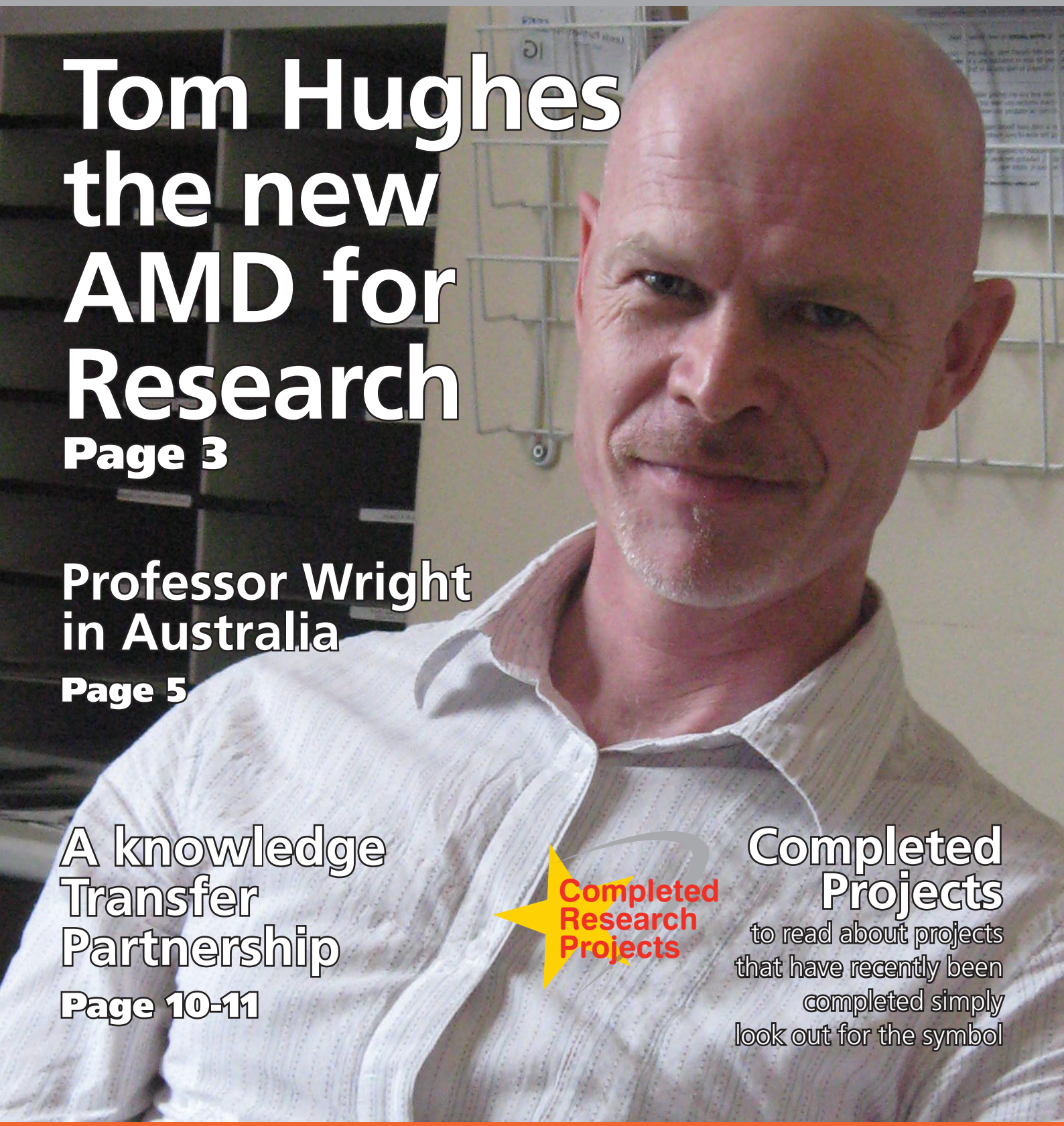
Leeds and York Partnership NHS
NHS Foundation Trust

# R & D Innovation

Research and Development Newsletter



## Tom Hughes the new AMD for Research

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## A knowledge Transfer Partnership

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Completed Research Projects

## Completed Projects

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

# Innovation Issue 15 October 2013
## Updated web pages now available

**Welcome to the 15th issue of Innovation. Take a look at our updated website pages at http://www.leedspft.nhs.uk/professionals/RD Now included is a very simple 3 step guide to help you decide if your work is service evaluation or research, how to apply for Research & Development approval and the registration forms you need.**

You will also find a list and details of publications authored by Trust staff, as well as contact details for the R&D team, useful links to other research-related organisations, universities and where to access training. We would welcome comments on any further improvement suggestions you have for these webpages.

This edition is packed with articles ranging from bedrooms to Brisbane and back. Dr Tom Hughes introduces himself as the Trust's new Associate Medical Director for Research. Professor Barry Wright summarises his lecture tour of Australia spreading good practice in services for deaf children. There are a bumper number of completed project reports and posters, a brief summary of the Research Standing Support Group July Forum, training opportunities, and research news from other linked organisations, notably the Medical Research Council that celebrates its 100th anniversary this year, please see back cover.

**The completed projects are:**

- Access to Psychiatric care through Accident and Emergence services
- A survey of club drugs
- Intensive support service for substance misuse patients
- A randomised controlled trial of the clinical and cost effectiveness of opportunistic screening and stepped care interventions for older hazardous alcohol users in primary care (AESOPS)
- Clinical Impact of a Psycho-oncology service: using the distress thermometer to evaluate symptoms, outcome and patient satisfaction
- An action orientated research
- High Blood Pressure during alcohol detoxification
- Do nurse mentors feel they receive adequate support in their role of mentoring students?
- Naturalistic evaluation and audit database of agomelatine (NEVADA)
- Imagine your bedroom is the entrance to the zoo – creative relaxation with adults with a mild to moderate intellectual disability
- Experiences of discrimination among people using mental health services in England 2008–2011 (VIEWPOINT)
- Leeds Dual Diagnosis Project: Pilot Service Evaluation
- A retrospective outcomes evaluation of cannabis use at Leeds Addiction Unit

**LAST COUPLE OF PLACES REMAINING: The R&D Annual Research Forum 16th October 2013 9.00 - 15.30, The Village Headingley LS16 5PR**. I look forward to meeting some of you at this annual event.

**Alison Thompson,** head of research and development
email: athompson11@nhs.net

# IRAS Workshop

***Organised by the Research Management & Support Team***

**Monday 28th October 2013 | 12.00-14.00**

**Teaching Room 2 | Field House | BRI**

**This IRAS workshop session is to enable researchers and trial co-ordinators to have a better understanding about how the IRAS system works, how to access the e-learning on IRAS, your responsibilities and what documentation should be submitted when seeking NHS Permission at the Trust.**

**To confirm your attendance at this workshop please email: rachael.sunter@bthft.nhs.uk**

# Tom Hughes
## New AMD for Research

**If you have opened Innovation and are reading this you probably have a bit of an interest in research or are wondering if it is something you would like to get involved in. I would like to tell you a bit about me, my role and what I hope to do to encourage you to get involved (or more involved) in research.**

I studied medicine at the University of Birmingham and came to Leeds so long ago that I came to a Senior Registrar job. I have been a consultant in General Adult Psychiatry in Leeds since 1998, always in the same sector and am now in a community post. My interest in research really began when I worked for Professor Dick Mindham in Leeds and worked on his study of the psychiatric aspects of Parkinson's disease. This work and my own contribution formed by MD from the University of Leeds in 2000. My research interest now is in mood disorder. I have always made some time for research in my working week but have had no protected time for this so that sometimes I spent very little time on research. So I know how difficult it can be to do this when the demands of clinical work are always pressing.

I am very pleased to have got the job of Associate Medical Director (AMD) for Research. I will use some of the time allocated to me as AMD to develop my own research. I am not an expert in research and probably like you will be asking for help from people who are real experts. But my main aim as AMD is to increase the opportunity for clinicians, patients and carers to take part in research. For the past four years I have been Clinical Lead for Mental Health Research for West Yorkshire Comprehensive Local Research Network (WYCLRN). The aim of that role is to increase the number of high-quality studies opened in the Leeds part of the Trust and the number of patients recruited to those studies. These high-quality studies are those on the National Institute for Health Research (NIHR) portfolio. With the merger of Leeds and York, in my AMD role I hope to give colleagues, patients and carers in York more opportunity to be involved in these studies.

