European Exchange Programme for Psychiatry Trainees: a Swedish Experience

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EFPT exchange: what is the fuss about?
Driven by my desire for travel and curiosity about healthcare systems outside of the NHS I took part in a professional exchange organised by the European Federation of Psychiatric Trainees. The programme offers an opportunity to visit a psychiatric department in one of participating EU countries and is customised to the needs of individual trainee. As a visiting trainee I had the opportunity to follow the work of fellow psychiatrists in training as well as more senior colleagues and members of the multidisciplinary team. The experience allowed me to learn as much as possible about the Swedish psychiatric health care system as well as immerse myself in a different culture.

My experience in Sweden
The child and adolescent university clinic of Gothenburg enrolls 4000 new patients each year, mainly from the Gothenburg area and is the only care provider in child and adolescent psychiatry in the city. It has an emergency inpatient unit with 8 hospital beds, a short term inpatient unit with 7 beds for assessment and treatment, five general outpatient units, a specialised outpatient unit for psychosis and OCD, a specialised in- and outpatient unit for eating disorders, a specialised neuropsychiatric unit and a dialectical behaviour therapy (DBT) team.

During my time in Gothenburg I visited a number of these units. I spent my first week with the team on the emergency inpatient ward. The team made every effort to involve me in their activities such as ward rounds, multidisciplinary discussions and planning meetings.

They accommodated my lack of Swedish language brilliantly either by simultaneous translation or conducting their meetings in English for my benefit. It was very inspiring and intellectually stimulating to be able to discuss real clinical cases in a very different clinical environment. All members of staff were very friendly and welcoming and made me feel part of their busy team for the short time I was there.

During my second week I visited the inpatient assessment unit where in depth psychological and psychiatric evaluations are conducted. The unit also offers support to children with school phobia and allows them gently back into education through a co-located, small teaching unit. I was again welcomed to join in with the ward rounds.

I also had the opportunity to speak at length with a young person and his mother, providing valuable insights into the health care system.

I also spent a day with the Swedish equivalent of Tier 3 CAMHS to explore how care is delivered in the community. My final day was spent in a secure state institution providing accommodation and care to young people at risk of absconding or presenting with challenging behaviours. The staff were very welcoming and took time out of their busy schedule to talk to me about the structure and purpose of their service. I was able to observe an ADHD clinic and speak to young people residing in the Unit too.
Learning from each other
The whole experience was rich in educational opportunities and I was constantly reflecting, comparing and contrasting.

I have keen interest in medical education and I was interested in comparing the UK curriculum with the model adopted in Sweden. I was jealous to hear that psychiatric trainees in Sweden don't have to face the expense and stress of mandatory college exams and do not need to maintain a portfolio. The assessment and supervision is more flexible and informal with emphasis on principles of adult learning. There are fewer structured, portfolio based activities such as Work Based Assessment. Nevertheless, a large amount of learning occurs in the departments with regular departmental teaching sessions and impromptu bedside teaching. I had the privilege of being invited to take part in those teaching sessions by delivering presentations to the Swedish teams on the UK Mental Health act and our training system.

What about the social programme?
Gothenburg is a very interesting and vibrant city with plenty to do to explore. The way EFPT is structured ensures that you have ample support along the way. I was offered free accommodation with a local Swedish psychiatry trainee. I could not have wished for a better host than Amelie, and she went out of her way to ensure I enjoyed my experience. Staying with a host as opposed to a hotel meant I could immerse myself in the daily life of Swedish people and gain a better understanding of their customs and culture.

It was reassuring to know that our practice in the UK does not differ massively from the interventions delivered by colleagues in Sweden and that we have a common approach to diagnosis and treatment. At the same time the differences in practice that did exist were very thought provoking. For example it was interesting to learn about use of mechanical restraints in child and adolescent psychiatry in Sweden and compare this with our local practice.

My trip to Sweden also provided the opportunity to deliver a presentation to an international audience. This was a great experience which will take a proud place on my CV.

Final words of wisdom
I would encourage any psychiatric trainee thinking about applying to take part in the EFPT exchange to take the plunge and go for it. Don’t be apprehensive about any language barrier as this can be worked around. Everyone I met both in the hospitals and in the community were friendly and keen to help. It was a fantastic experience both on a professional and personal level and I have left Gothenburg with plenty of new ideas and happy memories.

