Leeds and York Partnership NHS
NHS Foundation Trust

R&I Innovation

Research and Development Newsletter

Evaluation of Transformation

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Completed Projects

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Innovation Issue 13 March 2013

Welcome to our new research colleagues

Whether it feels like Spring or not, we have a range of interesting and informative articles for you in this Spring edition of Innovation. They cover summary results of completed projects, opportunities for training and updates on what research and evaluation has been going on in the Trust.

I would like to thank Kyla Pennington for her involvement in a number of National Institute for Health Research portfolio projects and for assisting in the development of new research ideas for genetic studies. Kyla is leaving at the end of March to take up a Psychology Lecturer and Early Career Researcher post at Psychology Department at Lincoln University. We wish her well in this new and exciting position.

A number of other staff changes have recently taken place. I am delighted to welcome Rebecca Hargate to the new role of Research Programme Manager working equally across both York and Leeds research teams. She vacated a Clinical Studies Officer position in York that has been filled by Katie Atherton who had been working as a Research Assistant in York, so is already familiar with the team and studies. Additionally, Josie Smith has started in post working specifically on recruitment to the studies involving deaf participants. We extend a very warm welcome to Josie. There will be more detail of these roles in the next edition of Innovation.

A round up of the articles in this edition follows:

- Summary of the Annual Research Forum held in November 2012
- The two prize-winning posters selected from the 17 posters displayed at the R&D Forum
- An update on the transition programme for the National Institute for Health Research
- Good news of successful and submitted research funding bids
- Progress report from the external team evaluating LYPFT's Transformation Programme
- Completed projects on the subjects of the management of self harm in female psychiatric inpatient units; de-escalation techniques for acute aggression; mental health service users' experience of the Care Programme Approach; Management of people with severe and enduring anorexia nervosa in the community and Disordered eating in a forensic hospital setting.
- Education, training and library skills course dates and venues

Do get in touch if the R&D team can help you with working up an evaluation or research idea, registering your project so the Trust has a reliable database of development work being carried out, advice on funding or training or if you wish to contribute an article for the next edition. We would be delighted to hear from you.

Alison Thompson - Athompson11@nhs.net

Front cover: Jules Beresford-Dent, evaluation project manager (Transformation). See article on pages 10 and 11

STOP PRESS • STOP PRESS • STOP PRESS

GOOD NEWS: Dr Barry Wright and his team have successfully secured research grant funding of £480k from the Medical Research Council to conduct a study entitled `Diagnostic Instruments for Autism in Deaf Children'. The study is due to start in September 2013.

NIHR bids

Dr Barry Wright has also submitted a bid to the NIHR Health Services and Delivery Research funding stream `Improving the identification of hallucinations in deaf people'.

Dr Martin Webber is working with Trust staff to submit a Research Programme Grant bid to look extensively at personal budgets in mental health. Eddie Devine will be a co-applicant on this bid, due in March.

Research and Development Forum 2012

21st November 2012

The annual R&D forum was held on 21st November in Weetwood Hall, Leeds. It was chaired by Dr Jim Isherwood, Medical Director and Alison Thompson, Head of Research and Development. Following feedback from the previous year's event it was decided that this year's forum should be a full day. 11 presentations covering a wide range of topics were heard by more than 70 delegates.

Representatives from the West Yorkshire Comprehensive Local Research Network, the Yorkshire and Humber Research Design Service and the Trust's Library and Knowledge Services were in attendance.

17 posters were displayed, covering a significant breadth of research topics and from various departments within LYPFT.

The Presenters were

Dr Barry Wright, Consultant Psychiatrist

Dr Barry Wright began by giving an overview of research currently being undertaken at Lime Trees, York. Lime Trees is a community and residential facility for 11 -18 year olds and is one of only four National Deaf CAMHS centres. The overarching aim of its child mental health research programme is to improve outcomes. There are three main elements to the programme: evaluation of interventions, research into autism spectrum disorders and research involving deaf young people.

Dr Wright has been successful in securing several research grants and gave an overview of the projects currently underway. The team is also involved in research being led by other centres such as Leeds and London.

Barry spoke about the importance of conducting feasibility trials in supporting funding applications.

Understanding funding streams, creating good links with experts and doing research that patients and public are interested in are just some of the ways in which the research team meet their objectives.

Dr Tariq Mahmood, Consultant Psychiatrist

Dr Mahmood thanked the organisers for the opportunity to speak about his research. He set the scene by giving a brief introduction to psychiatric genetics. He and his team are trying to establish whether there is a genetic link in conditions like OCD, schizophrenia and schizoaffective disorder. The long term aim is prevention through education.

Dr Mahmood spoke about the link between the environment and genes in consanguineous families and the acknowledgement that they are dislocated from their culture. He believes that it would be interesting to measure rates of schizophrenia in relatives living in native countries.

It is not known how rates of schizophrenia in consanguineous families compare with non consanguineous families.

Dr Mahmood pointed out that it is possible to do research with limited funding especially if clinicians are able to give up some of their spare time.

Dr Alistair Cardno is a Senior Lecturer in Psychiatry in the Academic Unit of Psychiatry and Behavioural Sciences, University of Leeds.

Dr Cardno provided an overview of research into psychotic and bipolar disorders, including results from family, twin and adoption studies, and from molecular genetic investigations including genome-wide association studies (GWAS) and studies of chromosomal abnormalities such as copy number variants (CNVs). Alistair gave an outline of two multicentre genetic studies being undertaken in LYPFT, one focusing on bipolar disorder, and one on schizophrenia and cognition, led by researchers at Cardiff University and University of Birmingham.

Dr Cardno spoke about the evidence of familial connection and talked through the approximate risks and heritability of schizophrenia, schizoaffective disorder and bipolar disorder in family relations. If someone has schizophrenia their relatives have increased risk of the condition so there are some shared genetic influences but environmental influences are also important; an accumulation of risk factors increases the overall risk.

The next approach will be large scale genetic sequencing.

Dr Tom Hughes Consultant Psychiatrist and Clinical Lead for Mental Health Research for West Yorkshire Comprehensive Local Research Network.

Dr Hughes started by giving an overview of the National Institute for Health Research (NIHR), The NIHR is a large, multi-faceted and nationally distributed organisation, funded through the Department of Health to improve the health and wealth of the nation through research

Dr Hughes confirmed that there has been a significant increase in the

Research and Development Forum 2012
21st November 2012

number of participants being recruited to NIHR Portfolio studies in LYPFT. The Comprehensive Local Research Networks (CLRN) manages the research budget on behalf of the Department of Health. Research Assistants and Clinical Studies Officer are funded from this budget. He provided an overview of the current Portfolio research being undertaken in LYPFT.

Dr Hughes spoke about the many benefits of getting involved in research which include career progression and improved patient care. There is evidence that participants who take part in clinical trials have better outcomes (it may be that the nature of inclusion/exclusion criteria means that participants have fewer co-morbidities).

