

Innovation

Research and Development
Newsletter

Research & Development

What do we do?

Page 2

Mental Health Nurse Prescribing

What is Nurse
Prescribing?

Page 4

Understanding Self Care in Mental Health

Page 6

The Dementia Toolkit

a resource for staff

Page 8



**Completed
Research
Projects**

Completed Projects

to read about projects
that have recently been
completed simply look
out for the symbol

Research & Development

What do we do?

Several staff I have spoken to, across different organisations, have expressed a lack of understanding about what the R&D Consortium is and how it is of relevance to them. I hope the following helps demystify us and encourages collaboration and sharing between staff involved in, or wishing to be involved in mental health and learning disability research in the NHS across West Yorkshire.

The West Yorkshire Mental Health Research and Development Consortium provides research advice, governance, management and support services for the three specialist mental health and learning disability NHS Trusts in West Yorkshire (Bradford District Care Trust, Leeds Mental Health NHS Teaching Trust, South West Yorkshire Mental Health NHS Trust). The Universities of Bradford, Huddersfield, Leeds, and Leeds Metropolitan University are also partners in the Consortium.

The mission of the consortium is to create a critical mass and centre of excellence for mental health and learning disabilities research in West Yorkshire. The aim is to:

- Produce high quality research in mental health and learning disabilities that will benefit the NHS and its service users and make a significant contribution to building the evidence base
- Build a strong link between research and practice that allows ideas for research to be generated from practice and results in the best evidence from research being implemented in NHS practice
- Maximise engagement with national mental health, learning disability, dementia and neurodegenerative disease research
- Contribute to, and develop, a national profile in mental health, learning disability, dementia and neurodegenerative disease research

The consortium aims to facilitate collaborations between academic partners and to attract increased funding and high calibre research and researchers.

The West Yorkshire Mental Health R & D Consortium is led by the Joint Research Governance Committee (JRGC) which reports to the Bradford District Care Trust, Leeds Mental Health NHS Teaching Trust, and South West Yorkshire Mental Health NHS Trust (BDCT, LMHTT, and SWYMHT) Trust Boards.

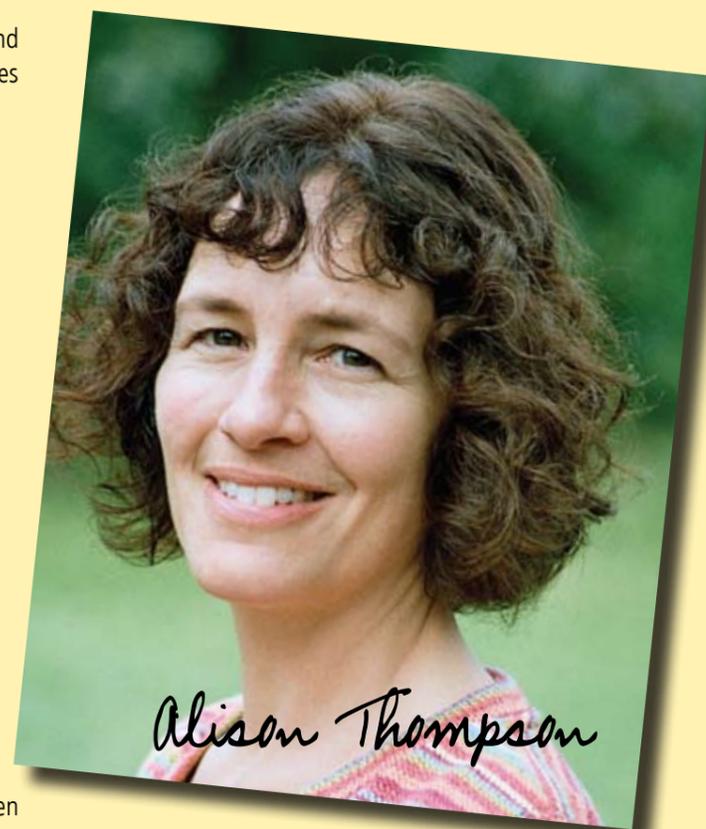
Please do contact me or any members of the consortium staff if you would like more information: include all contact names and numbers

Alison Thompson

Acting Head of WY MH R&D Consortium

T: 0113 295 2360

E: alison.thompson@leedspft.nhs.uk



Service User & Carer Involvement

In Mental Health Service Delivery and Planning

Throughout 2008 a team, led by Dr. Virginia Minogue, made up of healthcare professionals, researchers and service users and carers from across West Yorkshire carried out a study looking into service user and carer involvement in mental health education, training and research activities within West Yorkshire's three mental health Trusts and four Universities. The team, more than half of which use or care for someone who uses mental health services, secured funding for this project from the Assessment and Learning in Practice Setting (ALPS) research programme.

The project produced some very interesting findings identifying many areas of good practice within the Trusts and Universities in West Yorkshire. The overwhelming response from all staff members who involve people in their work and from the service users and carers themselves was that involvement is extremely valuable and greatly enhances the quality of work produced. There is however no set definition for what service user and carer involvement actually is and sadly some people who are involved do still believe they are only involved because involvement is a mandatory requirement.

- Tokenistic involvement can be avoided by following guidance and policies that are in place and ensuring that involvement is comprised of active, meaningful partnership work which has value and impact.

Some recommendations regarding service user and carer involvement were produced which could be considered in relation to any involvement activities:

- Current good practice regarding involvement should be built upon.
- Particular attention should be paid to the range of opportunities there are for service users and carers to become involved
- The expertise that service users and carers possess should be considered; are we involving the most suitable people for the activities we want them to participate in?
- Access should be considered, especially when trying to get representation from a broad range of people. Although there are often many opportunities for involvement, these

may not be accessible to everyone e.g. some service users may work and cannot attend meetings during the day.

How are we recruiting service users and carers? The study produced a vast list of methods of advertisement for opportunities but overwhelmingly the people who are involved stated that they found out about opportunities through personal approach. They also stated that once they became involved in one activity they found out about many more and often became overwhelmed by what was on offer.