But not all research can or should be NIHR portfolio research, and there are a large number of non-portfolio studies carried out in the Trust each year. I will have responsibility for 'signing-off' such studies on behalf of the Trust i.e. agreeing they are appropriate. There are other important parts of the AMD role such as representing the Trust at WYCLRN and opening a dialogue with bodies such as the Academic Health Science Network and the University of Leeds but these probably mean little to any clinicians or patients reading this. Perhaps of more interest is that if patients and carers are better informed about the research being conducted in the Trust, many will be very interested in taking part. I hope this will encourage clinicians to become more involved in research. I also think that if clinicians know a bit more about research they can get involved in they will be more likely to get involved. With colleagues in the R&D department I am developing ways of letting clinicians, patients and carers know about the research that we are doing.

With colleagues in the Research and Development department I will point researchers in the direction of resources and people that can help with their research. We are also planning some research skills training sessions. There may be times when I can help with the design or practical aspects of studies, though I am not a research expert.

I would like to talk to as many clinicians and groups of clinicians as I can and will be making contact with representatives. I would like to find out what you want of me as AMD for Research. Meanwhile, if you would like to find out more about how you can get involved in research, get in touch.

**Tom Hughes,** AMD for Research
email: tomhughes@nhs.net

# R&D Forum

**Wednesday 16 October 2013**

## Programme

**09:00** Registration
**09:30** Welcome, Jim Isherwood
**09:45** Prof Allan House, University of Leeds
**10:15** Josie Smith, CAMHS Lime Trees

**10:35** *Poster viewing and Coffee break*

**11:00** Vanessa Huke, Yorkshire Centre for Eating Disorders
**11.20** Prof Simon Gilbody, University of York
**11:40** Ann Starkey, Medipex
**12:00** Dr Stephen Wright, Aspire

**12:30** *Lunch*

**13.30** Dr Dawn Lawson, AHSN
**14.00** Jules Beresford-Dent, Transformation Evaluation Project Manager
**14.25** Dr David Owens, University of Leeds
**14.55** Eddie Devine, Community Services,
**15.15** Closing remarks and poster prizes
**15:30** Close

**Village Hotel, 186 Otley Road, Headingley Leeds LS16 5PR.**
**From 9.00am – 3.30pm**



# Professor Barry Wright's
## Lecture Tour in Australia

**Professor Barry Wright travelled to Australia in June/July for a three week lecture tour. Professor Wright travelled to Perth, Brisbane, Canberra and Melbourne before flying home.**

The lecture tour involves a series of lectures and workshops with child and adolescent mental health professionals across the country, finishing with a workshop and then a keynote speech at the ANZCED 2013 Conference in Melbourne where he discussed child mental health issues in deaf children, and also autism in deaf children.

Deaf Children Australia is a charitable organisation in Australia to promote services for deaf children. It is keen to focus on mental health and Barry will be running out a series of workshops and lectures to discuss and promote the importance of emotional and psychological development in deaf children, and to highlight the specific mental health needs of deaf children. Deaf children are two to three times more likely to have mental health problems, and this is a finding across a range of studies internationally.

Professor Barry Wright is the clinical lead of the National Deaf Child and Adolescent Mental Health Service (NDCAMHS) which was nationally commissioned in England in 2009. Whilst in other parts of the world there are single or dual centre services within specific countries for deaf children, the NDCAMHS in England is the only service in the world where deaf children and their families can access child mental health services within in any region of the country (there are ten centres in England). There are both deaf and hearing professionals with high quality communication facilities in every centre. The service outcomes have evaluated extremely well qualitatively and quantitatively, when independently assessed by the Social Policy Research Unit.

Professor Wright's visit to Australia is hopefully a way of spreading good practice and discussing different models for providing services for deaf children. Professor Wright has said: "whilst we always have more to learn, we are very proud of the high quality services we provide in England for deaf children, and we are keen to help our colleagues around the world as they seek to develop new services"

**Professor Barry Wright,** email: barry.wright1@nhs.net

Completed Research Projects

# Access to Psychiatric care
## by patients with mental illness

**Access to Psychiatric care by patients with mental illness through Accident and Emergency services from 5pm to 9am in Leeds - Service Evaluation.**

This study investigates the characteristics of patients who attend emergency services out of hours for mental health problems other than self-harm. It was hypothesized that patients would be male, Caucasian, with mild mental health problems, already in services, and live near the emergency services.

The Data on psychiatric assessments of 7769 poeple in Leeds over a two-year period (2010 to 2012) were derived from electronic records of patients attending emergency services. The data were analysed in SPSS using descriptive statistics and chi-square tests.

The results show more males (60.1%) than females (39.9) attend the services. The difference was statistically significant (chi-square 4.03, df 1, p=0.045). More males (79%) ended in psychiatric inpatients compared to (21%) females. However many males were also referred back to their GP following assessment. Those who attend emergency services tend to live nearer the hospital, where there is a direct bus route to the hospital and most patients are Caucasian (84%). The commonest days for emergency service attendances were weekends and also a slight weekday peak for Wednesdays. There are three peaks of commonest times of attendance which are 8am-10am (weekends), 5pm-6pm and 11pm-2am. The commonest reasons were suicidal ideas (27%), Psychosis (15%) and alcohol (11%). The majority of patients (68%) had a care plan prior to emergency service attendance.

This has implications for the planning of staffing and of care-plans. There is a need to develop a specific pathway which attracts men to seek mental health care during working hours and early identification and treatment of psychosis relapse.

**Dr Rebecca Lasseko** email: rebecca.lasseko@nhs.net

R & D

Completed Research Projects

# A Survey Of Club Drug Use
## in Patients Attending GUM Clinic

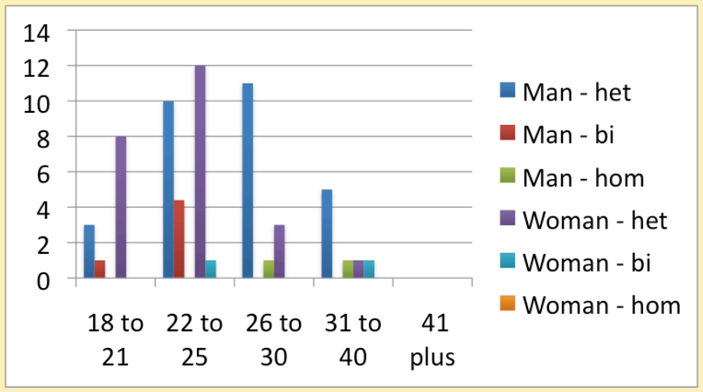
**We know that there are increasing levels of Sexually Transmitted Infections (STIs) in England, particularly amongst young people. We also know that in the USA, amongst men having sex with men (MSM), use of club drugs such as methamphetamine (crystal meth) is linked to increased sexual risk taking behaviour and STIs.**

There is new information from London clinics showing that certain groups of MSM are starting to inject drugs such as mephedrone, often during sex. However, not very much is known about whether there is a link between club drug use (GHB/GBL, mephedrone and ketamine) and STIs other than HIV, especially in people having sex with people of the opposite sex (heterosexual people).

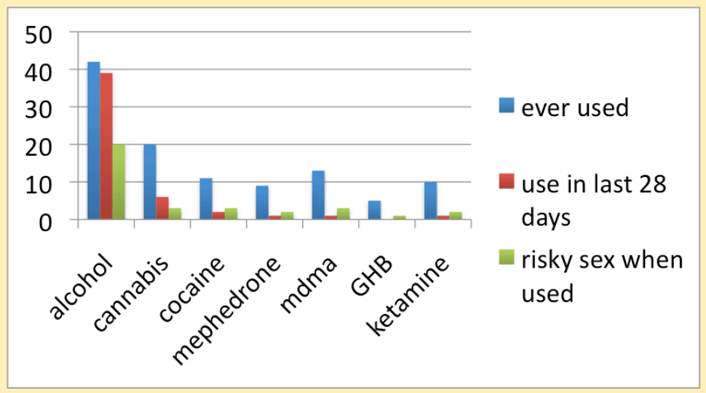
Our project aim was to find out whether people attending the Centre for Sexual Health in Leeds were using club drugs. Questionnaires were given to everyone, so both the heterosexual and MSM communities were included. The results of the questionnaire were then linked to sexually transmitted infections to show if people taking more club drugs are more likely to have an STI.