Anyone interested in finding out more or getting involved in research can contact Tom on tomhughes@nhs.net

Isla Dowds, Patient and Public Involvement (PPI) Development Officer for the West Yorkshire Comprehensive Clinical Research Network
Isla spoke about the benefits of public and patient engagement with research and also outlined some of the challenges.

Isla described the three main elements of PPI – participation in research, involvement (e.g. being involved in the design of research) and engagement (increasing awareness of research).

There has been a lot of progress in PPI in the last 10 years but there is still a long way to go with regard to research. Isla underlined the need to make people more aware of their right to be involved in research and pointed to the amount of academic evidence of the benefits of PPI.

Dr Sarah Thurgood, Researcher at Leeds Addiction Unit
Sarah gave a presentation about a research project currently being undertaken at the unit. The study explores the views of services users and their friends and family on the importance of outcome measurements for addiction interventions.

The research team consulted with the Trust's service user and carer group, Leeds Researchers and the Learning to Live Again programme to seek their input into the aims and design of the project.

Sarah talked through the first two stages of the research which have been undertaken. In the first stage, focus groups were held with a variety of stakeholders to identify outcome measures which were considered important to service users and their families and carers. Stage 2 involved defining those outcomes measures in a way that was meaningful.

The next stage will be to pilot the questionnaire before it is eventually distributed.

Pauline McAvoy, Practitioner Psychologist
Pauline spoke about her research into Reflective Practice Groups (RPGs). She explained that there has been little evaluation of the groups and it was therefore important to determine how they worked in practice. The aim of the service evaluation was to determine whether there is relationship between levels of attendance at RPG related to levels of wellbeing and burnout reported by staff.

Standardised measures on well being and burnout were distributed to staff in Becklin and Newsam Centres.

Thematic analysis produced five main themes. The majority of respondents placed high value on RPG and go for positive reasons. It was acknowledged that RPGs could make people more aware of their emotions which could explain the higher rates of emotional exhaustion.

The service evaluation indicated that staff use RPGs to measure their practice and as a means of benchmarking. The staff who responded to the survey enjoyed the opportunity to take time out and think together as a team. A significant piece of learning from this project was the benefit of a high level of ward Clinical Team Manager involvement.

Dr Maureen Twiddy, Research Fellow University of Leeds and PPI lead for the NIHR Research Design Service.
Maureen spoke about the NIHR Research Design Service (RDS) which offers free advice to researchers who are developing proposals for national, peer reviewed funding competitions.

The RDS advises on all aspects of the research proposal including study design, funding streams and involvement of patients and public.

Maureen underlined the importance of ensuring that applications can demonstrate to NIHR funding panels (and peer reviewers) that the proposed study will answer an important question that has not yet been answered and that can fill a gap in the evidence base.

An overview of the breadth of research funding programmes was provided, outlining the different types of studies they fund.
She informed delegates that WYCLRN is also a good source of advice for researchers; they can provide expertise on a range of issues from research governance to service support costs. They also have important contacts and can signpost researchers if necessary.

Dr Elizabeth Edginton, Research and Development Lead at Northern School of Child and Adult Psychotherapy
Dr Edginton outlined some of the steps involved in coming up with an idea for, and undertaking, a small-scale research project, using the example of a scoping study conducted in five regional Child and Adolescent Mental Health Service (CAMHS) clinics on children aged 11 and under with behavioural difficulties. She talked through the various stages of getting from A to B including sharing some of the key findings of the example study, and plans for their use. She is currently preparing a bid for funding to the NIHR Research for Patient Benefit grant scheme to undertake a clinical trial

Dr Lackson Mzizi, Education Specialty Doctor
Dr Mzizi provided some background to Community Treatment Orders (CTOs) which have been in use since November 2008. The main aims of CTOs are a reduction of readmission rates and length of hospital stay.
Dr Mzizi undertook a service evaluation to determine whether CTOs are effective in reducing health service use by reducing the rate and duration of readmissions and number of service contacts with a psychiatrist. This was a retrospective study using information extracted from case notes of patients under care of the Assertive Outreach Team (AOT). He compared the number of hospital re-admissions, duration of admissions and number of service contacts before and after implementation of the CTO. Due to the small, select sample size it is not possible to generalise the study findings. The results suggested that CTOs are effective in reducing health service use for a select group of patients. However more research with a pragmatic and comparative design is required to adequately test the hypothesis.

Saeideh Saeidi, Senior Research Nurse, Yorkshire Centre for Eating Disorders.
Saeideh spoke about `Using outcomes to improve health care'. Saeideh highlighted the importance of measuring outcomes and spoke about her work with colleagues to encourage them to do this. Measuring outcomes is a long term activity which involves collecting data. It has many purposes including improving the quality of services and identifying areas for quality improvement.

Patient and carer satisfaction is very important to NHS trusts. Discharge interviews and surveys are two ways in which this can be measured. The results can be used in various ways e.g. to inform staff training.
There are barriers to measuring outcomes and these can be related to staff, resources and service users.

The key message from this presentation was 'You can't manage what you can't measure'.

Jim Isherwood agreed that one of the Trust's tasks is to measure benefits to service users.

Poster Winners
Tom Hughes announced the winners of the poster prizes, adding that the quality of the posters overall was exceptional. The winners were Tendayi Guzha (Stress Shield Model: Examining resilience in critical occupations) and Holly Parker (Effects of a control theory based dietary intervention to promote fruit and vegetable consumption in young people experiencing a first episode of psychosis). (see pages 6 & 7)

Feedback
Positive feedback was received from the evaluation forms and we hope to welcome you to an even bigger, more successful event next year.
The R&I team would like to thank the speakers, poster presenters, information stall holders and delegates who made this years' forum such a success.

Copies of all the presentations can be found on StaffNet. http://staffnet/Topics/Professional%20Groups/Research%20%20Development/Document%20Library/Forms/AllItems.aspx?RootFolder=%2fTopics%2fProfessional%20Groups%2fResearch%20%20Development%2fDocument%20Library%2fResearch%20Forum%20November%202012%20Presentations&FolderCTID=&View=%7b9E837C18%2d4A52%2d4489%2d9427%2d0AE9A9C12310%7d

If you cannot access them please contact researchinnovation.lypft@nhs.net

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WINNER

Leeds Partnerships NHS
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Effects of a Control Theory Based Dietary Intervention to Promote Fruit and Vegetable Consumption in Young People experiencing a First Episode of Psychosis.

aspire young people and psychosis
community links
UNIVERSITY OF LEEDS

Authors : Castle, H., Dr Prestwich, A., & Dr Gupta, A.