- We need to be mindful that opportunities are made as widely available as possible so that all the users and carers of a service have the opportunity to choose whether they are involved; this would enhance the representativeness of people involved and ensure involvement within activities is not tokenistic.

The study identified many training opportunities and support systems for people who are involved but also recognised that these opportunities are often not accessed. It highlighted that the actual needs of service users and carers who become involved are very individual.

- The support and training available should reflect the needs of the individual and the particular involvement activity or project; accessibility and timeliness of training opportunities should be reviewed.

Finally, the study highlighted the fact that at present there are no real measures in place to quantify the value of user and carer involvement. People who are experienced in this area overwhelmingly state its value but no one has a way of measuring this. Further work to identify relevant outcome measures to determine the impact and effectiveness of service user and carer involvement needs to take place.

Author:

Sarah Hardy

(Research Assistant)

T: 0113 295 2387

E: sarah.hardy@leedspft.nhs.uk



Mental Health Nurse Prescribing

What is Nurse Prescribing?

Non medical prescribing (NMP) is considered an integral part of modernising the National Health Service (NHS). The term is used to denote all prescribing carried out by healthcare professionals other than doctors or dentists. Endorsed by the NHS Plan (Department of Health, 2000), its implementation has contributed to a significant shift in the clinical roles traditionally undertaken by healthcare professionals. The nursing profession has been at the forefront of these changes with health visitors and district nurses having had limited prescribing rights since 1994. In 2001 the prescribing initiative was extended to include all nurses and pharmacists opening up the potential for mental health nurse prescribing (Department of Health, 2001 and 2002).

In the UK there are currently two ways in which nurses can prescribe; namely supplementary and independent prescribing. The former was introduced in 2003 and is defined as a voluntary partnership between a doctor and a suitably trained nurse, to implement, with the patients' consent, an agreed patient-specific clinical management plan (CMP) (Department of Health, 2007). The CMP defines the scope of the supplementary prescriber and is usually written following a medical assessment and diagnosis by the doctor. On establishing a CMP a nurse can in theory prescribe any medicine, including controlled drugs and unlicensed medicines, for any medical condition (Department of Health, 2005). More recently, qualified nurses have been able to practice as independent prescribers. This form of prescribing allows suitably trained nurses to prescribe any licensed medicines, including some controlled drugs, for all medical conditions according to their level of competence and expertise (Department of Health, 2007). A key difference between supplementary and independent prescribing is that nurses can independently establish a diagnosis through means of a clinical assessment and formulate a CMP. Independent prescribers are also responsible for any necessary prescribing and determining the appropriateness of subsequent prescriptions (Aronson, 2003).

What is happening in the Consortium?

Within Leeds Partnerships Foundation Trust (LPFT) there are 20 qualified nurse prescribers, and 2 pharmacist prescribers.

In contrast, South West Yorkshire Mental Health Trust (SWYMHT) has 8 nurse prescribers who are qualified as both supplementary and independent prescribers.

Bradford District Care Trust (BDCT) is relatively new to NMP; as such there are no practicing prescribers although this expected to change with time.

To become an extended independent or supplementary nurse prescriber, registered nurses are required to attend a 26-day training programme. This programme should be university based and be validated by the Nursing and Midwifery Council (NMC). On completing the programme, the nurses are subsequently required to have a period of supervised practice with an experienced medical practitioner. This lasts for 12 days and provides an opportunity for the nurses to learn in practice. In general consultant psychiatrists take on the supervisory role, although the Trust notes that specialist registrars (SpR) and staff grade doctors may undertake this role if prior agreement is given by the responsible consultant psychiatrist.

What do service users think about nurse prescribing?

Research directly investigating service user perspectives of nurse prescribing is very limited. A literature review has been completed and found the following:

- Studies in favour of its implementation
- Studies relating to satisfaction with nurse prescribing
- Studies in relation to mental health nurse prescribing

Due to the lack of published literature concerning service user satisfaction with nurse prescribing, a small working group have been meeting in order to work up a formal research proposal within this area. The first phase of the project has received ethical approval and is currently in the process of recruiting service users to take part in the study. The data from the nurse prescriber interviews is also being analysed. The findings will be used to inform the research design of the second, larger phase of the project, which aims to investigate the wider impact of nurse prescribing across Yorkshire and Humber. The project team currently includes representatives from Huddersfield University, South West Yorkshire Mental Health Trust and Leeds Partnerships NHS Foundation Trust. The conclusions drawn have the potential to improve current prescribing policy and practice.

Where to find more information?

The main contacts are the authors of the article whose contact details are provided below.

Chris Collins

Lead Nurse, WAA Directorate
E: chris.collins@leedsaft.nhs.uk
T: 0113 305 6743

Helen Crosby

Research Fellow, R&D Department
E: helen.crosby@leedsaft.nhs.uk
T: 0113 295 2387



Vocational Service

Experiencing Modernisation

During the course of 2007, a review of day and vocational services in Kirklees led to the decision to close Vocational Enterprises (VE), a sheltered workshop in Huddersfield providing vocational rehabilitation for people with mental health problems. Its closure in December 2007 has been followed by the progressive development of a new service model for day and vocational services in Kirklees.

The attached report describes the findings and brief conclusions from a small research project, established by a group of clinical and academic staff associated with Kirklees' mental health services. This aimed to compare service users' experience of the new service model with that offered by VE. The project thus provided a means for concerns about the impact of closure to be articulated and tested, and also offered some early feedback to stakeholders about the progress of service modernisation.

The findings are based on initial interviews by the research team (all mental health practitioners) with 10 of the 50 people leaving Vocational Enterprises shortly after its closure, and further interviews with 8 of these, conducted around 7 months later. The views of key staff contributing to local service modernisation were also obtained at interview in December 08. The findings were briefly as follows. Full details are available in the attached report.