What did I get out of the participation in the exchange?
Through participation in the program I gained first-hand experience of different models of healthcare delivery and I hope to implement some of these ideas into services locally in the UK.

@EFPTTrainees

ARE YOU INTERESTED IN AN EU EXCHANGE? IF SO THEN CHECK OUT HTTP://EFPT.EU/EXCHANGE-PROGRAMME/
The brain. The organ of thought, of emotion, of movement. The organ of the mind. An organ about which we understand so much more than just a few years ago. And yet, neuroscience lies in many ways disconnected from psychiatry and of seemingly only distant relevance.

With support from The Gatsby Foundation and The Wellcome Trust, the Neuroscience Project grew from a desire to bridge the gap between psychiatry and neuroscience. This two-year initiative from the Royal College of Psychiatrists will reshape psychiatric training, introducing a modern neuroscience perspective that reflects the rapid, ongoing and exciting advances from basic and clinical research that are dramatically changing our understanding of how the brain works.

The Project is led by a 15-strong International expert Commission, set up to review the Core Curriculum and chaired by Dr Wendy Burn (RCPsych) and Professor Mike Travis (Pittsburgh). As the immediate past Dean of the Royal College, Wendy is a familiar figure throughout the profession and brings a wealth of experience in educational leadership and change management to the project. Meanwhile, Mike Travis has been instrumental in driving the highly successful development of the National Neuroscience Curriculum Initiative (www.nnci.org) in the USA.

Reaching out
The first phase of the Project has featured extensive consultation among stakeholders through outreach activities at faculty and divisional conferences, meetings with trusts and presentations to psychiatric trainees and medical students. Social media are providing an expansive forum for information sharing and dialogue.

Consultation gives members the chance to engage and give their opinions on the proposed changes to the curriculum and will continue into the Spring of 2017. Evidence gathered is being analysed and will inform the Commission’s review of the Core Curriculum.

Feedback from stakeholders has been overwhelmingly positive. Many members recognise the project’s timeliness and are very supportive of its aims. At the same time, challenging questions have emerged regarding both the neuroscience content of the revised Core Curriculum and its delivery. Concerns centre on the need to ensure the teaching of relevant, integrated content using a variety of approaches. The Neuroscience Project is sensitive to this need and is exploring a number of ways to facilitate and support the delivery of the neuroscience elements of the curriculum. These initiatives will include training events with expert teachers of Neuroscience and the creation of networks to enable the sharing of best practice.

Hearing the promise of Neuroscience
The Neuroscience Project is by no means concerned solely with the revision of a single document, the Core Curriculum. In March 2017, The Wellcome Collection in London will play host to a one-day conference — sponsored by the Neuroscience Project — that will bring together leading scientists and clinicians to discuss the role of neuroscience in contemporary Psychiatry. In June, the beautiful city of Edinburgh and the 2017 RCPsych International Congress will be the setting for a symposium featuring some of the most renowned figures in contemporary neuroscience research, who will speak on topics that have the potential to fundamentally change the way we understand mental illness and to influence approaches to therapy. Academic researchers will join us for these events to forge new links between
preclinical and clinical professionals, while also strengthening existing networks.

Ensuring Deliverability
Just as important as the revision of a curriculum is its projected delivery. We have set up a Project Implementation Group to discuss and comment on the proposed curriculum, and to make recommendations on the development of teaching materials and methodologies to support the delivery of the neuroscience content. The concerns voiced during stakeholder engagement are feeding into this Group’s work to appropriately support trainers in the effective delivery of quality neuroscience teaching and to provide ongoing support for trainees. TrOn, a resource provided by the College to aid trainees in preparing for the MRCPsych exam, will be enhanced to align its content with the new curriculum.

Integrating neuroscience with psychiatric training will equip trainees for the scientific advances that will be made over their working lives by ensuring that they are ‘neuroscientifically literate’. Ultimately, psychiatrists will be better prepared to develop and deliver innovative biomedical approaches, leading to better patient care.

To discover more, visit http://www.rcpsych.ac.uk/traininpsychiatry/corespecialtytraining/neuroscienceproject or contact us: Neuroscienceproject@rcpsych.ac.uk
An experience of changing junior medical cover out-of-hours from an on-call system to a full shift system

Dr Alexander Hartley, Dr Abigail Swift, & Dr Susan Howson
Correspondence: alexander.hartley@nhs.net

Innovation

Introduction

In this article we will describe our experience of developing and implementing a full shift system to provide the junior, first-on psychiatric cover out-of-hours for a large rural area surrounding and including a local county town in the South West of England, and of the process of change in switching to this from a system of non-residential on calls.