Approximately 100 questionnaires were given out over 3 days of which 60 were completed and handed back. Results are shown below.

**Distribution by gender/sexuality (n=60)**




**Use, recent use and risky sex by substance (n=60)**




These results seem to indicate that a larger research project would be warranted to establish whether there is a link between any specific drugs. This project could also look at different ways to support people to reduce their risk taking.

The results will provide a platform for establishing stronger links between LAU (Leeds addiction unit) and GUM (Genito-Urinary Medicine) clinic. It will also allow us to establish whether it is feasible to conduct a research project.

**Dr Phillip Charles** email: p.charles@nhs.net



Leeds and York Partnership NHS
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Leeds Addiction Unit

# Intensive support service for substance misuse patients at an addiction centre

**Dr Yasir Abbasi, Alexandra Marrin, Laura Gow, Dr Manoj Mathen. Leeds Addiction Unit, 19 Springfield Mount, Leeds LS2 9NG**

### Introduction

The benefits of intensive support or outreach have been well established in other disciplines of psychiatry.[1,2] This has often led to better engagement, increased monitoring and minimisation of mental health symptoms and risks. Some studies have shown significant benefits and improved outcomes in several domains on substance use disorder patients with assertive outreach and intensive continuing care than those without such interventions.[3] It is suggested that structured and intensive continuing care may be more effective for patients with severe substance dependence and associated problems. However, in the United Kingdom (UK), there are no standard guidelines or this.

A new service is set up:

A new Intensive Support Programme (ISP) for patients with substance misuse was set up at Leeds Addiction Unit (LAU) in January 2011. We aimed to provide a time limited service delivering Social Behavioural Network Therapy (SBNT) and Motivational Interviewing (MI), thereby increasing positive social networks, engagement in activities, improving motivation and decreasing social isolation thus facilitating harm reduction, abstinence and recovery[4]. At the LAU there are three main pathways, which offer treatment to patients with substance misuse problems: the Hospital Liaison (HL) team, the Pregnancy & Parenting (P&P) team and the Dual Diagnosis (DD) team. A Clinical Nurse Specialist (who is also a prescriber) and an Associate Practitioner were involved in setting up this service and they were in turn supervised by a Senior Clinical Psychologist and Consultant Psychiatrist.

### Method

A retrospective data analysis was conducted, which reviewed case notes of all referrals to ISP from January to December 2011. The outcomes were measured following the week of intervention and included motivation, achieving abstinence, prescribed relapse prevention medications and being on a substitute prescription. The outcomes were measured again, three months later.

### Results

The ISP received 64 referrals from the pathways at LAU. Out of 64 patients, 47 (73%) agreed to engage with this programme. Alcohol was the substance most misused at the time of referral and most of the patients had a co- morbid mental disorder.

**Fig. 1** Gender distribution at referral (n= 64)

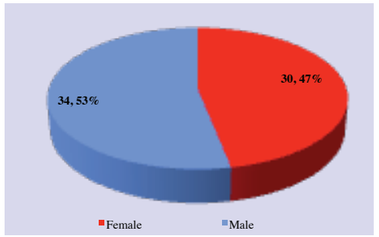
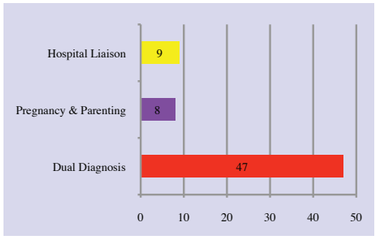
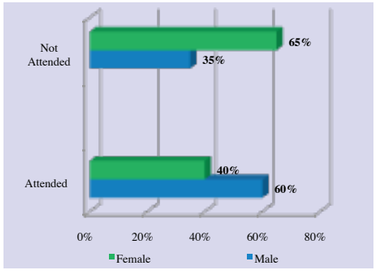



**Fig. 2** Referral from teams within LAU (n= 64)




Anecdotally, it appeared that patients who were physically unwell were unavailable for home visits, as well as mothers with new born babies who had childcare commitments and possible concerns regarding social services involvement. From all referrals received for ISP (n=64) 67% had a recorded mental health diagnosis with 33% having no recorded diagnosis.

**Fig. 3** Difference in gender for patients who engaged (n=64)




The ratio of females as compared to males was higher in those who could not attend the ISP. Of all the patients referred (n=64), 66% were referred for alcohol use, 30% for drug or poly-drug use and 4% for both drug and alcohol use. But of the patients who attended ISP (n=47), alcohol remained the most misused substance. This represented the usual pattern of substance misuse for patients at LAU.

**Fig. 4** Type of substance misused (n= 47)

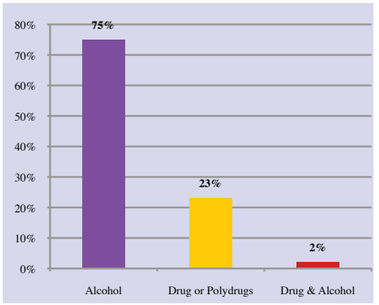



**Fig. 5** Outcomes following intensive support (n=47)

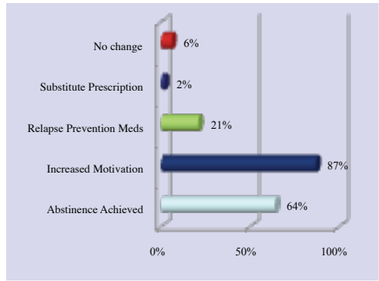
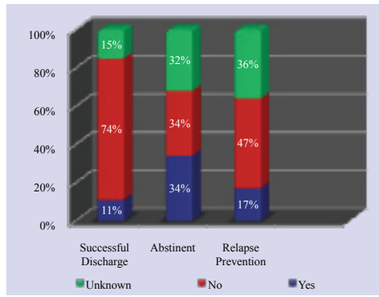



**Fig. 6** Outcomes after three months (n=47)




### Discussion

Intensive support could be a useful approach for some patients, who have complex needs, as it can assist in improving motivation and confidence. We have considered ways to improve the service further and plan to incorporate Cognitive Behavioural Therapy (CBT) assessments, graded exposure work and prescribing. Abstinence was 64% following initial week but reduced to 34% after three months. Patients may, therefore, benefit from further input in weeks following the initial week to improve three month outcomes. The ISP we describe was set up with existing resources. We think such services should be an integral part of health units delivering addiction treatment.

### References

1. Fisk D., Rakfeldt J., McCormack E. Assertive outreach: an effective strategy for engaging homeless persons with substance use disorders into treatment. Am J Drug Alcohol Abuse. 2006; 32(3):479-86.
2. Guidance to reduce unplanned drop out from, and promote reengagement with, substance misuse treatment services both sides of the story. National public health service for Wales. 2009
3. McKay J.R. Treating substance use disorders with adaptive continuing care, APA. 2009.
4. Copello A, Orford J, Hodgson R, Tober G, Barrett C. Social behaviour and network therapy: Basic principles and early experiences. Addictive Behaviors; 2002; 27, 345-366.

Completed Research Projects

R & D

Completed Research Projects

# AESOPS:
## a randomised controlled trial

**AESOPS: a randomised controlled trial of the clinical effectiveness and cost-effectiveness of opportunistic screening and stepped care interventions for older hazardous alcohol users in primary care.**

### Background
There is clear evidence of the detrimental impact of hazardous alcohol consumption on the physical and mental health of the population. Estimates suggest that hazardous alcohol consumption annually accounts for 150,000 hospital admissions and between 15,000 and 22,000 deaths in the UK. In the older population, hazardous alcohol consumption is associated with a wide range of physical, psychological and social problems. There is evidence of an association between increased alcohol consumption and increased risk of coronary heart disease, hypertension and haemorrhagic and ischaemic stroke, increased rates of alcohol-related liver disease and increased risk of a range of cancers. Alcohol is identified as one of the three main risk factors for falls. Excessive alcohol consumption in older age can also contribute to the onset of dementia and other age-related cognitive deficits and is implicated in one-third of all suicides in the older population.

### Objective
To compare the clinical effectiveness and cost-effectiveness of a stepped care intervention against a minimal intervention in the treatment of older hazardous alcohol users in primary care.