- most of the sample of service users leaving VE had achieved the goals they set before leaving, at least to some extent
- most of the concerns raised by service users and others during the closure of VE have not been realised. Those who wished to have been able to maintain the friendships they developed there, and geography has not been a major barrier to accessing alternative occupation e.g. at Pathways Day Services in Mirfield
- there is some evidence of expansion in the social networks of those leaving VE
- however, there is no evidence that their employment prospects have improved in the last 9 months.
- the closure of VE has clearly deprived one or two leavers of constructive occupation; they are quite unable to find this elsewhere, which appears to be placing their mental health at risk.
- an increasing range of vocational support is now available. However, there is some evidence that the increasing dispersal of this is jeopardising co-ordination, and confusing service users.

So in some important respects service users' experience endorses the strategic direction taken locally. Supporting people into employment clearly needs to remain a high priority. However, our findings also demonstrate the value service users attach to social contact, and to alternative opportunities for constructive occupation (such as volunteering). This suggests that a balance of investment is needed which reconciles mainstream policy aims of social inclusion through employment, with the need to affirm service users' individual aspirations and abilities, and to realise other policy aims of individual and collective wellbeing.

Chris Ring

chris.ring@ntu.ac.uk
0115 848 2632



Understanding Self Care in Mental Health: UKCRN Portfolio Research Project

A national study funded by the Service Delivery Organisation (SDO) is being conducted to see how self-care policy is implemented in mental health Trusts, the barriers and facilitators to supporting self care and considering what lessons that offers for other health service areas (see article in the June 2008 newsletter).

The research team across the three NHS Trust areas in West Yorkshire, London and Hampshire have now finished the analysis phase of the rich data and are currently writing the final report for the SDO.

The feedback conferences that took part in March 2009 at Huddersfield University and Fieldhead Hospital in Wakefield were very successful. There was a good mixture of service users, carers, staff and management, in addition to some stakeholders. People's discussions reiterated the themes that we had presented and we are confident the conferences broadly validate our findings.

The research and the feedback conferences were well received by participants.

One carer commented:

"..in all the years of involvement with services, this is the first time we've been asked what we think..."

The final report is due to be completed in September 2009. After this, additional research papers will be produced which analyse the data in more detail.

Katie Adams
T: 0113 295 2634
E: katie.adams@leedspft.nhs.uk



Katie Adams



Patients' experiences of a Specialist CFS/ME Service



concerns (89%) also scoring highly.

The service offers a variety of approaches provided by different professionals, and the patient chooses from the options that might be beneficial to them. Ratings of individual service options had all improved since the 2004 questionnaire, the highest rating therapies (scored as very helpful / helpful) being individual sessions with an occupational therapist (91%), CFS/ME management group programme (90%), individual sessions with a nurse (90%) and relaxation group (90%). For those people who felt that cognitive behavioural therapy might be beneficial in managing their condition, 84% found it to be very helpful / helpful. Questions were also asked about the different aspects of the therapies /interventions

that are offered. Most highly rated components (excellent / good) were; how to grade and manage activities (incorporating pacing approaches) (90%), responding to demand / dealing with stress (90%), written information provided (89%) and copies of letters to GPs/letters of support to other agencies (87%). The lowest rated components were support for carers (46%) and controlling symptoms through medication (61%), suggesting more attention needs to be given to these areas.

People were also asked about their experience of alternative therapies, though the numbers for each therapy were often low. The most helpful out of those tried by more than 10 people were; relaxation (90%), meditation (88%), massage (83%), osteopathy (cranial 80%, other 74%), nutrition/diet (75%) and yoga (72%).

Once the full results are available the service is aiming to produce a full report to help inform local service users, commissioners and shape future development of the service. The research team is also hoping to publish their findings in relation to the factors that have emerged which have influenced people's experiences and how this relates to the differing needs of people with the condition, such as length or duration of the condition. We hope to share more about this with Interaction in the future.

Sue Pemberton
sue.pemberton@leedspft.nhs.uk
0113 305 6515

In 2004 the Leeds and District ME Group completed a survey of their membership to ask them about their views of the long-established local CFS/ME service and obtain members opinions about the future development of the service, as part of the application process for the Department of Health Investment Programme. Now the clinical staff at the Leeds & West Yorkshire CFS/ME Service and some service users have worked jointly as a research team to repeat the survey and also find out more about the different needs and experiences of people using the clinic. They hope the results will demonstrate the benefits of the current service and help identify key factors that influence people's level of satisfaction with NHS services.

500 questionnaires were posted out to people who used the service between February and October 2007. 259 questionnaires were returned (52% response), of whom 66 people (25%) indicated that they were members of a local or national patient support group. The research team are still analysing the large amount of qualitative data that was obtained, but the initial results from the ratings of the service show the benefits that people are finding.

91% of people rated referral to a specialist service as very helpful / helpful. Ratings relating to the attitude and knowledge of the staff were very high, with 97% rating both the knowledge and the general attitude of staff as excellent / good, with other factors such as understanding the impact of the condition (93%), listening to your needs (89%) and responding to

The Dementia Toolkit: A New Resource for Staff

A new resource called 'The Dementia Toolkit' is now available to all staff in older people's services and is expected to make a real difference to their working lives. The toolkit was introduced as part of the Collaborative Project and has been commissioned by the Trust as a resource to support staff in dementia care services.

The toolkit was developed by staff from a range of disciplines across older people's services so its content reflects their key concerns and interests and is tailored to their needs.



The Dementia Toolkit resource folder is designed to support staff by giving them ideas about how to best care for people with dementia and their carers. It also provides information on relevant courses and training opportunities to help staff plan their personal development.

Research fellow Rebecca Spencer who led the Dementia Toolkit project said, 'The dementia toolkit aims to bridge the gap between research and practice by providing evidence based recommendations and real life case examples. There are many opportunities for training and development in older people's services that staff may not be aware of and it is hoped that by notifying staff of exactly what is on offer and when, the toolkit will help them complete their learning and development plans as part of the Knowledge and Skills Framework (KSF).'