Introduction

It is recognised that people with psychosis often have poor physical health with high rates of obesity, resulting in the development of physical illnesses such as diabetes and coronary heart disease, (Henderson el at., 2006; Brown et al., 1999). Interestingly, Parks et al., (2006) cited that this population of people are at risk of an earlier mortality by up to as much as 25 years in comparison to the general population. Numerous factors are thought to contribute to this risk of physical disease, including an unhealthy diet. Individuals' with psychosis have poor nutritional knowledge and are also less likely to consume fruit and vegetables, (McCreadie et al, 1998). To prevent risk of future physical disease in individuals with psychosis, mental health services need to work to reduce these health inequalities. Furthermore, a healthy eating intervention is required in light of the growing recognition for a link between eating healthily and good mental health. The effectiveness of interventions based on control theory in changing dietary behaviours is well evidenced, however the development of dietary interventions designed to engage people with psychosis are still required. Recent meta-analysis of interventions to promote healthy eating conducted by Michie et al (2009) suggest that interventions based on Control Theory (Carver & Scheier, 1982) are particularly effective in changing eating behaviours. Furthermore, Michie et al., (2009) posit that the self-regulation techniques derived from control theory work together synergistically, thus suggests the need for a multi-faceted intervention.

Aim and Hypothesis

Aim

To assess the effect of a control theory based healthy-eating intervention employing behavioural change techniques (prompting self-monitoring, providing feedback and prompting goal-setting) on consumption of fruit and vegetables (FV).

Hypothesis

- Prompting goal-setting, self-monitoring and providing feedback will increase self-reported consumption of fruits and vegetables.
- The healthy eating intervention will increase participant's perception of control and their self-efficacy towards being able to eat 5 fruit and vegetables a day.
- The effects of the control theory based intervention will remain over for the duration of the study, at time points 2 weeks and 4 weeks later.

Method

Research sample

This sample comprised of 18 service users on caseload with an Early Intervention service in Leeds; a service developed to treat individuals with first episode psychosis. The participants were aged between 21 and 35 years of age, 7 of which were male and 11 were female

Study design

A partially randomised control design was used, with follow-up 2 weeks and 4 weeks post-baseline. The study was longitudinal and involved three occasions of data collection over a time period of 4 weeks. This was a 2 x 3 mixed design with the first independent variable being condition and the second independent variable being time. Participants were randomly allocated to one of two groups: experimental group; who received a healthy eating education leaflet and a multifaceted goal-setting, self-monitoring with a food diary, and feedback intervention. The control group received 'treatment as usual' which consisted of the healthy eating education leaflet only.

Figure 1:
Fruit and vegetable intake diary from the '5 a Day, Just Eat More' leaflet (intervention group only)

Outcome measures

To gain a baseline measurement for current fruit and vegetable consumption, all participants were asked to complete a previously validated survey developed by Kellar and Abraham (2005). This screened for usual fruit and vegetable consumption, and self-efficacy towards fruit and vegetable consumption over the last week.

Data analysis

All data was subsequently entered into a spreadsheet and coded for analysis using the statistical package 'SPSS'. A regression based approach was taken to measure the effects of intervention on FV consumption. Self-efficacy was investigated as a mediator of the impact of intervention on FV consumption

Findings

There were mixed findings throughout the study. Although the intervention did not appear to increase vegetable consumption, or bring about success at meeting the recommended daily intake of fruit and vegetables (RDIFV) it did prove highly effective at increasing self-reported consumption of fruit over the previous week. These observations were especially significant considering the small size of 20 recruited for this pilot study.

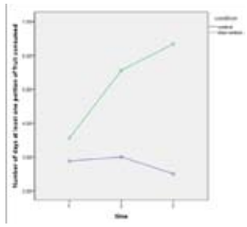

Figure One: Self-reported fruit consumption from baseline and across groups

[The lines represent number of days in which the participants self-report to have consumed at least once piece of fruit during the previous seven days. The data suggests that the intervention group experienced a greater increase in fruit consumption than the control group and this difference is largest at time point 3].

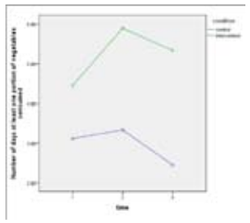

Figure Two: Self-reported vegetable consumption from baseline and across groups

[The lines represent number of days in which the participants self-report to have consumed at least once portion of vegetables during the previous seven days. Although insignificant the trend demonstrates that the intervention group experienced a greater overall increase in vegetable consumption than the control group].

Self-efficacy ratings from baseline across conditions

T-tests demonstrated that changes in self-efficacy to time 3 were only marginally insignificant, t (16) = .004, p >.05. This would suggest slight increases for self-efficacy when comparing the intervention and control group from time 1 to time 3.

Therefore, it could be said the intervention does not work by changing self-efficacy specifically. However, the three components of the control-theory based healthy eating intervention work together to change behaviour, especially with regards to the consumption of fruit.

Recommendations

Where results were insignificant although showing slight trends this could reflect a lack of power in the study due to the small sample size used. However this was a pilot study conducted to test for the feasibility of future research.

Supporting first-episode psychosis service users to change their health behaviour is a novel area of research. Future implications for this intervention would be to utilise it in mental health services. Further research required on improving motivation to engage in improving diet amongst this client group in addition to providing them with a sense of control over their health.

Through focusing research on health behavioural change interventions on obese populations we are neglecting those people who may have a healthy weight yet still have poor diet and may also be a risk of physical health related disease. It is imperative that Health psychology recognises this need to promote more robust links between mental and physical healthcare professionals. Only by doing this can we then begin to efficiently support service users to engage in changing their health behaviours.

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Evaluating the effect of Dialectical Behaviour Therapy (DBT) psycho-educational training on staff team resilience on a low secure forensic female ward. Using the Stress Shield Model of Resilience.

Tendayi Guzha, Supervised by Dr Jo Clarke

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WINNER

Background

Resilience has been defined in numerous ways in a number of disciplines. Research has developed from the study of children to looking at the impact in adults. It is the adaptable ability to function psychologically after experiencing a difficult event (Martin & Rankin, 2009).

A 'critical occupation' is when an individual, through their job, "can encounter traumatic events which may, under certain circumstances, exert critical impact on their psychological well-being" (Paton & Violanti, 1996, p.vii).

The stress shield model of resilience (Paton, Violanti, Johnston, Burke, Clarke & Keenan, 2008) was developed to describe police resilience. It is modelled on the idea that a person or group can use their psychological and physical resources and competencies to enable them to reduce challenging events to become manageable and meaningful. It can be used to inform the design of practical programs to develop resilience in staff.

There is a need to understand what determines resilience (Klien, Smit, Goosen & Hulsbergen, 1998) and how it can be measured, maintained and improved (Klien, Nicholls & Thomalla, 2003).

Within the resilience literature, the forensic mental health population lacks exploration and the stress shield model needs to be tested on different critical occupations.

Aims

- To provide further support for the stress shield model in a new critical occupation.
- To examine the impact of staff training on resilience.