Although this occurred in the context of a national dispute about terms and conditions for junior doctors where the status of out-of-hours cover was a key point of contention, this was not a driver for the change being described here, consideration of which long predated the contract dispute.

The new contract aligns closely with self-imposed restrictions on the frequency and duration of work that the shift system follows. The limits upon the number of consecutive nights and shifts, as well as a rest day following weekend late shifts were designed into the shift system to ease the burden on junior doctors and this remains viable on the new contract.

Why change?

Increasing Emergency Assessments

The previous system of ‘first-on’ medical cover was via a non-residential, on-call system, which was worked by almost all the junior doctors in training posts from F2 to CT3 and including GPVTSs. On-call duties were additional to daytime working duties and there was no automatic time off after nights and weekends on-call. The increasing pressure on mental health services, including out-of-hours services, had led to the workload becoming unmanageable under this system.

The terms of the Crisis Concordat and recommendations of the Emergency Psychiatry Taskforce and local changes in working relationships with other agencies, particularly the police, were leading to more people being brought to the designated, health based Place of Safety under section 136 of the mental health act and the number of presentations in the local emergency department were also increasing. The National bed shortage resulted in frequent transfers back of local patients from units many miles away, inevitably
requiring admission in the evening following long journeys.5, 6

**Higher expectations from other medical teams**

As non-residential on-call rotas of this nature are now uncommon at the level of first on-call in other medical specialties, it was increasingly difficult to restrict out-of-hours duties to emergencies only. Other teams, for example from the acute medical unit in the local DGH, had expectations about response times which were not realistic under this system. Particular issues related to requests for complete new assessments in the early hours of the morning, resulting in a severe lack of rest.

**Continuous working**

Most importantly, the long periods being worked at times led to concerns about the safety and quality of care provided. Continuous work throughout the evening and into the early hours of the morning following a normal working day was not uncommon.

**Daytime disruption**

These issues resulted in increased pressure on juniors who were experiencing high sickness rates.

Unplanned compensatory rest for busy nights was disrupting day time duties and training and after several near misses the rota failed the out-of-hours monitoring. A full shift system was devised to address all these issues and came into force on the rotation changeover date for core trainees, Wednesday 3rd February 2016.

**Previous non-residential on-call system**

The previous system consisted of 12 junior doctors working a 1 in 6 non-residential on-call rota in addition to the normal working day. From 5pm at night until 9am the next morning and from 9am Saturday morning until 9am Monday morning there were two junior doctors on-call with duties divided between them. Each junior had a 6 hour period during the night ‘protected’ where they would only be called in exceptional circumstances. There was also a senior night nurse practitioner who would take all initial calls from 20:30 until 07:00. Shortly before the change in rota, the liaison psychiatry team expanded their working hours with mental health practitioners providing 24/7 cover in the emergency department and support workers were recruited to assist the night nurse practitioners. This medical rota was banded at band 2B (normal salary plus 50%).

**Service Provision:**

This system provided cover for two 16 bed general adult, acute inpatient wards (both with a seclusion room), a functional older persons’ mental health ward, a specialist dementia assessment inpatient unit, a tier 4 specialist eating disorders unit, a specialist learning disability inpatient assessment unit, an inpatient rehabilitation unit, the local medium and low secure forensic unit, psychiatric advice for out-of-hours GP services,

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Table 1: One cycle of the shift system as an individual Junior Doctor

Presentations in the local emergency department and acute trust and the initial assessment of medical fitness to remain in the local designated place of safety. The night nurse practitioner also provided managerial support and telephone crisis response for service users. Urgent community assessments, including mental health act assessments, were referred directly to the consultant on-call.

**New full shift rota**

This was again based on 12 Junior Doctors and was constructed to a 12 week cycle. Each cycle, each Junior Doctor completes 7 nights on-call and 7 long day on-calls on a residential, full shift system during each 12 week cycle. These on-call shifts are spread throughout the cycle with nights split into blocks of 3 or 4 nights.

**Night Report**

A face-to-face handover was introduced at night for the first time. This occurs between the Late shift Junior Doctor (0900-2130), Night shift Junior Doctor (2100-0930) and Night Nurse Practitioner.