The Dementia Toolkit resource folders are currently being sent out to each older people's service for each team to use and the Dementia Toolkit is also available at the library in the Education Centre at Fieldhead Hospital and The Yearn to Learn Centre at St Luke's Hospital. It can also be found on the intranet at:

<http://nww.swyt.nhs.uk/dementia-toolkit>
<http://www.southwestyorkshire.nhs.uk/dementia-toolkit>

For further information please contact
Rebecca Spencer, Research Fellow
T: 01924 327101
E: rebecca.fellow@swyt.nhs.uk

How can the dementia toolkit help?

The toolkit helps staff working in older people's services tackle key questions relevant to dementia care including:

- *How can I support a person with dementia and challenging behaviour?*
- *What strategies can I use to better communicate with a person with dementia?*
- *What approaches can I use to help alleviate carer stress?*
- *What is validation therapy and how effective is it?*
- *How does structured exercise activity help a person with dementia?*
- *How effective is cognitive stimulation and reality orientation therapy?*
- *How effective is life history work and reminiscence therapy?*
- *What courses and training opportunities are available to me?*

NHS Researcher wins prestigious award for innovation

A Research Fellow, Rebecca Spencer working for South West Yorkshire Partnership NHS Foundation Trust in Wakefield has won the Medipex Innovator of the Quarter Award for developing



Above: *Rebecca Spencer, (Research Fellow), Suzanne Wightman (Senior Manager & Practice Development, South West Yorkshire Partnership Foundation Trust) and Ann Starkey, (General Manager, Medipex)*

The Dementia Toolkit. This is a unique resource to support staff working with people with dementia provide even better care for this group of patients.

The innovative project lead by Rebecca was launched this year in a novel way using a quiz with prizes to ensure staff knew how to use it. Now it is her turn to win a prize as the Innovator of the Quarter.

The dementia toolkit is a staff resource folder which provides a quick reference guide to evidence based interventions and approaches for people with dementia and their carers. It also provides staff with a training directory of opportunities to improve their knowledge and skills. The toolkit promotes meaningful engagement, wellbeing and personhood as well as positive relationships between people with dementia and their carers.

The project was commissioned by the R&D Business Group

of South West Yorkshire Partnership NHS Foundation Trust and took 18 months to complete. Further information can be accessed at: www.southwestyorkshire.nhs.uk/dementia-toolkit A multi-disciplinary focus group was held so Rebecca could identify the gaps in knowledge, and current sources of evidence based practice.

It was at the collaborative stage when service users and carers became involved that Rebecca first met Suzanne Wightman who nominated her for the award.

"I could see it was a really useful piece of work" said Suzanne "and I think people were very impressed with Rebecca's commitment to it and how thorough and professional she was in her approach. So when we got the Innovator of the Quarter email we thought it would be a good idea to nominate her."



Rebecca said *"I am thrilled to have won the award and hope that the recognition will raise the profile of the Toolkit further so it can go on to improve care for more people with dementia and their carers. So many staff contributed to this project and I would particularly like to thank Suzanne Wightman, Professor Stephen Curran, Dr Virginia Minogue and Sue Barton."*

If you would like to nominate someone for the next Innovator of the Quarter Award for a chance to win a luxury hamper and £150 towards the innovation fill in the enclosed application form or visit www.medipex.co.uk and navigate to Latest News page.



Psychiatry SSC Project Report

University of Leeds

Nobody loves me everybody hates me, think I'll become a psychiatrist!

Why do medical students not want to become psychiatrists?

Matilda Frisk, Ellen Åkeson, Michelle Egan. June 2007
Supervised by: Dr Simon Budd

Abstract

Objective: The aim of this study was to determine why the recruitment into psychiatry is low, and has been for the last 40 years. In order to answer this, research was done about the attitudes towards psychiatry among both doctors and students. To be able give suggestions on improving the recruitment, an investigation was made to explore which influences that are most important when choosing medical speciality.

Methods: Mixed methods were used, with both face to face interviews and questionnaires. People from five different cohort groups were interviewed; 3rd year students, 4th year students, foundation year 1 doctors, foundation year 2 doctors and psychiatrists. Before it was possible to interview doctors, it was necessary to obtain ethical approval. The questionnaires were handed out both in person and by email. The data collected was then analysed, using both qualitative and quantitative methods.

Results: This study confirms that psychiatry has low status compared to other specialities, and a large amount of students would not consider psychiatry as their career of choice. A lot of people commented on having bad knowledge of psychiatry before starting medical school, and that this is one of the main reasons to misconceptions and the stigma attached to the speciality. It was also stated that personality, lifestyle and exposure are key factors influencing students and doctors

when deciding which speciality they would like to enter. Due to the quantitative results, the 4th year students, who had done the psychiatry placement, had a much more positive attitude towards psychiatry in comparison to the 3rd years, which also was confirmed with data from the qualitative results. The introduction of MMC (Modernising Medical Careers) might imply that a lesser amount of junior doctors get exposed to psychiatry, since they do not have the opportunity to rotate between a variety of different specialities as a SHO (Senior House Officer).

Conclusion: Exposure is one of the main things that could change people's attitudes towards psychiatry, consequently a good clinical placement are of major importance. The MMC system will presumably, because of decreased experience of mental illness, precipitate lesser understanding, and may breed more misconceptions of psychiatry. It takes a certain kind of person to appreciate psychiatry as a profession, and therefore it may be favourable to focus on finding these persons with aptitude for psychiatry early during the medical training. The lifestyle in psychiatry is attractive to those people who want to have a family. It might be beneficial bringing this to the attention of medical students in order to highlight the advantages of psychiatry as a profession.