Hypotheses

1. There will be a significant difference between pre and post training scores on measures of empowerment, trust, peer cohesion, supervisor support and organisational climate.
2. There will be a significant difference between pre and post training scores on resilience and on job satisfaction.
3. Empowerment, trust, peer cohesion, supervisor support and organisational climate will predict levels of resilience as suggested by the stress shield model.
4. Empowerment, trust, peer cohesion, supervisor support and organisational climate will predict levels of job satisfaction as suggested by the stress shield model.
5. There will be a relationship between resilience levels [measured by adaptive capacity (RCSQ) and job satisfaction (JSI) scores] in staff members' scores.

Method

Participants

Ward group: 8 (forensic mental health staff team members working with female service users).
Wider group: 211 (staff within a critical occupation)

Materials

A consent form , a battery of questionnaires; (demographics and work-place, 34 items, 13 validated questionnaires measuring aspects of the stress shield model.

Procedure

Ward participants were approached during weekly staff meetings, given information about the study and a week later gave consent and completed questionnaires. Training began after baseline data was collected, 4 weeks after training participants completed the questionnaires a second time and were given a debrief form. The wider group either received an e-mail or through word of mouth completed the questionnaires on survey monkey.

Results

H1+2. Completing the training programme did not significantly increase empowerment, organisational climate, peer cohesion, supervisor support, trust, resilience or empowerment meaning hypothesis 1 and 2 were not met.

H3. Empowerment, organisational climate, peer cohesion, supervisor support and trust, as discussed by the stress shield model were significant predictors of resilience, F(5, 172)=11.867, p<.001, and accounted for 24% of the variance, meeting the hypothesis.

H4. Empowerment, organisational climate, peer cohesion, supervisor support and trust, as predicted by the stress shield model were significant predictors of job satisfaction, F(5, 172)=7.210, p<.001, and accounted for 15% of the variance, meeting the hypothesis.

H5. A weak, positive correlation, with high levels of resilience associated with high levels of job satisfaction, r=.27, p<.001 R2 = .05 meant the hypothesis was met.

Conclusion

Understanding resilience within forensic organisations can help promote well-being amongst employees, which in turn benefits organisations and service users. This study found staff resilience may be increased through training if some of the aspects included in the stress shield model such as trust, organisational climate and supervisor support are developed.

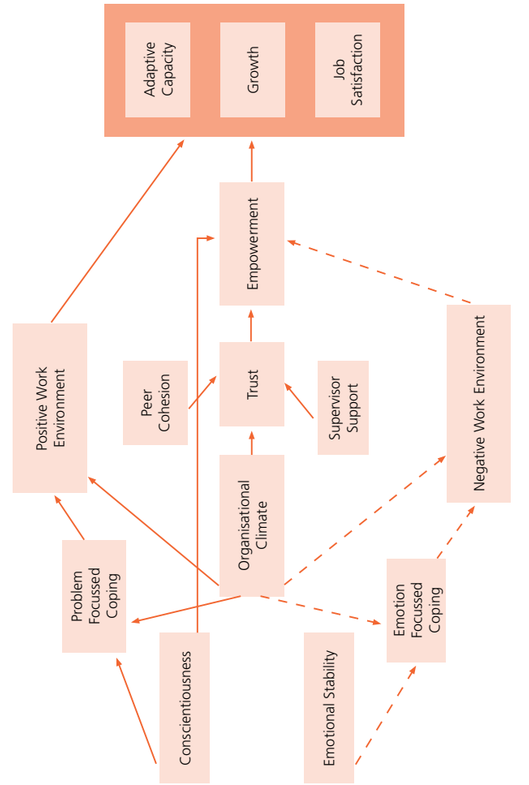
Future Research

The results indicate there is a need for future research to explore how to increase an individual's resilience such as through DBT training packages run longitudinally.

Future research could also investigate whether resilient people are attracted to critical occupations or whether the job creates resilient people, as some literature suggests.

Fig 1. Stress Shield Model of Resilience

Solid lines indicate positive influences on adaptive capacity and growth. Dashed lines indicate pathways with a negative influence on empowerment.



Completed Research Projects

Self harm within
Female Psychiatric Inpatient Units

Self Harm Within Female Psychiatric Inpatient Units
A Service Evaluation of the Management Strategies Utilised Over a Five Year Period on a Female Inpatient Ward

Introduction
Self harm is a term encompassing all acts of intentionally inflicting injury upon oneself; it is used to include acts both with and without suicidal intent. This is a complex phenomenon influenced by a number of factors. Self harm occurring within psychiatric units can be viewed as having marked differences to self harm in other environments due to the presence of supervision and restriction of means. Self harm is responsible for the use of a considerable proportion of inpatient psychiatric resources; however there is limited research specifically looking at the phenomenon within this population. Although not specific to one diagnosis it is widely accepted that those with borderline personality disorder self harm more frequently, particularly within inpatient units. Many differing management strategies have been used on inpatient units with varying effectiveness. Attachment theory proposes an alternative approach to the management of self harm, which may improve the relationship between those who frequently self harm and staff, and thereby reduce the overall frequency of self harm. This approach was adopted by one of the two female wards within the Becklin Centre, Leeds and York Partnership Foundation Trust from June 2009. These changes are thought to be most effective in the management of those individuals who repeatedly self harm and are likely to have a diagnosis of borderline personality disorder.

Aim and Hypotheses
This service evaluation investigated the association between the introduction of a team based approach centred upon attachment theory and the frequency of self harm incidents within a female inpatient psychiatric ward.

It was proposed that the implementation of these new management strategies would be followed by less frequent self harm incidents within the ward, with a specific reduction in repetitive self harm. Also, a decreased use of observations, particularly close observations, restraint, detention under the Mental Health Act and transfer to Psychiatric Intensive Care in response to self harm within the ward was expected following the change in approach.

Method
A review of all the Incident Report forms completed following each episode of self harm on two female inpatient psychiatric wards within the same unit from 2007 to 2011 was conducted. The total number of incidents, method of self harm and immediate management was recorded and the two wards compared.

Results
Over the five year period there was a clear trend showing a reduction in the number of self harm incidents within the ward with the specified management change, and there was also a decrease in the number of incidents completed by those who repeatedly self harm. This reduction in total number of incidents and repetitive self harm was not reflected on the comparison ward. The reduction in both the total number of incidents and repetitive self harm was found to be statistically significant.

The rates of transfer to Psychiatric Intensive Care Unit and restraint within the ward were also reduced. Despite the trends showing a reduction in use of these management strategies within the ward only the reduction in the number of incidents occurring whilst on close observations was statistically significant.

Conclusion
Due to the complex nature of self harm and the many factors that influence this, it is difficult to say with certainty that any one factor is responsible for the reduction of self harm within the inpatient unit. However, the findings are consistent with the utilisation of a team approach based on attachment theory and positive risk taking having an influence in reducing the frequency of self harming behaviour within a female inpatient unit.