### Design
A multicentre, pragmatic, two-armed randomised controlled trial with an economic evaluation, conducted in general practices in primary care in England and Scotland between April 2008 and October 2010.

### Participants
Adults aged 55 years scoring 8 on the Alcohol Use Disorders Identification Test (10-item) (AUDIT) were eligible. In total, 529 patients were randomised in the study.

### Interventions
The minimal intervention group received a 5-minute brief advice intervention with the practice or research nurse involving feedback of the screening results and discussion regarding the health consequences of continued hazardous alcohol consumption. Those in the stepped care arm initially received a 20-minute session of behavioural change counselling, with referral to step 2 (motivational enhancement therapy) and step 3 (local specialist alcohol services) if indicated. Sessions were recorded and rated to ensure treatment fidelity.

### Main outcome measures and results
The primary outcome was average drinks per day (ADD) derived from extended AUDIT - Consumption (3-item) (AUDIT-C) at 12 months. Secondary outcomes were AUDIT-C score at 6 and 12 months; alcohol-related problems assessed using the Drinking Problems Index (DPI) at 6 and 12 months; health-related quality of life assessed using the Short Form Questionnaire-12 items (SF-12) at 6 and 12 months; ADD at 6 months; quality-adjusted life-years (QALYs) (for cost-utility analysis derived from European Quality of Life-5 Dimensions); and health and social care resource use associated with the two groups.

Both groups reduced alcohol consumption between baseline and 12 months. The difference between groups in log-transformed ADD at 12 months was very small, at 0.025 [95% confidence interval (CI) -0.060 to 0.119], and not statistically significant. At month 6 the stepped care group had a lower ADD, but again the difference was not statistically significant. At months 6 and 12, the stepped care group had a lower DPI score, but this difference was not statistically significant at the 5% level. The stepped care group had a lower SF-12 mental component score and lower physical component score at month 6 and month 12, but these differences were not statistically significant at the 5% level. The overall average cost per patient, taking into account health and social care resource use, was £488 [standard deviation (SD) £826] in the stepped care group and £482 (SD £826) in the minimal intervention group at month 6. The mean QALY gains were slightly greater in the stepped care group than in the minimal intervention group, with a mean difference of 0.0058 (95% CI -0.0018 to 0.0133), generating an incremental cost-effectiveness ratio (ICER) of £1100 per QALY gained. At month 12, participants in the stepped care group incurred fewer costs, with a mean difference of -£194 (95% CI -£585 to £198), and had gained 0.0117 more QALYs (95% CI -0.0084 to 0.0318) than the control group. Therefore, from an economic perspective the minimal intervention was dominated by stepped care but, as would be expected given the effectiveness results, the difference was small and not statistically significant.

### Conclusions
Stepped care does not confer an advantage over minimal intervention in terms of reduction in alcohol consumption at 12 months post intervention when compared with a 5-minute brief (minimal) intervention.

**Funding:** This project was funded by the NIHR Health Technology Assessment programme and will be published in full in Health Technology Assessment; Vol. 17, No. 25. See the HTA programme website for further project information.

**Authors:** Watson J, Crosby H, Dale V, Tober G, Wu Q, Lang J, McGovern R, Newbury-Birch D, Parrott S, Bland J, Drummond C, Godfrey C, Kaner E, Coulton S

**Journal:** Health Technology Assessment Volume: 17 Issue: 25 Publication date: June 2013. DOI: 10.3310/hta17250



# CLINICAL IMPACT OF A PSYCHO-ONCOLOGY SERVICE: USING THE DISTRESS THERMOMETER TO EVALUATE SYMPTOMS, OUTCOME AND PATIENT SATISFACTION

1. **Paul Blenkiron*** (Consultant Liaison Psychiatrist, Leeds & York Partnership NHS Foundation Trust, NICE Fellow & Hon. Senior Lecturer, Hull York Medical School,)
2. **Alexander Brooks and Richard Dearden** (Trainees in Clinical Psychology, Cancer Psychology Service, York Teaching Hospital NHS Foundation Trust)
3. **Joanne McVey** (Consultant Clinical Psychologist, Dept of Psychological Medicine, York Teaching Hospital NHS Foundation Trust)

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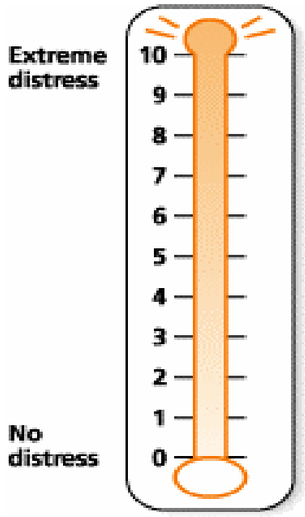
Completed Research Projects

## Background
NICE recommends the use of structured tools to improve holistic care for patients with cancer. The Distress Thermometer and Problem Checklist (DT) is commonly used for screening in physical health settings. Prospective research suggests that the DT can help to facilitate communication and monitor changes in psychological distress over time. However, to date it has not been integrated into the clinical pathway within specialist psycho-oncology services.

## Aims & Hypothesis
We used the DT to examine the clinical effectiveness of psycho-oncology intervention, ascertain factors linked to an improved outcome and evaluate patients' satisfaction with their care.

## Method
111 adult outpatients referred to York Psycho-oncology Service completed the DT at their first appointment. Individuals offered a period of psycho-oncology care re-rated their emotional distress, problems and service satisfaction measures on the DT at discharge.



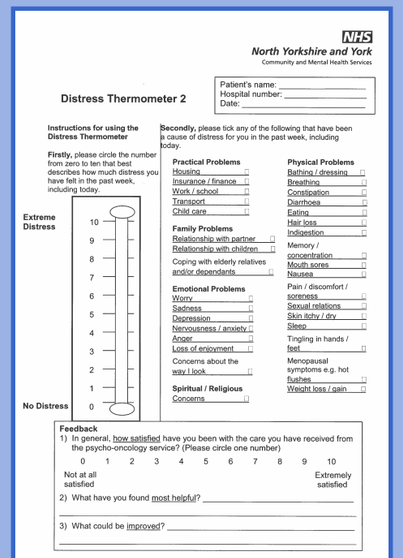

## Results
Median distress scores decreased significantly (from 6 to 4, Wilcoxon's z = -4.83, p<0.001) indicating a large clinical effect (Cohen's d = 1.22). Frequency of emotional problems (anxiety, depression and anger) fell significantly by 15-24%, despite no significant change in patients' physical health or practical problems. Number of emotional problems was the best predictor of distress at discharge (beta = 0.468, p = 0.002). Satisfaction was high and correlated with lower distress scores (r= -0.42, p=0.005) and fewer emotional problems (r = -0.31, p = 0.04) at discharge but not with number of appointments attended. Qualitative thematic analysis showed patients particularly value supportive listening and advice on coping strategies delivered by professionals who are independent from their physical care.

## Conclusions
The DT is an acceptable and useful tool for enhancing the delivery of structured psycho-oncology care. It also provides evidence to support the effectiveness of specialist psycho-oncology interventions.

TABLE 1: Problems Identified by Distress Thermometer: Number of Patients Affected at Start versus End of Care

| Type of Problem | Patients Affected at Start (n=106) No. (%) | Patients Affected at End (n=50) No. (%) | Chi Sq (p value) |
|---|---|---|---|
| **All Problems** | 102 (97) | 47 (94) | 0.39 (0.53) |
| **Practical** | 40 (45) | 18 (36) | 0.04 (0.83) |
| **Family** | 39 (37) | 18 (36) | 0.01 (0.92) |
| **Spiritual/ Religious** | 4 (4) | 3 (6) | 0.39 (0.53) |
| **Physical** | 91 (87) | 39 (78) | 1.51 (0.22) |
| **Emotional (all types)** | 98 (93) | 38 (76) | 8.23 (0.004)** |
| **Worry** | 74 (70) | 23 (46) | 8.19 (0.004)** |
| **Sadness** | 47 (45) | 14 (28) | 3.81 (0.05)* |
| **Depression** | 35 (33) | 8 (16) | 4.93 (0.02)* |
| **Nervousness/ Anxiety** | 64 (61) | 20 (40) | 5.68 (0.02)* |
| **Anger** | 38 (36) | 9 (18) | 5.14 (0.02)* |
| **Loss of Enjoyment** | 35 (33) | 9 (18) | 3.79 (0.05)* |
| **Concerns about the way I look** | 37 (35) | 13 (26) | 1.24 (0.27) |

* p<0.05, ** p<0.01



NHS North Yorkshire and York Community and Mental Health Services

Distress Thermometer 2

Patient's name:
Hospital number:
Date:

**Instructions for using the Distress Thermometer**

**Firstly,** please circle the number from zero to ten that best describes how much distress you have felt in the past week, including today.