An Exploration of the Links between Trauma and Delusional Ideation in Secure Services

Abstract. Relationships between trauma symptoms and delusional ideation were explored in a forensic sample. A between-subjects design compared low and high trauma scoring patients on measures of delusional ideation and paranoia. A within-subjects design examined associations between trauma-related cognitions, delusional ideation and paranoia. Thirty-four participants were recruited from a number of secure units. Participants' "worst trauma" was identified using a self-report analogue scale. Self-report measures of trauma symptoms, trauma-related beliefs, delusions and paranoia were completed. Thirteen patients scored above the cut-off on the trauma measure, indicating a high rate of trauma symptoms. The most frequently cited worst traumas were committing an offence and the experience of psychosis.

Correlational analyses revealed positive associations between traumatization and intensity of delusional ideation and paranoia. Trauma-related negative cognitions about the self

were positively associated with level of delusional ideation, associated distress, and preoccupation. Negative cognitions about the world were associated with paranoia. Findings provide some evidence for associations between traumatization and delusional ideation and paranoia in this population. Future research should aim to replicate and extend the study, using a larger sample size and diagnostic measures of post-traumatic stress disorder (PTSD).

Behavioural and Cognitive Psychotherapy, 2008, 36, 1–16
Printed in the United Kingdom doi: 10.1017/
S1352465808004621

Clare Calvert

Programme in Clinical Psychology
Leeds Institute of Health Sciences
Charles Thackrah Building, 101 Clarendon Road
Woodhouse, Leeds, LS2 9LJ
T: 0113 343 2732

Transferring research knowledge

Transferring research knowledge into action is an extremely important task and successfully doing so can contribute to the delivery of better health services. However, this process does not always run smoothly. One of the main obstacles to transferring research into practice is the presence of a gap between those who produce research and those who use it. Different ways of bridging this gap have been proposed, but one of the most popular involves employing individuals to act as 'knowledge brokers'. Their job is to go beyond the one-way push of information from researchers to decision makers by facilitating a two-way transfer of knowledge.

To find out more about knowledge transfer and knowledge brokering, a team from the University of Leeds are carrying out three case studies within Leeds PFT. Each case study involves a team of practitioners who want to be able to use research and other evidence to help them plan, deliver or evaluate their services. Each of the three teams has access to a dedicated 'knowledge

broker' who is helping them find and manage a range of research and other evidence, facilitating their interactions with relevant experts and helping them develop skills which will enable them to continue with the process of transferring knowledge into action.

Case studies are all due to finish in the next few months and the research team will use the information they have collected to develop a tool which can help researchers and users to think about how to transfer knowledge into action. For more information about the project please contact

Vicky Ward

T: 0113 343 0848
E: v.l.ward@leeds.ac.uk

Hospital Catering Systems

Do they comply ?

Do Various Hospital Catering Systems Comply With Recommendations For Nutrient Content Per Meal?

Introduction

Malnutrition risk currently affects more than 1 in 4 adults in the UK and causes muscle weakness, impaired immune response, reduced psychological health and electrolyte disturbances. It is associated with longer hospital stays, increased morbidity and mortality, and higher costs. Although some effort has been made to improve the nutritional adequacy of hospital food, there remains large variation in catering practices and nutritional provision due to minimal mandatory standards. The British Dietetic Association (BDA 2006) provides the most recent guidelines for energy and protein content of hospitals meals. In view of the adverse effects of malnutrition, this study aims to analyse the energy and protein content of main meals served by different hospital trusts each employing different catering systems, and compare the analyses to the BDA guidelines and to each other.

Methods

Three different hospital trusts in the Yorkshire and Humber Strategic Health Authority, each employing a different catering system including cook-serve (CS), cook-chill/cook-freeze (CC), or external contractor (EC) agreed to be involved in the study. Data was collected on all hot main meals served for one week of the menu provided by each trust. Data was then analysed using Netwisp; a dietary analysis software package, for energy and protein content per meal including all possible combinations.

Mean daily averages for each trust were then compared to the BDA (2006) guidelines for energy and protein content per main meal using one sample t-tests, and were compared with each other using analysis of variance with post hoc tests ($p < 0.05$).

Results

Each overall average for each trust met the BDA guideline figures for energy and protein, which were significantly different to the guidelines ($p < 0.05$) except for energy and protein content in vegetarian meals in the CS trust which were not significantly different. The CS trust provided on average the most energy and protein, and the EC trust provided the least per meal. Although the CS trust showed 4 individual averages which failed to meet the guideline, these were not significant. The CS trust demonstrated the most inconsistent energy and protein content overall, whereas the EC trust was found to be the most consistent. The CC trust showed no significant difference in comparison to the other two trusts.

Conclusion

This study has failed to provide a clear conclusion of which catering system seems best able to meet nutritional recommendations due to irregularity in the nutritional analysis method. However, results do suggest all catering systems are capable of meeting guidelines whilst vegetarian meals appear to require the most attention when developing nutritionally adequate menus.

Alex Wraith

alexandrawraith@hotmail.com



Facilitators' experiences

of a therapeutic bereavement group

Facilitators' experiences of a therapeutic bereavement group for people with intellectual disabilities: a qualitative study

Author: Dr Jo Grant and Nicole Dobson

Abstract: Aim: to explore facilitators' experiences of a therapeutic group of adults with intellectual disabilities.

Method: Discussions between the group facilitators were tape-recorded following each session of an eight week bereavement group for five individuals with intellectual disabilities. The recordings were then transcribed and the transcripts were subject to Interpretative Phenomenological Analysis (IPA) to explore the facilitators' experiences of the group.

Results: the analysis highlighted two primary themes; **1.** The facilitators own experiences. **2.** The facilitators experiences

of interactions with and between group members. The first theme includes subthemes of uncertainty, searching for meaning/ understanding, managing group balance, from overprotection to empowerment and our emotional responses. The second theme involved subthemes relating to group connections and psychological defences including avoidance, handicapped smile and difference and disability.