Following this meeting, the Night shift Junior Doctor will call the Non-residential On-call Consultant Psychiatrist to provide a handover and discuss the workload.
Day Report
On weekend mornings, there is a handover called the ‘Day Report’ meeting. This takes place from 0900-0930 between the Night shift Junior Doctor and the Late shift Junior Doctor. On weekday mornings, this occurs via telephone contact as the Late shift junior doctor may be covering on different sites.

Being based on a 12 week cycle, it fits well with the working patterns of core trainees and GP trainees working 6 month blocks. It fits less well with the foundation year 2 doctors on the rota, working 4 month blocks.

Benefits
Shift Pattern Working
Overall, by far the most significant benefit was improved access to medical support for mental health patients in the area in the middle of the night and improved handover arrangements. Changing from non-residential on-calls to a residential shift system for Junior Doctors enables continuous working 24/7 with on-site medical cover.

Improved Support and Team-working
The hospital at night team included formal arrangements for handovers out-of-hours for the first time. This improves continuity of care in ensuring appropriate handover of matters arising overnight.

The formation of a hospital at night structure resulted in improved support as part of a team at night. This was particularly valuable as the rota included Foundation year 2 doctors and GP trainees who may have very little previous experience in psychiatry and helped reduce the sense of isolation in lone working at night, although this problem was exacerbated at weekend daytimes, with the reduction to one junior doctor working. As duties were spread over multiple sites with travel required between them, there had been concerns about the safety of lone working at night. More frequent contact with other members of a hospital at night team went some way to improving that although this remains a concern.

Experience of Emergency Psychiatry
The Royal College of Psychiatrists Core curriculum requires emergency psychiatry experience equivalent to ‘a minimum of 55 nights on-call over three years of training (i.e. at least 50 cases with a range of diagnosed conditions and with first line management plans conceived and implemented.)’

Although the previous rota more than met the requirements for number of nights on-call, as the out-of-hours’ workload increased on-calls were increasingly dominated by emergencies on the mental health wards, admission of transfers, physical health concerns, seclusion reviews and other matters which although urgent, did not provide varied emergency psychiatry experience.

New presentations were increasingly seen by nurse practitioners rather than junior doctors. In order to maintain adequate rest and safe working practices, junior doctors were unable to take on assessments which would be good for training purposes but which could also be managed by nurse practitioners. Thus, emergency psychiatry experience was becoming narrower and providing a less positive training experience.

Changing to a full shift system with the expectation that juniors would be available for work the entire time on shift results in Junior Doctors being called in to help with a wider range of assessments in different settings, improving this experience of emergency psychiatry. Although supported by members of the wider multidisciplinary team, out-of-hours’ work also involves more autonomous practice improving opportunities for junior doctors to form their own management plans.

Multidisciplinary Emergency Assessments
The Emergency Psychiatry Taskforce report recommends that Junior Doctors work as part of a multidisciplinary team and this was integrated into the shift system guidelines. Now, Junior Doctors can expect the standard new assessment to be in collaboration with liaison psychiatry rather than alone. This provides numerous benefits from supporting inexperienced trainees, to sharing risk burdens and in providing an immediate medical perspective on possible organic or complex presentations. Lastly, senior core trainees (CT2/3) have improved opportunities to be consulted for advice and to lead joint assessments.

Challenges
Reduced Daytime Availability
The main disadvantage of this system in provision of care is the reduction in Junior Doctor cover Monday-Friday 0900-1700 with daytime absences from normal working duties due to Nights, Days off in Lieu and Late shifts. The implications of this include less supervised practice and less attendance at formal supervision, less opportunities for involvement in a wider range of therapeutic activities for example led by occupational therapists, increased absences from formal training events and less availability for psychotherapy cases and training.

Particular concern around this pattern of working
was expressed regarding the older persons' wards where continuity of care was felt to be most important. The total additional absences result in a 23% reduction in availability of junior doctors on Normal Working Days.

**Complexity of Rota Design**

The shift system rota was carefully crafted to ensure no two Junior Doctors will be absent from the same site on the same day which ensures immediate medical cover in the event of emergencies. Arranging the rota in this manner was significantly more complex than the previous system and required medical input. The previous rota was constructed by medical staffing.

The rota is also significantly less flexible, with increased difficulties in arranging study and annual leave. This was partially offset by people working together to cross-cover and early leave requests being facilitated by people being slotted into positions on the rota that accommodates their leave, without requiring swaps. Nevertheless, leave arrangements and swaps remain more difficult under this system.

