Improving Trainee Doctor Participation in Undergraduate Psychiatry Teaching: A Quality Improvement Project

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Aims. Good medical practice encompasses teaching students which is a core competency for trainee doctors. The aim of this project was to assess and improve junior doctor participation in undergraduate psychiatry teaching.
Methods. 2 surveys were conducted: 1) Psychiatry-related trainee doctors working in Severn Deanery were emailed a questionnaire to assess their involvement in undergraduate teaching, including barriers and motivators for teaching; 2) doctors with a formal role in teaching were sent a questionnaire to explore their views on recruiting trainee doctors to teach. Questionnaires consisted of multiple answer questions, matrix questions and qualitative free text answer questions. Trainees were then delivered a presentation advertising teaching opportunities. The impact of this on recruitment into psychiatry undergraduate teaching was reassessed by questionnaire.
Results. 44 responses were received to the first survey; 13 to the second. The most common answer trainees gave for factors that prevented involvement with teaching students was "unaware of teaching opportunities," and "lack of overall availability due to clinical commitments." The most common factor chosen as a motivator for involvement was "notification of session date/timing early in placement" and "protected teaching time in job-plan." The results highlighted difficulties recruiting trainee doctors to teach, resulting in tutors reducing, cancelling or adapting sessions due to lack of support.
Conclusion. This project identifies barriers and motivators of trainee doctor involvement in undergraduate medical education. To ensure lasting participation of trainees in medical education, support is needed for protected time to teach in clinical roles.

Documentation of Driving Status and of Fitness to Drive Following Admission of Patients to Clock View Hospital - How Are We Doing?

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Aims. Developing a mental illness and being commenced on psychotropic medication are factors that may interfere with the ability of an individual to drive safely as both can impact information processing, psychomotor actions and social interpretation. The Driver and Vehicle Licensing Agency (DVLA) suggests that certain medical conditions require driving licence holders to notify them for further assessment of their ability to drive. DVLA notifiable mental disorders include psychosis, schizophrenia, bipolar disorder, dementia and personality disorders. The doctor's legal duty is to assess the patient for any relevant diagnosis, inform the patient of their duty to report their medical condition to the DVLA and for the doctor to comply with the legal duty to inform the DVLA of any patient who won't or can't notify the DVLA of their medical condition. The authors conducted a quality improvement project to evaluate and improve the number of fitness to drive assessments completed for patients admitted to the five wards (three general adult, one older adult and the Psychiatric Intensive Care Unit) at Clock View Hospital.
Methods. The electronic (RiO) record for each inpatient on the five wards was scrutinised for: whether the patient's driving status was established on admission; whether the patient was notified of the DVLA rules if they did drive; whether the patient agreed to fulfil their duty of notification and, in instances where they were not, whether the medical professional had taken appropriate steps to address this.
Results. 74 patients on the five wards were included in the sample. Only nine of the 74 patients had driving status documented on admission. Three of these nine patients were noted to be driving or learning to drive and were not notified of the DVLA rules. Four of the nine patients were no longer driving and so discussion about DVLA guidance was unnecessary. The remaining two patients were confirmed to be driving and informed of the DVLA regulations. Both patients agreed to comply and therefore no further action was indicated.
Conclusion. A review of current practice indicates a deficit in incorporating driving status and fitness to drive assessment into the clerking proforma following admission to Clock View Hospital. The second half of this cycle will implement change and raise awareness amongst inpatient medical and nursing staff of the need to consider this important issue prior to discharge. A re-assessment of the effectiveness of these changes will be carried out in the future.

The Impact of Policing on Involuntary Routes of Admission: A QIP on Patient Experiences

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Aims. Patients often have negative experiences of police in their daily lives. Police involvement in mental health services can make an encounter feel disciplinary rather than therapeutic and exacerbate mental distress. People with mental illness, especially of minoritised backgrounds, are more likely to die after police contact, than other groups. Our aims were to: 1) explore patient experiences of being admitted onto the ward under section via the police, 2) explore patient understanding of the role the police play in mental health services 3) Use experiential data towards introducing trauma informed care in an inpatient setting
Methods. A clinician administered questionnaire was conducted on an acute male inpatient ward, with 12 consenting male inpatient participants. All were involuntarily detained, ranging in age from 22 to 56 years; 11 out of 12 were of an ethnic minority background.

The questionnaire consisted of a mixture of open-ended questions and closed Likert scale questions with answers ranging from "strongly agree" to "strongly disagree". Questions covered themes relating to the experience of admission and the ward environment, personal and communal experiences of policing, views on

the role of policing in mental health service provision. Data were collated and presented in a local QIP showcase.