Conclusions: this study has highlighted various experiences that may be had by facilitators of groups with people with intellectual disabilities. Some of these issues are reflections of those already seen in society and other psychotherapeutic settings. For example: Valerie Sinason's Pain of Difference reflected by the initial difficulties in the group (including facilitators) becoming cohesive and equal; the difficulty in balancing the responsibilities of being the facilitator and the "assumed" responsibilities of being in a carer role, highlighted by concerns of overprotection and disempowerment; the importance of listening to and responding to nonverbal communication. Finally, the study demonstrated the importance of facilitators receiving supervision and a space to reflect on their practice and their unconscious responses relating to issues of difference and disability.

Contact Details: Pat Frankish Associates, 54 Bridge Street, Brigg, North Lincolnshire, DN20 8NS





Using Q methodology to explore beliefs

Using Q methodology to explore beliefs about parenting amongst social workers, clinical psychologists, paediatricians and psychiatrists.

Abstract

The study described in this thesis investigated beliefs about what represents 'good' parenting amongst social workers, psychiatrists, paediatricians and clinical psychologists. It is argued that because parenting is a socially constructed concept and because there is no universal agreement as to what makes a 'good enough' parent, practitioners' judgements about parenting are likely to be influenced by their personal beliefs. Only two studies have directly investigated beliefs about parenting amongst professionals (Daniel, 2000; Woodcock, 2003) and both of these involved social workers only and investigated beliefs related to the assessment of children on the child protection register.

The study used Q methodology, a method appropriate for eliciting, modelling and comparing complex beliefs. Participants were asked to rank order a set of statements of opinion about parenting behaviours (Q set) according to how much they agreed or disagreed with them. The participants' patterns of responses to the Q set were correlated and subject to by-person factor analysis. This analysis revealed five statistically independent viewpoints of parenting that were interpreted by the researcher.



1. The 'liberal parent with the bottom line' was open-minded in views about parenting but alert to potentially harmful behaviours of parents.
2. The 'Webster-Stratton parent' valued stimulation and positive behaviour management, a view of good parenting similar to that of the 'Incredible Years' approach (Webster-Stratton, 2006).
3. The 'attachment perspective' valued the attachment relationship, even if this meant maintaining it when a child was at risk of sexual abuse.
4. The 'absolute parent' made clear judgements about the minimum requirements of 'good enough' parents, valued children achieving, and risk taking.
5. The 'protective parent' attended strongly to risks to children's physical and emotional health and focused on harmful behaviours of parents more than on the general emotional environment.

The main area of agreement between viewpoints was about the importance of a secure attachment relationship, although a number of other areas of consensus about 'good parenting' were identified. This suggests some consistency amongst practitioners in their beliefs about parenting and it is suggested that this is important for facilitating relationships in multi disciplinary teams. Differing viewpoints could lead to diversity in parenting assessments and to disagreement amongst professionals but they could also be viewed as a strength if they are reflected upon and discussed with colleagues.

Sarah Louise Wharton

Programme in Clinical Psychology
Leeds Institute of Health Sciences
Charles Thackrah Building
101 Clarendon Road
Woodhouse, Leeds, LS2 9LJ
T: 0113 343 2732



Academic Unit of Primary Care Ways of working

A team from the Leeds Institute of Health Sciences (House, Ward, Hamer) have been implementing a knowledge brokering intervention with three teams from Leeds PFT. We worked with the Personality Disorder Network to help them find the best ways of implementing routine outcome measurement across their service; the Community Forensic Nursing Team to help them find the best ways of addressing the physical health needs of their clients and; the Older People's Directorate to help them produce a framework for how psychological and vocational therapies could be offered within the directorate. A knowledge broker helped the teams identify and refine their key issues, questions and needs; found and fed back relevant research and other evidence to the teams; found appropriate experts to inform and assist the teams with their questions; facilitated interactions between the teams and relevant experts; and transferred information searching and other skills to the teams. As a result of the intervention, the Community Forensic Nursing Team has implemented a research-based physical health check across their service. It has also led to discussions about whether this health check could be implemented more

widely across the organisation as part of the Physical Health Improvement Procedure. The knowledge brokering intervention has also helped the team from the Older People's Directorate to develop a framework for psychological and vocational therapies by providing research based evidence and advice on the content and format of the framework.

For more information please see the Consortium's website or contact Vicky Ward whose details are listed below:

Vicky Ward

T: 0113 343 0848
E: v.l.ward@leeds.ac.uk

<http://www.leeds.ac.uk/lihs/pc/Staff%20Profiles/vickyward.html>
<http://www.leeds.ac.uk/lihs/psychiatry/research/knowledgebrokering.htm>



Stakeholder Survey – The LOSS Study

Background

Randomised controlled trials relevant to people with schizophrenia are often small (mean ~100 participants) and of short duration (mean ~12 weeks) but, nevertheless, attrition from these studies can be considerable. Statistical techniques have evolved to compensate for this loss to follow up but, at some point, the findings must begin to lose credibility. In this study we investigated the level of attrition at which results of drug trials for people with schizophrenia lose so much credibility with three relevant groups of stakeholders, so as to mistrust.

Methods

A piloted questionnaire was sent to 128 local clinicians, a sample of 100 relevant researchers, and 104 carers/consumers.

Results

Response rate of clinicians was poor (55/128, 43%), as was that

of researchers (32/100, 32%). Carers/consumers return rate was high (81/104, 76%). All three groups, however, suggested that follow up at the end of a 12 week schizophrenia drug trial should be around 70-75% to be credible.

Conclusions

Currently clinicians, policy makers and consumers of care have to come to decisions about treatments based on information that they feel to be of questionable credibility. Although statistical techniques can go some way to manage incomplete datasets, this survey suggests that relevant stakeholders, including researchers, fundamentally mistrust results of the majority of drug trials in this area. Adopting a more pragmatic trial design can help address this gap in credibility.