Finally, there was concern from trainees with childcare responsibilities that arranging cover for blocks of consecutive nights may be more difficult than for occasional single nights.

**Training Opportunities**

Another concern about this system was the impact upon other regular daytime activities. Consideration was given for regular teaching, supervision and psychotherapy cases. However, the rota also included Academic Clinical Fellows whose contract made provision for 25% of time to be spent on academic activities. This was generally arranged by a regular day per week spent on these activities, with the additional quarter days aggregated for conferences etc. The previous on-call system had a negative impact on this at times, if trainees were too tired after shifts, but it was accepted this rota may lead to more missed academic days.

Similarly, the time away from daytime jobs was of particular concern for any trainee undertaking a full medical psychotherapy job. Single cases on Thursdays could be protected to some extent but not the full week and this system could therefore lead to an unacceptable frequency of absences from cases. There is not routinely a medical psychotherapy job available to core trainees and therefore this problem did not require immediate solution but trainees occasionally have their request for an exceptional placement approved. It was acknowledged this would need further consideration and it may be required that trainees working 6 month psychotherapy jobs would have to come off the rota for that period.

**Conclusion**

The original vision for the shift system was that it would provide a definite end-point after a long day or night on-call. Many Junior Doctors found the most challenging part of the non-residential on-calls to be the psychological distress as a result of finishing one assessment close to midnight, only to be called shortly after going to bed with a further assessment. Changing to a shift system prevents this, yet without the thorough review of all aspects of our work as Junior Doctors, we would not have been able to make our out-of-hours experience a better one.

**References**


During my CT2 training in Psychiatry I was invited to participate in a group run by the local Recovery College. The intention of the half-day event was to explore Bipolar Disorder from a variety of angles. It was aimed at current service users and their friends, family and carers. The event was being facilitated by one of the Recovery College volunteers, Ian, and Bob, an individual with a personal experience of Bipolar Disorder.

I met up with Bob and Ian a few weeks before the group to discuss how we would organize ourselves. Ian and Bob had run a similar course before and so I was pleased to be guided by their experience. Bob and Ian wanted me to bring a medical perspective and so I suggested a brief presentation on the current understanding of the aetiology, course, treatment and prognosis of bipolar whilst leaving plenty of time for questions and comments.

Initially, I felt confident about doing this but when Bob cut me off as I began talking about neuronal tracts in prefrontal lobes and the latest neuroimaging findings, I realised I was not sure at what level to pitch my presentation. As is true of all trainees I have given presentations to peers and colleagues as part of my training but not to a room full of ‘lay’ people before. We agreed it might be a good idea if I used a patient information leaflet, such as the one on Bipolar Disease produced by the Royal College, as a guide. The more we talked the more I became aware that I might have some understanding of the aetiology of bipolar in medical terms (as much as any of us can have) but my audience would know more about what it actually means to live with bipolar than I ever would. My apprehension grew. I really didn't want to pretend to be an ‘expert’ about something I knew so little especially in a non-medicalized way. I expressed my concerns to Bob and Ian and was surprised with Bob’s thoughtful response.

Keeping his eyes on his cup of coffee Bob took a deep breath and said: 'It is so wonderful to have doctors who think about people with mental illness as more than just their disease.' A tear rolled down his cheek.

I was taken aback by his reaction and tried to cover my own discomfort and anxiety with polite smiles while mumbling something like ‘times have changed and I’m sure most doctors think of their patients as more than just a collection of symptoms’. Bob went on to describe the role doctors had played in his life. He had experienced episodes of being mentally unwell on and off for the past 35 years. In between these he worked as the director of a successful multi-national company. He spoke of ‘traumatic and dehumanising’ experiences during compulsory admissions that took place mainly, but not exclusively, in the 1960s and 70s. ‘The worst part was not the treatment or side effects of the medication… it was that I felt no-one listened to me or even saw me as a person.’ I could see it was difficult for Bob to talk about his experiences and was relieved when he went on to say: 'I feel like it [psychiatry] is changing. Things like the Recovery College and sitting here with you now. I also have a really good relationship with my current consultant. He listens to me and we decide together when anything needs to be changed with my medication. He even encourages me to adjust the doses myself if I feel it is necessary. I feel like I am in control for the first time since I became...
unwell and I think my mental health has really improved as a result of this.’