**Secondly,** please tick any of the following that have been a cause of distress for you in the past week, including today.

**Practical Problems**
Housing
Insurance / finance
Work / school
Transport
Child care

**Family Problems**
Relationship with partner
Relationship with children
Coping with elderly relatives and/or dependants

**Emotional Problems**
Worry
Sadness
Depression
Nervousness / anxiety
Anger
Loss of enjoyment
Concerns about the way I look

**Spiritual / Religious**
Concerns

**Physical Problems**
Bathing / dressing
Breathing
Constipation
Diarrhoea
Eating
Hair loss
Indigestion
Memory / concentration
Mouth sores
Nausea
Pain / discomfort / soreness
Sexual relations
Skin itchy / dry
Sleep
Tingling in hands / feet
Menopausal symptoms e.g. hot flushes
Weight loss / gain

Extreme Distress
10 9 8 7 6 5 4 3 2 1 0
No Distress

**Feedback**
1) In general, how satisfied have you been with the care you have received from the psycho-oncology service? (Please circle one number)
0 1 2 3 4 5 6 7 8 9 10
Not at all satisfied — Extremely satisfied
2) What have you found most helpful?
3) What could be improved?

| Most Helpful Aspect of Care | No. of Responses (n=57) | Examples (anonymised quotes) |
|---|---|---|
| **Being able to talk openly** | 16 | Feeling free to talk/ Being able to open up<br>Discussing cancer and using the 'C' word<br>Just talking – but in a controlled environment<br>Discussing my problems in an objective way |
| **Feeling supported/ listened to/ understood** | 14 | Support with my illness<br>Reassurance I won't be left alone<br>Regular appointments with a sympathetic listener<br>Being listened to without feeling judged |
| **Advice on coping strategies** | 10 | Clear ideas about how to improve my quality of life<br>Practical/ CBT suggestions on coping<br>Methods learned to deal with stress/ anxiety/ OCD<br>Thinking differently about all aspects of my life |
| **Professional is independent** | 8 | Someone neutral to discuss my thoughts with<br>Being able to talk about my fears with a person not involved in my physical care |
| **Other** | 9 | Talking to psychiatrist to review medication<br>Getting test results<br>Clarifying concerns about cancer treatment & surgery<br>Helpfulness, kindness, approachability |

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http://www.yorkshire-cancer-net.org.uk/html/downloads/ycn-distressthermometer-guidelines-2011.pdf

**CONTACT**
Dr Paul Blenkiron*, Bootham Park Hospital, York, North Yorkshire, YO30 7BY, UK. paul.blenkiron@nhs.net Tel. 01904 725643

Completed Research Projects

# Improving the Vocational Outcomes
## of Mental Health Service Users

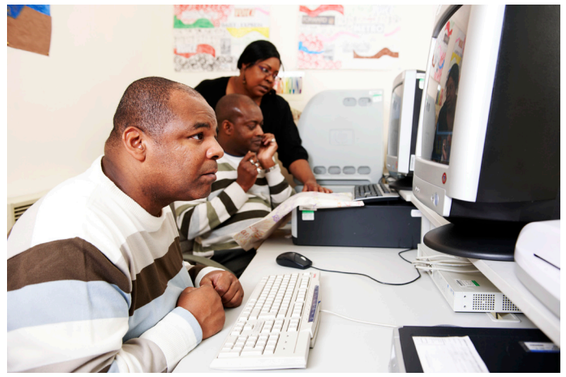
Knowledge Transfer Partnerships

UNIVERSITY OF LEEDS

**An action orientated research project to serve the development, validation and embedding of an evidence-based organisational approach for assisting people experiencing mental health problems to retain, gain or sustain, meaningful employment.**

The overall aim of the Knowledge Transfer Partnership (KTP) was to develop an evidence-based model that would enable people with poor mental health to gain meaningful and sustainable employment, thereby contributing to their improved mental state. Although there was a developing evidence base about best practice both nationally and internationally, embedding vocational support into the core business of provider organisations remained a challenge. The key focus was on the development, implementation and evaluation of a transferable model to capture the benefits of investment in vocational support.

Leeds and York Partnership NHS Foundation Trust (LYPFT) had very limited knowledge and expertise in the development, evaluation and transferability of appropriate models that measure the combined aspects of financial and social benefits which facilitate and justify continued investment in employment initiatives. This specific capability in the social and mental health arena is also not available from the wider healthcare community and the expert support from the Associate and the University of Leeds Knowledge Partner has been invaluable to achieve outcomes and to make future recommendations.



Co-production with service users, clinicians and employment specialists to develop skill sets and knowledge bases in these key areas has ensured that the approaches and processes implemented during the project have had local ownership in the Trust and are sustainable. Close service user and carer involvement in the project has enhanced its value and transferability, both within the mental health and social sector and as a 'best practice' model for other settings.

**As action research, it has already influenced practice and policy in the following ways:**

- A clear set of Principles for Practice in Vocational Rehabilitation have been incorporated into Trust CPA guidelines (Details below).
- Job retention was included within the NHS vocational services commissioning and some value placed on voluntary, educational and work placement outcomes.
- A specific trigger question was added to the new holistic assessment document that will initiate earlier action in responding to vocational needs.
- A strong vocational component was contributed to the Social, Occupational & Vocational element of the Community Integrated Care Pathway.
- A ten minute practice development DVD was produced.
- The project made specific input into a Leeds City College Employment Skills Pilot Partnership Project.
- There has been an added emphasis on the value of peer support roles and life skills within the recovery strand of Transformation.

### Principles for practice

- Planned vocational rehabilitation assists recovery by working with a person to develop their hopes, confidence and abilities in successfully engaging with a structured routine of everyday life activity that is both personally meaningful and rewarding. This may mean them, for example, engaging in some kind of work, accessing education, undergoing training, or any combination of the three.
- Supported employment is specifically about helping someone to retain, gain or maintain paid employment. It can be either a major vehicle for or an end goal of vocational rehabilitation. Service users are often willing and able to take up paid employment straight away, or can be encouraged to do so when specialist employment support and benefits advice is available to them. Others might not want to talk about paid work at all, but they could still want to explore their vocational options.

- Starting vocational rehabilitation early on in someone's use of services is often much more helpful than waiting until they are viewed as being 'ready for discharge'. Developing basic life skills, such as using public transport, can constitute important initial progress in meeting a person's vocational goals. Volunteering, whilst a useful way to build confidence, gain work experience and elicit work references, usually requires a similar level of commitment to that expected in paid work.

- A trial period in a simple but low paid job is a useful stepping stone for many people, but menial jobs are not for everybody and could be disheartening to some. Supported employment can be significantly enhanced if some form of social skills training is also provided.
- Clinical support and specialist vocational support should ideally mesh.

**The aims of the project were further embedded, externally to the Trust, as follows:**

- A system for measuring Social and economic evaluation impact questions was agreed with Work Place Leeds and integrated into the WPL service existing assessment documentation and a client progress review process developed, including exit questions. These went 'live' after the Associate and Trust partners liaised with the WPL Deputy Manager to support the development of MS Excel being used as a platform for carrying out statistical tests.