Jun Xia

jun.xia@leedspft.nhs.uk T: 0113 305 8302

NIHR CSP

Summary Guidance for Researchers

NIHR CSP Go-Live

The National Institute for Health Research (NIHR) Coordinated System for gaining NHS Permission (CSP) is a new system that standardises and streamlines the process for gaining NHS permission for clinical research studies in England.

NIHR CSP will ensure that the relevant quality assurance and statutory requirements are met whilst reducing approval times and cutting bureaucracy. NIHR CSP has been developed as a result of the Government NHS R&D strategy "Best Research for Best Health".

Initially NIHR CSP is only available for studies in the NIHR Portfolio

The benefits of the new system are:

- **C**onsistency: A consistent and comprehensive set of NHS research governance checks for all new studies
- **S**peed: Streamlining and rationalising processes to reduce NHS R&D approval times
- **P**redictability: A single system for processing and reviewing applications for NHS permission, coordinated by a central CSP Unit and with local processes supported through NIHR Comprehensive Local Research Networks (CLRNs).

NIHR CSP went 'LIVE' in the NHS on 18 November 2008:

- From 18 November 2008, NIHR CSP should be used as the default system for gaining NHS permission for NIHR portfolio studies and researchers are encouraged to submit all applications through NIHR CSP
- NIHR CSP does not change the requirement for each NHS organisation to confirm permission for new research to be carried out
- NIHR CSP does not change the duty of care placed upon NHS organisations when carrying out studies
- From 01 April 2009, NHS organisations will need to use NIHR CSP exclusively for NIHR portfolio studies in order to continue receiving NIHR clinical research network funding

NIHR CSP will be reviewed and refined on an ongoing basis. This will be a collaborative process to ensure the benefits of CSP are optimised.

Any questions / queries should be raised with your local R&D Office

Integrated Research Application System (IRAS)

Only by using IRAS (<https://www.myresearchproject.org.uk/>), can you access NIHR CSP.

The IRAS website has been updated and will allow the flow of portfolio studies into the CSP process. Even though there will be a change to what researchers will see on the front screens / filter questions, their data sets will not have been effected as a result of this update.

For studies to flow through CSP the Chief Investigator will need to complete a couple of new questions in the IRAS Project Filter page.



Q3 asks within which of the devolved countries of the UK, will research sites be based? This questions needs to be answered and it is different to the questions being asked in 3a.

Q3a - will ask "In which country of the UK will the lead R&D

NIHR CSP

Continued

office be located?" - this is where the CI is based and will be within the CLRN that the CI is based. For a researcher based within The LTHT / UoL the Lead R&D Office will be based within the LTHT, which is in the West Yorkshire CLRN.

If ENGLAND is selected then a new **Q5a** will appear which will ask "Do you want your NHS R&D application(s) to be processed through the NIHR Coordinated System for gaining NHS Permission?" If this is ticked YES then a Portfolio Adoption Form (PAF) will appear on the left hand side of the Navigation Page in the project forms section.

If you are not sure if your study is eligible for adoption, then it is recommend that you complete questions **3a** and **5a** and the CSP Unit will assess your study for potential adoption. All the remaining questions within the Project Filter Form must be carefully completed to ensure they fully reflect the study.

If you want to use NIHR CSP you will need to complete the following forms in the order listed:

1. Portfolio Adoption Form (PAF) – The information in the form is used by the CSP Unit to assess your study for adoption. Whilst you are awaiting confirmation that your study is potentially eligible to enter the NIHR Clinical Research Network Portfolio (which only takes a short time) you can continue to complete other forms within IRAS, ready to submit for approval.

2. NHS R&D Form – The information in this form is used to perform an element of the research governance checks. This is sent via IRAS to the CSP Unit and is validated within 3 working days. Once validated the Chief Investigator will receive an e-mail to confirm validation, what further action is required and how to submit study documents. Once the NHS R&D form has been submitted to the CSP Unit, then it can be printed and signed / dated. The submitted NHS R&D form is printed by going into the Submission tab and by pressing the print button next to the relevant form that has just been submitted in the submission history listing.

3. SSI Forms for multi centre studies – If

your study involves more than one research site then, just as you do at present, a Site Specific Information (SSI) Form for each site should be submitted via IRAS to the local Principal Investigator (PI). The local PI completes their own SSI form and sends an electronic version of the form back into CSP ReDA by pressing the submit button in the Submission tab of their Site Specific Forms section (lower left hand side of IRAS, under the Projects Forms section). Once the SSI Form is received by the CLRN (in CSP ReDA) the form is validated within 3 working days and an e-mail is sent to the local PI confirming validation has taken place, what further action is required and how to submit local study documents (patient information sheet on local headed paper etc).

4. SSI Form for a single site study – The Chief Investigator also needs to complete an SSI Form so that local site assessment can be performed. The CI completes their SSI Form and sends an electronic version of the form back into CSP ReDA by pressing the submit button in the Submission tab of their Site Specific Forms section (lower left hand side of IRAS, under the Projects Forms section). Once the SSI Form is received by the CLRN (in CSP ReDA) the form is validated within 3 working days and an e-mail is sent to the local PI confirming validation has taken place, what further action is required and how to submit local study documents (patient information sheet on local headed paper etc).

Not eligible for UKCRN Adoption?

If your study is not eligible for the NIHR Clinical Research Network Portfolio, you will not be able to seek NHS permission through NIHR CSP. You should contact your local R&D office which manages research for each NHS organisation involved in the study to ascertain the local arrangements for gaining NHS permission. Please note that you can still use IRAS to complete relevant application forms.

Eligible for UKCRN Adoption

If your study is automatically eligible or potentially eligible to be included in the NIHR Clinical Research Network Portfolio, data entered into IRAS will be automatically transferred through NIHR CSP for review.