Bob went on to say that our meeting was the first time he had ever sat down with a doctor and felt an equal and that it was an almost overwhelming experience for him. It was a profoundly humbling experience for me too.

Having finalised our plans we finished our meeting. I had a better sense of what level to pitch my talk leaving room to improvise with more or less technical information. I got over my nerves and event went well according to the feedback we received. Using the patient information leaflet as a guide I found a good balance of providing factual information without becoming too technical. I was also genuinely curious and interested to hear from those with lived experience about what it is like to be affected by bipolar disease. I learned more about what it means to have bipolar from listening to Bob address the group than I could have learned from any textbook. When the event drew to a close I received feedback from those present on what they felt was helpful about my presentation and style and what could be improved, Ian also agreed to complete an Assessment of Competency of Teaching workplace based assessment for my portfolio.

What has struck me the most however is what Bob revealed during our initial meeting about how he felt disempowered and somehow not seen as an individual by the psychiatric profession for most of his life. I reflected on the immense power we as healthcare professionals hold over the lives of those with mental health difficulties and how this affects the relationship between service user and doctor. During periods of good mental health Bob held a position of responsibility and power himself and so was used to making far-reaching decisions. I realised that to Bob I was a representative of a profession which could, and on several occasions had, ruled that he no longer had the stability of life. I reflected on the immense power we as individuals by the psychiatric profession for most of his life. I reflected on the immensity power we as healthcare professionals hold over the lives of those with mental health difficulties and how this affects the relationship between service user and doctor. During periods of good mental health Bob held a position of responsibility and power himself and so was used to making far-reaching decisions. I realised that to Bob I was a representative of a profession which could, and on several occasions had, ruled that he no longer had the stability of life. I reflected on the immense power we as healthcare professionals hold over the lives of those with mental health difficulties and how this affects the relationship between service user and doctor. During periods of good mental health Bob held a position of responsibility and power himself and so was used to making far-reaching decisions.

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Three reasons why volunteering to participate in Recovery College activities can be a great learning experience: A ‘How to Guide for Trainees’

1. It can be an opportunity to get Workplace Based Assessments done. For example, an Assessment of Teaching Competency could be completed by recovery college staff after you participate in a teaching activity. For instance, delivering a presentation on the medical understanding of bipolar disorder to a group of recovery college students (usually people with lived experience, carers, relatives, friends, other health professionals etc).

2. It can be a great source for reflective portfolio entries. It is an opportunity to meet and work with people with lived experience of mental illness in a collaborative way. Being removed from a clinical setting and the conventions of the usual doctor-patient relationship can allow for a different kind of interaction and learning. This could give rise to a deeper understanding of what it means for someone to live with mental health difficulties and makes for good reflective portfolio entries.

3. It can be energising and motivating. It is an opportunity to meet people with experience of mental health problems who are thriving rather than suffering. As doctors we usually only see people when they are having difficulties and this can give us a skewed view of what it means to live with mental health problems. Meeting with and listening to experts-by-experience at the Recovery College is an opportunity to see that people can get better and live well despite having experienced mental health difficulties.

How to go about volunteering:

1. Contact your local Recovery College and ask if it is possible to become involved in some way. They are often keen for doctors to participate in education sessions and struggle to get time-strapped consultants to commit to attending.

2. Speak to your clinical and educational supervisors - make it a point in your Personal Development Plan to participate in a Recovery College activity and that way you should be able to
negotiate some time away from your day job to do so.

3. Meet up with the Recovery College facilitators and volunteers in advance so you can work together/ co-produce the material you are going to deliver. Explain that you would like to get feedback in the form of a WBA/AOT.

4. Use patient information leaflets, such as the ones produced by the Royal College, as a guide for the level at which to pitch your presentation and be prepared to be flexible with the amount of technical information you present. Invite questions and comments.

5. Be curious about what the other participants have to say - you will probably learn more about what it means to live with an illness by listening to experts by experience talk than you could ever learn from a textbook.

6. Talk about your experience in supervision and write it up in your portfolio afterwards - you should have plenty of good material for a reflective entry.
CALLING ALL PSYCHIATRIST'S…

Are you a psychiatry trainee with an interest and involvement in the arts?

Literature, music, art, design, to name but a few possibilities

For our next issue of the REGISTRAR, we want to hear from you

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Thank you