- An on-going monitoring and statistical analysis process was agreed with NHS Leeds commissioner and with WorkPlace Leeds to support the above process. It was envisaged that data analysis would commence once sufficient data had been gathered to enable on-going socio and economic benefits analysis to be undertaken

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Leeds Addiction Unit

Leeds and York Partnership NHS
NHS Foundation Trust

# High blood pressure during alcohol detoxification

**Dr Rajini Mulukutla** BSc (Hons) MBChB. CT3 Core Psychiatry Trainee, **Dr Yasir Abbasi**, MBBS PG Dip. Med. Sci, MRCPsych, Consultant Psychiatrist in Addictions and Honorary Senior Lecturer, University of Leeds.
Leeds Addiction Unit, 19 Springfield Mount, Leeds, LS2 9NG. Email: rajini.mulukutla@nhs.net

## Background

- Raised blood pressure is commonly seen during supported acute alcohol withdrawal (detoxification) at the Leeds Addiction Unit (LAU)
- It is usually transient, but on occasions can persist, causing concern to the administering practitioner
- It was agreed at the unit that more guidelines were needed to aid clinical decision making in such situations

## Improving and evaluating current practice

- We developed a flow chart based on current evidence and guidelines (Kumar & Clark, 2012 and NICE, 2011), which would aid decision-making for practitioners when treating patients who present with persistent high blood pressure during alcohol detoxification.
- Practitioners were also asked to complete a monitoring form which was printed on the back of the flow chart. This helped us to evaluate patient outcomes, as well as, the ease of use and usefulness of the flow chart.
- The flow chart (Fig.1) consisted of five pathways which then led to different outcomes:

1. New onset marked high blood pressure
2. High baseline blood pressure
3. Hypertensive crisis
4. New onset high blood pressure with cardiovascular risk factors
5. High blood pressure despite existing anti-hypertensive use

## Why is raised blood pressure seen during alcohol detoxification?

- Alcohol blocks glutamate receptors and sensitises GABA receptors (Glutamate = excitatory, GABA = inhibitory)
- The principle of receptor sensitivity, i.e. down-regulation of GABA receptors and up-regulation of glutamate receptors is seen in chronic alcohol use.
- Patients experience withdrawal symptoms when alcohol consumption ceases, as so many new glutamate receptors are created and GABA receptors are rendered insensitive, this leads to a surge in glutamate activity. This in turn may be associated with overactivity of sympathetic nervous system thereby increasing catecholamine release (Clark & Friedman, 1985).
- There is increased vascular sensitivity and adrenergic activity, both peripherally and centrally (Bär et al, 2006) as well as a reduction in baroreceptor reflex sensitivity.
- Fluctuations in blood pressure caused by the release of catecholamines are not dealt with as efficiently by the normal negative feedback loop (Bär et al, 2006).
- After a few days, the baroreceptor reflex responds to the increased autonomic activity (Kähkönen & Bondarenko, 2000), and the blood pressure returns to acceptable limits.
- However, sustained hypertension and autonomic instability can occur, which increases the risk of cardiac arrhythmia (Bär et al, 2006).

## Methods:

- The proposed project was presented to staff at LAU's training day in November 2012 and the feedback was used to improve the flow chart.
- The flow chart and monitoring forms were introduced to the LAU outpatient department in January 2013.
- Practitioners using the flow chart were asked to complete the monitoring form for each patient attending for alcohol detoxification.
- The forms after completion were collected in a designated tray easily accessible to all staff.
- After ten weeks of data collection, the results were collated, anonymised, analysed and were tabulated using Microsoft Excel.

## Results

- A total of 48 forms were returned
- Of these, patient outcomes were documented for all 48 patients and the usefulness questionnaire was completed for 36 patients (Fig 2.)
- Nine patients (approx. 19%) had high blood pressure during detoxification which had to be discussed with a doctor. The usefulness questionnaire was completed for all nine patients. (Fig 3)
- All returned monitoring forms indicated that the tool should be added to our standard practice
- There was only one occasion where a practitioner did not feel confident in approaching a doctor for advice after using the tool. (Fig 4)

## Conclusions and future directions

- The tool has generally been well received by practitioners at LAU
- Some staff commented that the flow chart could be simplified by re-evaluating some of the suggested steps in the pathways
- Practitioner sometimes did not have access to the baseline blood pressure from the time of assessment and therefore were uncertain of which pathway to choose
- Although designed to be used for outpatient alcohol detoxification, we feel the chart can be adapted by practitioners for use in community or inpatient settings to aid decision-making.

## References

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- Kumar, P and Clark, M (2012). Clinical Medicine. London: Saunders Ltd.
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  Available: http://publications.nice.org.uk/hypertension-cg127

**Figure 1: Flow chart developed for use in the assessment of high blood pressure during alcohol detoxification**

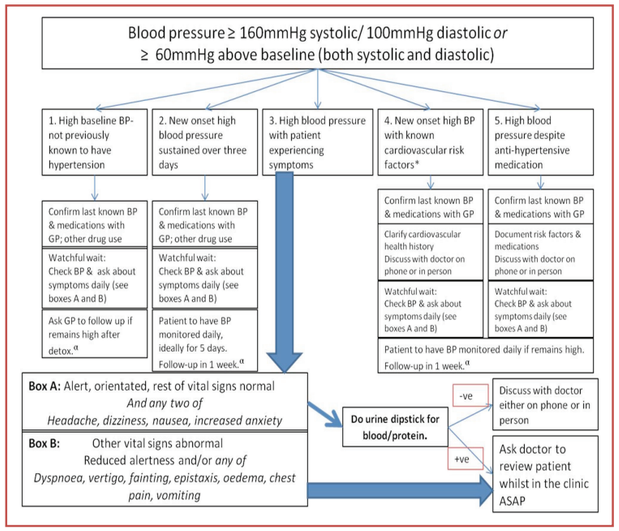



**Figure 2a-c: Graphs depicting frequency of high blood pressure & actions**

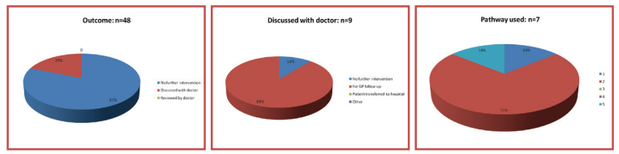



**Figure 3a-b: Usefulness of chart in assessment of all patients**

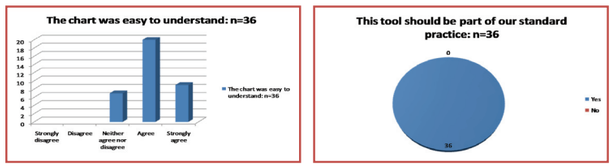
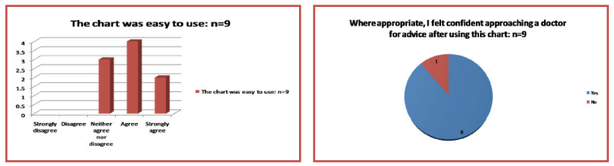



**Figure 4a-b: Usefulness of chart when patient had high blood pressure**




**Acknowledgements:**
We would like to thank all staff at the Leeds Addiction Unit for their help, particularly Steve Redknap (Clinical Nurse Specialist) and Joanne Percival (Staff Nurse). We would also like to thank Joanne Meager, (Design Manager), LYPFT Trust Headquarters, for her assistance with poster design and printing.

Completed Research Projects



Leeds and York Partnership NHS
NHS Foundation Trust

Completed Research Projects

# Nurse mentors are they
## supported in their role of mentoring students?

### Do nurse mentors feel they receive adequate support in their role of mentoring students?

## Abstract

Utilising a qualitative approach this study examines the perceptions and feelings of nurse mentors regarding the receipt of adequate support in their mentoring role. This research took place in the organisation which employed the author in the role of Practice Learning Facilitator during a period of extensive service reorganisation, from January to August 2012.

## Introduction

The role of Practice Learning Facilitator is designed to support health care professionals who support students in practice based education. Although not exclusive to nurse mentors the rationale for this focus was the volume of student nurses together with the level of preparation and maintenance nurses are required to undertake in order to mentor students (NMC 2008), unlike some other professions.

## Methods

- Grounded Theory method seeking an emic perspective. (An emic perspective is the insider's or native's perspective of reality).
- Purposive sample from a population of experienced nurse mentors in the authors NHS Foundation Trust
- Data collection via questionnaires and triangulated with semi-structured interviews (Charmaz 2006)

## Results

Four main themes:

- Time management issues
- Stress/pressure associated with nurse mentor role
- Awareness of the support mechanisms available, both academic and organisational
- Awareness of the individual professional development (both mentor and student)

## Discussion

Nurse mentors are generally positive towards the mentor role recognising the mutual benefits for both mentor and student but feel the responsibility can be stressful given current busy clinical workloads. Nurse mentors are also very aware of the support mechanisms available to them however they have strong concerns towards, what they perceive, as the lack of time and acknowledgement afforded to their role by some managers.