NIHR CSP Continued

NIHR CSP governance checks

Governance checks are a standard set of checks undertaken as part of NIHR CSP to ensure that studies meet the requirements of the Research Governance Framework and other applicable standards / regulations. Governance checks are undertaken by the CSP Unit and CLRNs. For each study one CLRN is nominated to be the Lead CLRN (usually the CLRN where the Chief Investigator is based).

The CSP Unit and the Lead CLRN carry out the 'global' governance checks. These are the checks that only need doing once for a study. These checks are based on information submitted via IRAS, approval letters from NRES and other regulatory bodies.

Each participating CLRN facilitates the undertaking of 'local' governance checks for each participating NHS organisation (e.g. whether the pharmacy department can undertake the study). These checks are based on documents submitted for the global review, the SSI Form and discussions with staff in participating NHS organisations. In addition, each CLRN facilitates the contracting process and ensures that Honorary Research Contracts are in place, where appropriate.

Gaining NHS Permissions

For each participating NHS organisation, once all the governance checks are complete, the study enters a quality assurance process which ensures that all these requirements are fulfilled. This process takes a maximum of seven days.

A Governance Report is generated for each NHS organisation which summarises the governance checks completed and the documentary evidence used to undertake the checks. This report is required by NHS organisations to confirm NHS permission for the study to proceed. An email is sent to the Chief Investigator and the NHS organisation is asked to issue a letter of NHS permission within 21 days.

Contact

Please contact your local R&D Department for further information.

Other sources of information can be found below:

For more information on NIHR CSP within the West Yorkshire CLRN please contact:

Tomasz Kurdziel
Lead RM&G Manager
tomasz.kurdziel@wyclrn.org.uk
Telephone: 0113 – 384 5702 / 384 5705

for information on the West Yorkshire CLRN please visit our web site at:

<http://westyorks.ukcrn.org.uk>

for general information on NIHR CSP please visit:

<http://www.ukcrn.org.uk/index/clinical/csp.html>

IRAS is the only entry point to NIHR CSP – to enter research study data sets please visit:

<https://www.myresearchproject.org.uk/Home.aspx>

for information on the UKCRN Clinical Research Portfolio and it's benefits please visit:

http://www.ukcrn.org.uk/index/clinical/portfolio_new.html



Jargon Buster Research, Clinical Audit, or Service Evaluation?

Research Is:-

"The attempt to derive generalisable new knowledge by addressing clearly defined questions with systematic and rigorous methods" (Research Governance Framework for Health and Social Care 2005)

Research Projects Should:-

- Provide new knowledge
- Be generalisable beyond the particular setting of the project
- Be Peer-reviewed
- Be undertaken with the intention to seek publication of results in a peer-reviewed journal

Clinical Audit Is:-

"A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change" (NICE 2002, Principles for Best Practice in Clinical Audit, p1)

Clinical Audit Projects Should:-

- Answer such questions as:
 - "Is what is happening what should be happening?"
 - Are we doing what the evidence says we should be doing?
 - Does practice follow current published guidelines / standards?

Service Evaluation Is:-

"A set of procedures to judge a services' merit by providing a systematic assessment of its aims, objectives, activities, outputs, outcomes and costs" (NHS Executive, 1997)

Service Evaluations Should:-

- Answer such questions as:
 - "What standard does this service achieve?"
 - Measure current service without reference to a standard.

When Is Ethical Review / Approval Needed?

Research, Clinical Audit, Service Evaluation may all raise ethical issues. Under current guidance:-

Research usually requires Research Ethics Committee review

Audit does not usually require Research Ethics Committee review

Service evaluation does not usually require Research Ethics Committee review

The above information was sourced from a NRES ethics e-group document (April 2007) and 'Clinical Audit, Service Evaluation or Research?' (a Leaflet published by WYMHR&D Consortium)

What Are The Differences Between Quantitative And Qualitative Research Methodologies?

Quantitative research:-

- Uses numerical data
- Is often designed to test a hypothesis.
- May involve evaluating or comparing interventions, particularly new ones using methodologies including:-
 - The generation of models, theories and hypotheses
 - The development of instruments and methods for measurement
 - Experimental control and manipulation of variables
 - Collection of empirical data
 - Modelling and analysis of data

Qualitative research:-

- Uses non-numerical data
- Usually involves studying how interventions and relationships are experienced.
- Identifies/explores themes following established methodologies such as:-
 - Grounded Theory
 - Phenomenology
 - Ethnology
 - Conversation, Discourse Analysis
 - Action Research
 - Feminist Standpoint Research

David Woodcock (Research Assistant)

Simon Budd E: simon.budd@leedsptf.nhs.uk T: 0113 295 5418



Consortium Contacts

Innovation is a newsletter for sharing and learning about research. This includes information about projects being carried out in your area. As such we welcome any articles or suggestions for future editions.

For more information please contact:

Susan Moore

Research Governance Administrator/PA West Yorkshire Mental Health R&D Consortium
North Wing
St Mary's House
St Mary's Road
Leeds
LS7 3JX

T: 0113 295 2387

E: susan.moore@leedspft.nhs.uk

Alison Thompson

Acting Head of West Yorkshire Mental Health R&D Consortium
North Wing
St Mary's House
St Mary's Road
Leeds
LS7 3JX

T: 0113 295 2360

E: alison.thompson@leedspft.nhs.uk

Who, What, When, Where?

West Yorkshire Mental Health Research & Development Consortium

4th Annual Conference – MENTAL HEALTH RESEARCH: What is happening?

date tbc

Medical Education Centre, Fieldhead Hospital

Service user or carer? Work in mental health or learning disability services? Want to be involved?

For more information please contact Susan Moore, Research & Development Team Administrator on 0113 295 2387 Or e-mail susan.moore@leedspft.nhs.uk

Getting Published

The journal is available online at http://www.kmpt.nhs.uk/kent_journal, and the article can be found by clicking on Issue 2.

This article is written by the editor of an emerging journal, The Kent Journal of Mental Health, and offers helpful guidance for all those engaged in attempts to get research published.