Elizabeth Cashman elizabeth.cashman@nhs.net

Completed Research Projects

De-escalation techniques
for acute aggression

De-escalation techniques for acute aggression – A systematic review and survey of current practices

Author: Harish Rao, Core Trainee Psychiatry, Leeds and York Partnership NHS Foundation Trust (LYPFT), pictured above, Leeds. Supervised by Dr Mahesh Jayaram, Consultant Psychiatrist, LYPFT.

Acute aggression can present in a variety of settings including emergency rooms, inpatient unit and sometimes in police cells. De-escalation is part of the process of managing acute aggression and is usually recommended as either a preventative measure or an early step to prevent deterioration in the patient's condition. There has been little research conducted into the effectiveness of different approaches to de-escalation, or, for that matter, into the effectiveness of training in any given approach.

Aim: To systematically evaluate the effectiveness of de-escalation techniques in the management of acute aggression and subsequently conduct a survey of staff preferences for techniques to use in these acute situations.

Methods: For the systematic review, I used the Cochrane standardised systematic review model and for the survey, a standardised questionnaire disseminated amongst all the inpatient staff working in acute inpatient settings in Leeds.

Results: The systematic review failed to identify any randomised controlled trials for this intervention. This led to the important conclusion that what we are practicing is based on good clinical care as identified by clinicians.

80 staff were given questionnaires of which the response rate was 76%. Nearly half the staff were able to identify the varied situations where aggression could be escalated. About 50% also stated that they would ensure their own safety when faced with an aggressive patient who they had to deal with. In managing a 30 year old male, suffering from schizophrenia, who is agitated and throwing punches in the air, with a history of violence, 67% of respondents chose to acknowledge distress and offer choices with consistent responses. In a 50 year old who is verbally abusive, refusing to take medications and wanting to leave the ward, 85% stated that they would use calm and respectful language and have consistent firm responses. In managing an agitated patient who is hostile and threatening to kill herself after barricading her room, 18% stated that they would call for help from police/security. In managing an agitated patient on a medical ward, 35% stated that they would familiarise the patient with the ward. 62% stated that they would maintain the patient's personal space and respond to feelings when faced with a distressed patient with hearing and speech impairment and screaming at staff.

Conclusion: There seemed to be an overall awareness of the de-escalation skills used in clinical practice with the majority of them able to judge individual situations to apply their de-escalation skills. However, there are certain situations where improvement can be achieved by making staff aware of their de-escalation skills and also ensuring their own safety. This survey seems to have taken a near realistic approach as possible to capture the working minds of the staff. However there is no equivalent to the actual practices observed in clinical settings which is impossible to ascertain due to various ongoing conflicts in the mind of the individual staff member.

Harish Rao email: a.rao@nhs.net

Evaluation of Transformation

Meet the evaluation team

Background

In early 2011 LYPFT embarked on an ambitious project to transform its mental health and learning disability services: the Transformation Programme. The Trust Board agreed that an evaluation of the Transformation Programme would be of benefit, external funding was secured through NHS Leeds and Leeds, York and Bradford CLAHRC (Collaboration for Leadership in Applied Heath Research and Care) and a small external objective evaluation team came into post in August 2012.

Meet the evaluation team

The Trust is working in partnership with the University of York's 'Translating Research into Practice in Leeds and Bradford' (TRiPLaB) team, the University of Leeds, Firefly Research and Real World Group. The external evaluators will bring academic rigour and objectivity to the evaluation and all have extensive experience of conducting research in mental health services. The evaluation team includes:

Liz Newbronner - lead evaluator for Firefly Research overseeing the quantitative elements of the evaluation. She is interested in the organisation and delivery of services and the ways in which service users, carers and staff can shape the services they use or work within.

Mary Godfrey - lead researcher for the qualitative element of the evaluation and is a Senior Research Fellow at Leeds Institute for Health Sciences at the University of Leeds. She has developed innovative ways of involving older people meaningfully in the qualitative research process for example data collection through life histories and involvement in the process of analysis and writing.

Margaret Bradley - lead for the staff questionnaires and is an organisational psychology researcher for Real World Group, an independent organisation that specialises in leadership and team working. She has extensive experience of qualitative and quantitative research and has been involved in major research projects concerning leadership and team working in mental health teams.

Diana Sanderson is an independent Health Economist working with Firefly Research and will focus on the efficiency and financial aspects of the evaluation. She has extensive experience of undertaking health and social care research and consultancy and has contributed to many studies relating to mental health.

Martin Baxter is an Information Analyst at Firefly Research and will lead on the analysis of Trust routine activity data. He has extensive experience of quantitative data analysis and specialises in analysing health and social care data.

Jules Beresford-Dent (above) is the Evaluation Project Manager and will co-ordinate evaluation activity. She has worked in the NHS and third sector since 2001 and has managed significant service improvement projects primarily in mental health and substance misuse services including in Leeds and York.

Evaluation aims and approach

The evaluation will employ a 'Theory of Change' approach (ToC) (Connell and Kubisch 1998, Weiss 1995) to examine not only whether the programme works to achieve the changes intended but how it works. It seeks to do this by engaging in a systematic and cumulative examination of the linkages between action (activities and processes) and outcomes and the contextual factors that may have an effect on their potential to bring about the desired programme outcomes. The ToC aims to make explicit the underlying assumptions about how the programme is meant to work (and each component of it) (Anderson 2005); and how it actually works in real life.

The evaluation will look at both the outcome of the changes as well as the process of making the changes and identify what's working well so it might be replicated elsewhere. It can also identify any 'unintended consequences' of the changes or the process of change so the Trust can learn from them for future phases of the Transformation Programme (both for Leeds and York based services). In summary the evaluation aims to:

1. Assess the impact of the Transformation Programme for Leeds based services on the quality and efficiency of services provided by the Trust and on the Trust's workforce

2. Examine how and why the service changes introduced as part of the Transformation Programme have affected service quality, service efficiency, and the Trust's workforce

3. Provide independent feedback to the Trust on the implementation of the Transformation Programme so it can be used to inform the development and roll-out of the programme going forward

4. Identify wider learning about the use of integrated care pathways which may be of interest to both health service and academic communities

The evaluation will use mixed methods to explore the impact of Transformation and will capture a balance of numerical and experiential data that will help us understand measurable improvements as well as understanding the 'experience' of Transformation and how it has affected the quality of service for different groups of people affected by the changes.

Evaluation Scope

The initial evaluation will focus on the new Single Point of Access (SPA), the Crisis Assessment Service (CAS) and the new Locality Teams: both Community Mental Health and Community Learning Disability Teams and the Intensive Community Service. These elements are now in place and therefore can be evaluated and also provide the foundations for the new Integrated Care Pathways (ICPs) so it is vital to gain an early understanding of how elements of the service are working.