## Conclusion

- It is not sufficient to provide mentors with a list of support mechanisms with the onus for seeking these out solely with the mentor
- Organisations involved in practice based education must actively support all mentors, including mentors and acknowledging and raising the profile of nurse mentors.
- Support and raise the profile of the Practice Learning Facilitator, and important support for mentors and practice learning.
- Ensure protected time for Education Leads, mentors who take the lead in their practice placement, of one day per month. This will add to enhancing quality of this Trust's learning environments and student experience.
- As we move towards full student tariff the quality of our practice placements and the importance of the quality metrics will increase.

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Completed Research Projects

# Imagine your bedroom

## Is the entrance to a zoo

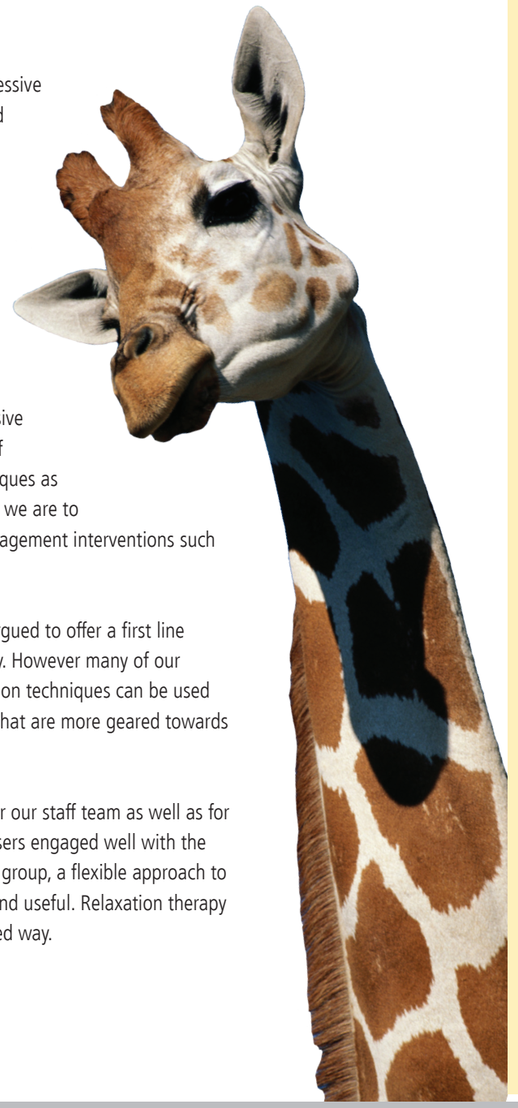
**Creative relaxation – exploring and evaluating the effectiveness of a person-centred programme of relaxation therapies with adults with a mild to moderate intellectual disability**

### Background:

Over an eighteen month period a group of adult service users with mild to moderate learning disabilities referred to the Leeds and York NHS Foundation Trust, and who were identified as suffering from anxiety-related disorders, attended a 12-week course of relaxation therapy and the results recorded. In order to remain true to person-centred values a creative approach was taken in delivery of the core relaxation techniques.

### Method and Materials:

3 core relaxation techniques were used: controlled breathing; guided imagery; and progressive muscle relaxation. These were creatively adapted to each individual. Results were recorded using the CUXOS measurement tool and pulse readings taken using a pulse oximeter.



### Results and Conclusions:

The results indicated an overall decrease in physical and psychological symptoms of anxiety.

The findings support the work of Lindsey et al (1996) in showing consistent improvement in anxiety levels over the course of the relaxation sessions. Similarly the Wachelka and Katz' (1999) study is also supported by our findings, with guided imagery shown to be particularly successful and popular with this client group. Our use of progressive muscle relaxation as a successful anger management tool also supports the conclusions of Whitaker (2001). However as Oliver (2003) has suggested, research into relaxation techniques as an anxiety management tool with this client group is sparse and further study is needed if we are to establish these techniques as a useful and non-invasive alternative to current anxiety management interventions such as medication.

Relaxation techniques can help with reducing anxiety levels and this approach could be argued to offer a first line intervention in line with the Improving Access to Psychological Therapies (IAPT) philosophy. However many of our service users have complex family histories, with issues of abuse common. As such relaxation techniques can be used to complement more specific psychological therapies and interventions, for example CBT, that are more geared towards resolving the root causes of anxiety.

As this was a new therapy for the Ventures team to undertake it was a learning process for our staff team as well as for our service users. Flexibility was one of the main strengths of this approach, and service users engaged well with the process. With such a varied level of physical and cognitive ability present within this client group, a flexible approach to using core relaxation techniques in a creative way has been shown to be highly relevant and useful. Relaxation therapy can be beneficial to this client group, especially when used in a creative and person-centred way.

**Nick D Hart** email: nick.hart@nhs.net

# Training & Events

## Good Clinical Practice (GCP) Training

These courses are available to all staff who are working on NIHR Portfolio Research.

### How to book:

Go to the NIHR Learning Management System and click 'REGISTER' to be taken to the form. You will need to enter your name and work email address, and choose a user name and password. Then you will be taken to a form to complete some details. These should be self-explanatory, apart from the following boxes:

- **Network/Organisation - choose CCRN**
- **Local Network/Organisation - choose CLRN West Yorkshire**
- **NIHR Portfolio Trial Title - if you are not working on a portfolio study at present, enter the words 'Research Ready'**

Once you have submitted the form you will be sent an activation email which will allow you to log back in and book the course you require.

**GCP e-learning Course Introduction to Good Clinical Practice e-learning: A practical guide to ethical and scientific quality standards in clinical research.** This online course is now available via the Learning Management System as explained above. However please note that your request has to be approved centrally before you can begin the online course so allow plenty of time before you wish to complete it.

### Introduction to GCP - Course Dates

**Friday 1 November 2013**
St James's Hospital, LS9 7TF

**Wednesday 20 November 2013**
Bradford Royal Infirmary, BD9 6RJ

**Monday 2 December 2013**
Huddersfield Royal Infirmary, HD3 3EA

### 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 26 November 2013, 09:00 - 12:30**
Airedale General Hospital

**Wednesday 4 December 2013, 09:30 - 13:30**
The Annexe, Leeds, LS2 9LN

**Friday 20 December 2013, 09:30 - 12:30**
Temple Bank House, Bradford Royal Infirmary, BD9 6RJ

**Friday 20 December 2013, 13:30 - 16:30**
Temple Bank House, Bradford Royal Infirmary, BD9 6RJ

### Other Local Training/Events

### 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.

**Wednesday 20 November 2013, 9:00 - 13:00,**
The Annexe, 34 Hyde Terrace, Leeds, LS2 9LN

**Monday 27 January 2014, 9:00 - 13:00,**
The Annexe, 34 Hyde Terrace, Leeds, LS2 9LN

**Thursday 6 March 2014, 9:00 - 13:00,**
The Annexe, 34 Hyde Terrace, Leeds, LS2 9LN

Please contact industry@wyclrn.org.uk to book a place.

### Study advice drop-in sessions

The WYCLRN Research Facilitator Team will be hosting 'drop-in' sessions for all research team staff (investigators, research nurses, study coordinators etc) involved in NIHR Portfolio studies in the NHS which will offer the opportunity to bring any study specific issues or general queries for discussion and review. We will also provide advice and guidance on issues relating to IRAS and the CSP processes. Researchers can also book a one-to-one appointment in advance and are welcome to bring study documentation or just the protocol to discuss what support the Facilitators can offer. Alternatively time with one of Research Facilitators will be on a first-come-first-served basis. The drop-in sessions will be delivered in various locations within 4 main geographical areas of West Yorkshire.

If you have any queries on the above, please email **csp@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 Y&H and 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.**

### Other Training/Events

The 2nd conference on Clinical Trials Methodology will be held in Edinburgh on 18-19 November at the EICC. Registration and abstract submission is now open online at **www.methodologyconference2013.org.uk.**

# Research and Development
## Standing support group forum feedback

**On the 16th July the standing support group held a mini – forum to showcase on-going research projects. This was attended by research staff from Leeds and York along with other members of trust staff.**

The first presentation was by Professor Carl Thompson Professor and Deputy Head of Department: Graduate School and Kate Farley, Programme Lead who provided an update of the TRiP – LaB programme.

This was followed by a presentation from Jules Beresford – Dent, Evaluation project manager for the Transformation Evaluation Project.