Results. A significant split was identified between answers to open-ended and closed questions. When offering Likert based responses, 66% of participants felt safe with the police and believed that the police had a role in keeping people with mental health problems safe; 50% felt the police role should be greater in the future.

When responding to discussion-based questions, participants were critical of policing in relation to managing mental crises. Participants offered elucidative answers covering themes ranging from feeling a lack of agency, and the traumatic nature of criminalising mental distress, to concerns about abuse of power, the desire to limit the policing role to criminality and lack of trust engendered from experiences of racial injustice.

Conclusion. Our results demonstrate that patient views on policing roles in mental health service provision are complex. The experiences of involuntary admission through the police are often traumatic, rooted in past police involvement in patient's lives. Although it is acknowledged that at times no feasible alternative is available in hostile situations, this QIP opened an important, previously avoided, discussion. This will hopefully lead to introduction of more trauma informed care in an inpatient setting.

Reducing the Pressure on Mental Health Team by Improving Post-Discharge Follow-Up of Self-Harm or Suicidal Patients in Primary Care

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Aims. Northern Ireland has had the highest suicide and self-harm rate in the UK since 2012 according to National Statistics Office with 12.5 deaths per 100,000 population compared to 10.5 in the rest of the country. Evidence shows that the risk of suicide hugely increases following self-harm, and the greatest risk is immediately after the self-harm episode. Better access to health care, especially to primary care, in this period, can actively reduce the risk to this vulnerable patient group. Patients assessed for self-harm in the emergency department are often followed up by the mental health/crisis team. Due to lack of resources and staff shortages this is often not possible in a timely fashion. NICE suggests that patients should be offered a follow-up appointment in primary care within 48 hours of discharge. We aimed to ensure 70% of patients discharged from secondary care following an episode of suicidal ideation or self-harm are contacted proactively by mental health practitioner (MHP) or GP within 48 hours of communication from secondary care.

Methods. The project underwent two PDSA cycles. An electronic workflow was created to provide easy patient identification, assessment and follow-up. A process mapping was done after discussion with the GPs, administrative team, practice nurses and MHP. Outcome was measured by finding out percentage of patients: 1) Contacted within 48 hours of communication following an episode of self-harm 2) Appropriately coded 3) Comprehensively assessed 4) Risk stratified and minimized following each cycle.

Results. Over a period of three months, following two PDSA cycles, the frequency of these contacts increased from 0 to 80% (median) with an average 3.8 (83%) patients reviewed per week. The patient experience and satisfaction also improved significantly.

Conclusion. General practice (GP) has long been known as the next of kin for patients in the health care system. As GP is mostly the first point of contact for the patients, it can contribute significantly to ease the rising pressure on the mental health team. Also, a small number of weekly contacts from each GP can make a huge difference in nationwide patient safety and experience. We hope this intervention will significantly improve patient safety and reduce further self-harm presentation to ED in the long run.

Evaluation of a Trauma Pathway Within an Increasing Access to Psychological Therapies (IAPT) Service

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Aims. The Enhanced Trauma Pathway (ETP) at Berkshire Healthcare NHS Foundation Trust was established in 2018 to manage high demand on a highly specialist psychology team called the Berkshire Traumatic Stress Service (BTSS). The ETP is used to treat complicated cases of Post-Traumatic Stress Disorder (PTSD) within the IAPT service. However, because of the ETP there is now a cohort of Service Users (SUs) presenting to IAPT with a higher complexity than has been typical, presenting new challenges for the service. We aim to evaluate and redesign the ETP within IAPT to meet the needs of the changing population.

Methods. Clinically Led workforcE and Activity Redesign (CLEAR) is a workforce transformation methodology with four unique stages: i) Clinical Engagement: in-depth qualitative analysis of interview data from staff ii) Data Interrogation: cohort analysis using clinical and workforce data visualisations and analysis, iii) Innovation: developing novel solutions with insights from triangulated qualitative and quantitative data, iv) Recommendations: formulation of new models of care (NMOC) and smaller quick high impact service innovations. Thematic analysis was used for the qualitative data. Quantitative data analysis was conducted using the IAPT dataset.

Results. 27 semi-structured interviews were conducted with staff. SUs on the ETP had longer waiting times, their treatment took longer (18 sessions for ETP Vs 12 for core step 3) and they had lower recovery rates: 32.9% for ETP, 49.9% for core step 3 in IAPT and 57.3% for the whole IAPT service. SUs on the ETP presented with increased risk concerns, often not mitigated by stabilisation work offered. Thematic analysis also identified challenges with recruitment, a lack of qualified staff and inefficient use of skills across the pathway. Staff well-being was found to be paramount, however supporting staff was found to be challenging due to national constraints placed upon IAPT and the targets