The initial evaluation will run from August 2012 through to January 2014 with data collection, analysis and reports being completed during 2013 and is limited to Leeds based services as described above. Discrete pieces of evaluation work will be undertaken in phases: as service changes are implemented time will be allowed for embedding the change and then evaluation will be undertaken at a sensible juncture agreed with the staff working in the services. The detailed evaluation protocol, and a summary version, is available on StaffNet.

The Trust will bid for additional funding during 2013 and if secured this will enable further evaluation work to be carried out so the Trust can evaluate parts of the Transformation Programme that are currently out of scope of the evaluation.

Benefits

Our approach will allow us to conduct mini evaluations that will enable us to provide early formative feedback that can inform how the Transformation Programme progresses as well as providing service specific feedback. The formative reports produced by the evaluation team will be used to share learning across the Trust thus benefiting services outside of the scope of the initial evaluation.

Want to find out more?

If you want to find out more about the evaluation then please visit the R+I Staff Net page or contact Jules Beresford-Dent, Evaluation Project Manager, on 0113 29 52425 or julesberesford-dent1@nhs.net.

Clinical Research Network
Transition to new organisational structure

National Institute for Health Research Clinical Research Network (NIHR CRN)- Transition Programme update

A transition plan for the NIHR Clinical Research Network has had the green-light from the Department of Health. By April 2014 the network will comprise 15 Local Clinical Research Networks, each with a single host organisation. The area host will hold the contractual responsibility for achieving the performance standards set by an integrated CRN Coordinating Centre, and for disseminating funding for research delivery across the area.

What changes are taking place?

The organisational structure is changing in three main ways:

- Different parts of the Clinical Research Network are being brought together to form a more integrated and flexible organisation.
- The focus on different clinical themes is being retained (since this has been successful to date). However, in future, these themes will be delivered through a simplified national structure comprising 15 Local Clinical Research Networks, in place of the current structure of more than 100 local Networks with different boundaries.
- Create a more inclusive and collective coordinating function, to set performance standards for the 15 Local Clinical Research Networks, bring a national oversight to delivery of the CRN portfolio, and ensure that funding to deliver local priorities is allocated appropriately.

Why is the structure of the Network changing?

- *To increase transparency and efficiency in governance and administration*

The government is keen to see maximum transparency and efficiency in all publicly-funded organisations, and the structure needs to meet this agenda. The current administrative model is complex, bureaucratic and hard to understand, but by simplifying the area boundaries and hosting arrangements this can be improved dramatically.

- *To improve the ability to respond to the changing healthcare environment*

The Health and Social Care Act is changing the landscape for healthcare services. If the Network is to be "future-proof", it needs a more flexible structure, which allows us to respond to these changes, and to new government research priorities that may emerge in the future. A more integrated Network model will be more agile and responsive.

- *To simplify the setting of performance standards, and increase consistency in allocating funding*

To date, the Topic Networks have had "flat" funding, and have applied to the Comprehensive Clinical Research Network for additional resources to meet local needs. However differences in boundaries have made this a complex and burdensome process. By simplifying the organisational structure, delivery priorities can be set at national level, clear performance standards can be given to Local Clinical Research Networks and funding allocated accordingly. This should reduce the admin burden, to ensure concentration on research delivery.

For further information see www.westyorks.crncc.nihr.ac.uk

From	To
9 NIHR CRN Coordinating Centres	1 NIHR CRN Coordinating Centre with thematic leadership
102 Local Research Networks	15 Local Clinical Research Networks
Inconsistent national coverage with complex geographical configuration	Simplified national coverage across all therapy areas
Inconsistent and complex structures leading to fragmented workforce coordination and funding allocation for research delivery across geographic areas	Single more responsive strategic model providing consistent and simple structures and funding allocation for the delivery of research across all therapy and geographic areas

Good Clinical Practice
(GCP) Training

Introduction to GCP - Course Dates

Tuesday 12 March 2013
Temple Bank House, Bradford Royal Infirmary, BD9 6RJ
Friday 15 March 2013
Airedale General Hospital, Keighley, West Yorkshire, BD20 6TD
Wednesday 20 March 2013
St James's Hospital, LS9 7TF
Wednesday 17 April 2013
Fairburn House, Leeds
Wednesday 24 April 2013
The Annexe, 34 Hyde Terrace, Leeds, LS2 9LN
Friday 3 May 2013
Sunnybank Medical Centre, Bradford
Monday 20 May 2013
Pinderfields Hospital, Wakefield, WF1 4DG
Thursday 13 June 2013
Worsley Building, Clarendon Way, Leeds University, Leeds, LS2 QNL
Monday 24 June 2013
Huddersfield Royal Infirmary, HD3 3EA
Monday 1 July 2013
Bradford Institute of Health Research, Bradford Royal Infirmary

GCP Refresher Course

This is a course for those who have attended the Introduction to GCP course and have experience of working on clinical trials.

Tuesday 12 March 2013, 13:30 - 16:30
Moorfield House Surgery, LS25 1AN
Thursday 6 June 2013, 09:30 - 12:30
Huddersfield Royal Infirmary, HD3 3EA
Wednesday 12 June 2013, 09:30 - 12:30
Temple Bank House, Bradford Royal Infirmary, BD9 6RJ
Wednesday 12 June 2013, 13:30 - 16:30
Temple Bank House, Bradford Royal Infirmary, BD9 6RJ
Thursday 20 June 2013
The Annexe, 34 Hyde Terrace, Leeds, LS2 9LN

See back cover for details of how to book on these and other NIHR training courses

Commercial Research: A Masterclass

An interactive workshop designed to help researchers improve collaboration with pharma companies, identify strategies to achieve successful site selection and improve delivery of commercial research.

Monday 25 March 2013, 9:00 - 13:00,
Fairburn House, Leeds. Please contact e.k.giddings@wyclrn.org.uk to book a place.

Informed Consent Workshop

A course for those currently working on or with experience of, clinical trials who will be obtaining informed consent from study participants.

Monday 29 July 2013, New Mill, Saltaire
Monday 2 September 2013, Garland Gallery, Leeds General Infirmary

To book a place please email l.pryer@wyclrn.org.uk

CLAHRC Events

The NIHR CLAHRC for Leeds, York and Bradford is now offering a series of outstanding, free, research training opportunities to all NHS staff (clinicians and managers) in Yorkshire & Humberside supported by the SHA and NIHR.
Details are at: www.clahrc-lyb.nihr.ac.uk/events
All are encouraged to review these outstanding training programmes and register.

NRES Training Opportunities

The National Research Ethics Service (NRES) provides training and development for researchers, R&D staff, NRES members and REC members. A full list of the training days can be found on the Training page of the HRA website.

If you have any queries, comments or suggestions please email HRA.training@nhs.net or call a member of the HRA Training Team on 020 797 22654.

Completed Research Projects

Disordered Eating in a Forensic Hospital Setting

Disordered Eating in a Forensic Hospital Setting: Study to Investigate Clinical Characteristics and Associated Pathology

Dr Jonathan Green

Abstract

Background

The prevalence of eating disorders among female forensic inpatients is unknown. However, limited evidence from female prison studies suggest high levels of disordered eating and general psychopathology compared with females living in the community. There also appears to be a link between disordered eating and other self-damaging impulsive behaviours such as self-harm and substance misuse.

Aims

To describe the prevalence and characteristics of disordered eating patterns, together with associated pathology, in a sample of female patients in a forensic hospital setting. A secondary aim was to investigate whether there is an historic association between past impulsivity and disordered eating.

Methods

Self-report questionnaires measuring disordered eating and general psychopathology, as well as past impulsivity, were administered verbally to 19 female forensic inpatients within three adult units across Yorkshire, (two low secure units and one medium secure unit). Basic demographic data including height and weight was also collected.

Results

Two participants (11%) had binge eating disorder. Levels of eating disorder attitudes were similar to a normative community sample. There was an association between eating disorder attitudes and neurotic psychopathology including anxiety. There was an historic association between regular past impulsive behaviours and concurrent disordered eating psychopathology. A key demographic finding was the high prevalence of obesity within the sample (79%).

Conclusions

Binge eating disorder was over represented in this study. It is likely that forensic inpatient populations have high levels of disordered eating. This may serve to regulate emotions and represent an expression of impulsivity. Consideration should be given to the process of screening for and treating eating disorders within forensic hospitals. Furthermore, urgent action is needed to address the issue of obesity, given the considerable evidence for obesity-related morbidity and mortality.

Dr Jonny Green email: Jonny.Green2@swyt.nhs.uk

Completed Research Projects

The CORE study: CRT Optimisation and RElapse prevention

RESEARCH DEPARTMENT OF MENTAL HEALTH SCIENCES
DIVISION OF POPULATION HEALTH

The CORE study: CRT Optimisation and RElapse prevention

CRT National Survey: Report for participating Trusts

From November 2011 to July 2012, the CORE team contacted the manager for every Crisis Resolution / Home Treatment / Crisis Assessment and Treatment team in England to ask them to complete a survey on team characteristics and services provided.

By March 2012, 218 teams were identified in 65 NHS Trusts. 192 teams (88% of total) responded and completed at least part of the survey, and teams based in York were amongst those who took part. 84.4% of teams completed all or at least two thirds of the survey.

For a copy of the report providing a summary of descriptive data please contact **bethan.paterson@ucl.ac.uk**

How to Increase Response Rates

to Surveys and Questionnaires

Leeds and York Partnership NHS
NHS Foundation Trust

There are a number of advantages to using a questionnaire or survey design. A lot of information can be collected from a large sample size and over a large geographical area. Information can be collected over a short time period and analysed quickly using statistical programmes. These factors make surveys and questionnaires cost effective in comparison to face-to-face interviews. However, one major disadvantage to using a questionnaire design is that response rates are usually low. With the help of the literature searching service at the Mental Health Library, some factors that are evidenced to increase response rates are presented below.

Survey Design

- Offer survey in different formats such as postal, telephone or online [16, 17, 18, 20]
- Personalise letters or surveys or include hand written compliment slip [1, 3]
- Keep it short [1, 3, 9]
- Coloured ink [1, 8]
- Pink paper [10]
- Questions set out in a chronological order [14]
- Survey sent from a university [1]

Incentives

- Cash [1, 2, 4, 5, 7, 20]
- Voucher [6]
- Study Logo Pen [12, 13]

Some research has found incentives are more effective if they are NOT conditional on survey being completed.

Returning Survey

- Reminders [3, 15]
- Email reminders [17]
- Personalised reminders [3]
- Option to fax completed survey [19]
- Send a second copy [1]
- Provide stamped return envelopes [1]
- Contact participants before sending survey [1]
- Recorded delivery or 1st class delivery [1, 2, 11]

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School of Healthcare
Leeds Institute of Health Sciences
FACULTY OF MEDICINE AND HEALTH

UNIVERSITY OF LEEDS

MSc Clinical Research Methods

Recruiting now for September 2013, full and part-time programmes available

Application deadline 31st May

This is an exciting research methods programme of study specifically designed for NIHR to develop research skills and academic careers for nurses, midwives and allied health professionals, launching in January 2013.

Funded programme

There are 12 full-time and 12 part-time places available. Each place is supported by a bursary of up to £44,000 per student payable to the employing organisation.

Why study this programme?

MSc Clinical Research Methods is the starting point for nurses, midwives and allied health professionals who wish to pursue a career as a clinical academic combining research with clinical practice.

How will I benefit from this programme?

The programme provides clinical research training – which can then be used as the basis for a career in research, whether working towards a PhD or to provide an understanding of clinical research to underpin managerial positions in the NHS.

A bespoke masters degree

The programme has been designed to be student - centred, providing the opportunity to shape learning to specific training needs and clinical settings. For example, by tailoring option modules, assessment, and a clinically focused research dissertation.

Flexible delivery

The programme will be delivered full-time (over one year) and part-time (over two years), for September 2013 and 2014.

yced
Yorkshire Centre for Eating Disorders

Leeds and York Partnership NHS
NHS Foundation Trust

Completed Research Projects

Anorexia nervosa in the community

a pilot study

Management of people with severe and enduring anorexia nervosa in the community - a pilot study

We aimed to develop and evaluate a community based rehabilitation model to manage complex needs of people with severe and enduring anorexia nervosa as an alternative to being in hospital by offering an intensive home intervention programme.

The service was nurse-delivered and staff included a clinical team manager (CTM), 2 health support workers (HSWs) and a sessional dietician. The team provided care aimed at preventing individuals with severe and enduring anorexia nervosa from unnecessary admission to hospital through supporting them to maintain a level health and social functioning community.

The main focus of the work was on the individual needs of the service users and interventions to support them to achieve full independent living, promoting confidence, self-efficacy and autonomy. The team supported service users with the development of strategies which could manage their symptoms, whilst continually appraising the risks to monitor whether it was safe to continue this as an outpatient.

Findings

- The service users started accessing the service from September 2010. The Yorkshire Centre for Eating Disorders senior managers decided to initially recruit 5 service users. Therefore, five service users were assessed and offered treatment by outreach teams between September and November 2010.
- All service users in the service were discharged from CMHTs. Outreach team liaised with other professionals involved e.g. social care. The care coordination for all service users accessing the service was transferred from CMHT to CTM.
- The team had contact with service users either face to face, by telephone or text. The total number of face to face contact was 1066 hours, an average of 76 hours per month.
- Length of contacts varied from 2 to 7.5 hours. The frequency of visits was variable from weekly contact up to five visits per week depending on the service users' needs and levels of risk.
- The team had regular contact with other health care professional involved in service users' care including GP, social service, and LTHT staff. The data showed that the team had a total of 137 hours of contact, giving an average of 10 hour per month.
- By investing in outreach, the service has reduced the number of inpatient admissions by 38%.
- The mean scores on all outcome measures (quality of life, self esteem and mood) slightly improved at the end of the evaluation in comparison to baseline.
- The findings from interviews with service users show that outreach provided treatment and care specific to the diagnosis and needs of each individual and reflect the priorities of the service users and coordinated care among primary and secondary health care professionals.
- The findings from interviews with YCED staff indicated that staff were satisfied with outreach and identified a number of positive ways that it had impacted their work. It appeared that staff would like outreach not only to continue but also to expand.
- Feedback from primary care professionals show that not all GPs were satisfied with the service. It may be useful for the service to review and develop a more effective method of communication with the GPs and primary care professionals if the service is to continue.
- Feedback from LTHT staff shows that outreach had helped to improve access for severe and enduring eating disorder (SEED) patients to LTHT by facilitating admission at an early stage, having a clear plan of action in place for service users before admission and supporting LTHT staff to manage SEED service users while on the ward.
- Three carers returned the completed questionnaires. The respondents rated their satisfaction with the service at 3.5 out of 4.

Recommendations

1. To continue with outreach service
   - To offer outreach service to more service users. In its current form the service can be offered to more service users with severe and enduring eating disorders.
   - To offer outreach to service users with less severe eating disorders after an episode of care on the inpatient unit. Outreach in partnership with outpatient can offer intervention to service users that are less severe than SEED patients. Outreach in this form can facilitate early discharge from the inpatient unit.
2. To continue with monthly dietetic clinic
3. To continue to offer flexibility with appointments, as identified by service users for example early morning and evening appointments, service to be offered 8am – 7pm.
4. To increase staffing in outreach.
5. To have more than one qualified nurse to work within outreach, currently only CTM, thus weekly one to one sessions (talking therapy) can be offered to service users (as recommended by service users accessing the service).
6. To consider rotation of both qualified and HSW's working with SEED patients.

Saeideh Saeidi, Gemma Fieldsend and **John Morgan**
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Finding the Evidence Training Dates

Courses free to Leeds NHS staff

Please contact the LGI library on 0113 3926445 for more information. Full details and booking forms can be found on the training calendar at: http://www.libraries.leeds.nhs.uk/Training

March				
05/03/2013	Tuesday	09.30-10.30	E-journals	St Mary's Hospital, RIO Training Room
07/03/2013	Thursday	10.00-12.30	Healthcare Databases	It Suite, Mount Annexe
07/03/2013	Thursday	09.30-11.30	Critical Appraisal	LGI library
08/03/2013	Friday	9.30-12.00	Healthcare Databases	St Mary's Hospital, RIO Training Room
08/03/2013	Friday	14.00-16.00	Cochrane Library	St Mary's Hospital, RIO Training Room
11/03/2013	Monday	09.30-12.00	Healthcare Databases	St Mary's Hospital, RIO Training Room
11/03/2013	Monday	14.00-16000	Cochrane Library	St Mary's Hospital, RIO Training Room
14/03/2013	Thursday	10.00-11.30	Google	Bexley IT Suite
18/03/2013	Monday	09.30-11.30	Cochrane Library	Bexley IT Suite
20/03/2013	Wednesday	14.00-15.00	Making the most of your NHS Athens account	IT Suite, Mount Annexe
26/03/2013	Tuesday	10.00-11.30	Google	IT Suite, Mount Annexe
26/03/2013	Tuesday	09.30-12.00	Healthcare Databases	LGI library
27/03/2013	Wednesday	12.00-13.00	E-journals	LGI library
April				
18/4/2013	Thursday	10.00-12.00	Cochrane Library	LGI library
25/4/2013	Thursday	10.00-12.30	Healthcare Databases	LGI library

Cochrane Library Training - This course focuses on the skills required to search the Cochrane Library effectively to retrieve high quality evidence to support work and study.

Critical Appraisal - This course focuses on why it is important to appraise journal articles, how to go about doing this, and how to obtain further help.

Current Awareness - Aimed at all Leeds NHS staff who wish to set up and use email and RSS alerts and feeds to support their practice or professional development.

E-Journals & E-books - Aimed at all Leeds NHS staff who wish to use e-journals and e-books to support their practice or professional development.

Google Training - Aimed at all Leeds NHS staff who wish to gain skills in searching Google for information to support their work,practice or professional development.

Healthcare Databases - This course focuses on searching healthcare databases

Mental Health Service Users'

Experience of the Care Programme Approach

Mental Health Service Users' Experience of the Care Programme Approach: A Qualitative Description

Background: The Care Programme Approach (CPA) is the preferred framework used within secondary mental health services for the planning, delivery and evaluation of care. It has become accepted practice within statutory mental health services as a means of involving service users in their care and ensuring that services remain responsive to their needs.

Aim: This qualitative descriptive study aims to contribute to a richer understanding and evaluation of CPA from the perspective of adult mental health service users currently engaged with community mental health teams

Methods: A qualitative descriptive design was used. The study undertook audio taped semi-structured interviews, with a purposively selected sample of five mental health service users currently in receipt of the CPA within adult community mental health teams. Qualitative data was iteratively analysed using a template approach to thematic content analysis which also allowed some a priori themes to guide the scope of the study.

Findings: Four broad themes emerged from the data analysis; implementation of the components of CPA from the user perspective, choice and decision making, relationships, recovery. Barriers to user involvement in CPA present some challenges in practice. Service users stressed the importance of their social needs in improving recovery outcomes. The therapeutic value of the relationship with the care co-ordinator was identified along with the importance of the role of carers.

Conclusion: The CPA national policy guidance suggests that the service user is placed at the centre of the care planning process to promote recovery and personalised care, (DoH, 2008). The findings indicated that although service users had an understanding of the components of CPA, there is a lack of ownership of the process. Recommendations for service improvement to ensure user centred care planning and further study have been made.

Edward Devine email:edevine@nhs.net

Contact us
Research and Development

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:

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Learning Management System (LMS)

www.learning.nihr.ac.uk

Our online Learning Management System (LMS) allows you to book the courses you want and helps us to automate the management of our courses

Our eligibility criteria

You need to check our eligibility criteria before you register for our training. Don't create more than one account for yourself as this may affect your ability to book courses.

Our training is free of charge if you work on a clinical trial or study which has been accepted onto the NIHR CRN Portfolio of studies and if you work directly with an NIHR Clinical Research Network, including patient and public representatives. You need to check our eligibility criteria before you register for our training. Don't create more than one account for yourself as this may affect your ability to book courses.

Course dates

You can book courses via the Learning Management System (LMS). Please ensure that you have booked your chosen course date via the online booking system and received email confirmation prior to attending the course