Finally Dr Tom Hughes presented an NIHR Mental Health Research Update.

The mini forum was a great way to showcase some of the active research currently being carried out in our trust and provided encouragement for researchers that their work really does make a difference.


Completed Research Projects

# Leeds Dual Diagnosis Project:
## A Pilot Service Evaluation

**Purpose** – To pilot a service evaluation method to identify if network members of Leeds Dual Diagnosis Project are able to provide data on the prevalence of people with coexisting mental health and substance use problems accessing their service. And to identify what standard of care network members are currently providing for people with co-existing mental health and substance use problems in relation to the practice identified in the Leeds Care Co-ordination Protocol.

SurveyMonkey™

**Methodology** – Two questionnaires were administered using Survey Monkey an online data collection service and piloted on a small sample of network member services and practitioners.

**Findings** – The pilot service evaluation demonstrated that a multi-service evaluation of the Leeds Dual Diagnosis Network is potentially feasible. Participating services were able to provide information on the prevalence of people with co-existing mental health and substance use problems accessing there services. Practitioners in these services were also able to identify the standard of care they currently provide for people with coexisting mental health and substance use problems. The pilot process highlighted that further improvements will be required to the questionnaire design, procedure and data analysis process to facilitate successful delivery on a larger scale.

**Conclusion** – The completion of the service evaluation pilot has created the framework of a process which will allow the prevalence of dual diagnosis and the standard of care provided by services to be identified locally across the Leeds Dual Diagnosis Network. This process could be used as cyclical method of evaluating Leeds Dual Diagnosis Network informing the continued improvement of access to treatment and outcomes for people who experience dual diagnosis.

**Richard Bell** email: richard.bell@st-annes.org.uk

Completed Research Projects

# Experiences of discrimination
## among people using mental health services England

**As part of the evaluation for Time to Change, the Viewpoint Survey was a cross-sectional assessment of the experiences of stigma and discrimination among 1000 representative individuals receiving mental health treatment in five regions of England.**

Leeds Partnerships NHS Trust took part in the survey in 2010-2011 and recruited 258 participants.

The aim of the survey was to track mental health service users' self reported experiences of stigma and discrimination over time. In addition, the survey aimed to define the most appropriate methodology to inform surveys in future years, and to explore variations in mental health service users' experiences of stigma and discrimination by gender, age, diagnosis and ethnicity.

Between 2008 and 2011 a total of 3579 participants took part in the survey. 91% of these participants reported one or more experiences of discrimination in 2008, compared with 88% in 2011 (Corker et al., 2013). Family, friends and social contacts were the main sources of discrimination. Reports of being shunned or avoided were also common. These all showed a significant reduction between 2008 and 2011 (Corker et al., 2013).

For more information about the survey and its results, the British Journal of Psychiatry has published a whole supplement on Phase 1 of the anti-stigma campaign. You can find a pdf of the Viewpoint article here: http://bjp.rcpsych.org/content/202/s55/s58.full.pdf+html

For more information, the whole Time to Change supplement can be found at: **http://bjp.rcpsych.org/content/202/s55.toc**

# PGDip Health Research
## Post Graduate Diploma

UNIVERSITY OF LEEDS

**Overview Key facts:** Year of entry 2013/14 Qualification: PGD Fees: The fee for 2013/14 entry for the Diploma programme is £2000 per 60 credits for UK/EU students and £2700 for international students. Applicants register initially for the certificate programme and progress through to the Diploma programme.

**Modes of study and duration of the course:** 18 Months Part Time

**Entry requirements:** Normally, a degree in medicine, dentistry, nursing, health care, health management, a biological science, a social science or in a profession allied to medicine. Applications are encouraged from non-graduates with work experience in health research.

**How to apply**
A paper application form is available to download from the University Admissions website or

**Contact Lesley Patchett for further information: l.a.patchett@leeds.ac.uk**

# Finding the Evidence Training Dates

## Courses free to Leeds and York NHS staff

**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 and York NHS staff who wish to set up and use email and RSS alerts and feeds to support their practice or professional development.

**Healthcare Databases** - This course focuses on searching healthcare databases.

**Google Training** - Aimed at all Leeds and York NHS staff who wish to gain skills in searching Google for information to support their work,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.

**Making the Most of your Athens Account** - This course is aimed at all Leeds and York NHS staff who wish to better understand their Athens account and learn about the e-resources that are accessible to them.

| October | | | | |
|---|---|---|---|---|
| 14/10/13 | Monday | 10.00-12.30 | Healthcare Databases | The Boardroom, Bootham Park Hospital |
| 14/10/13 | Monday | 14.00-15.00 | E-journal and e-books | The Boardroom, Bootham Park Hospital |
| 16/10/13 | Wednesday | 10.00-12.00 | Cochrane Library | IT Suite, Mount Annexe |
| 17/10/13 | Thursday | 12.00-13.00 | E-journal and e-books | LGI library |
| 22/10/13 | Tuesday | 09.00-16.30 | Return to Study | LGI library |
| 23/10/13 | Wednesday | 10.00-12.30 | Healthcare Databases | The Boardroom, Bootham Park Hospital |
| 23/10/13 | Wednesday | 14.00-15.00 | Making the Most of your Athens Account | The Boardroom, Bootham Park Hospital |
| 25/10/13 | Friday | 09.00-10.30 | Google | LGI library |
| 30/10/13 | Wednesday | 14.00-16.00 | Critical Appraisal | St Gemma's Hospice |

**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**



Completed Research Projects

# NEVADA:

## Clinical outcome at 14 months

**Clinical outcome at 14 months Naturalistic evaluation and audit database of agomelatine (NEVADA):**

**Citation:** Clinical Pharmacist, March 2011, vol./is. 3/3(S6-S7), 1758-9061 (March 2011)

**Author(s):** Sparshatt A,., Baldwin D.S., Bazire S., Haddad P.M., Weston E., McAllister Williams R.H., Taylor D.

**Abstract:**

Agomelatine is a recently licensed antidepressant drug with a novel mode of action. Agomelatine exerts agonist activity at melatonergic MT1 and MT2 receptors and antagonist activity at 5HT2c receptors.1 Published data suggest a preferable side effect profile compared with other licensed antidepressants.2,3 While trial data and local experience may provide guidance as to agomelatine's clinical value, naturalistic reports from a wider clinical environment may determine its ultimate place in treatment. The NEVADA programme is a naturalistic UK-wide two-year evaluation designed to provide a national picture of the clinical value of agomelatine. Here we report data collected at 14 months. AIMS: To collect outcome data that can inform decision making regarding agomelatine in the treatment of depression, and to identify appropriate patient groups for whom treatment with agomelatine may be particularly beneficial.

**Objectives:**

To develop a secure live database to collect data from various centres across the UK. Demographic and treatment outcome data will be collected for all patients prescribed agomelatine.

**Method:**

Secondary care centres from across the UK were approached to participate in the NEVADA service development study. Following local approvals, staff were trained on the use of the database and provided with access. Data were collected for all patients prescribed agomelatine following an independent prescribing decision. Data were collected at treatment initiation, and at Weeks 4, 8 and 12.

**Results:**

After 14 months of data collection, 12 centres were enrolled in the study, and 89 reports were collected. The study cohort was aged between 19 and 75, 95% had an ICD-10 diagnosis of severe and/or recurrent depression and 57% of patients had experienced three or more prior episodes of depression. At the time of agomelatine initiation, 96% had received at least one antidepressant in the current depressive episode, and 58% of patients were suffering an episode lasting over twelve months. At 14 months, 58 patients had either completed 12 weeks of agomelatine treatment or discontinued their treatment prior to the 12-week study period. Sixty per cent of those with complete data sets continued on treatment at 12 weeks. Of those who discontinued, 61% discontinued due to lack of efficacy, and 26% due to an adverse event. The adverse events believed by the prescribers to be possibly associated with treatment (13 adverse events, 9 patients) were diarrhoea (n=2), increased aggression and irritability (n=1), cold-like symptoms (n=1), sleep disturbance (n=1), taste disturbance (n=1), susceptibility to the sun (n=2), sedation (n=3), hyperphagia (n=1) and weight gain (n=1).

**Discussion and Conclusion:**

Treatment discontinuation within 12 weeks of agomelatine treatment was 40%; the majority of these discontinuations were due to lack of efficacy. This study suggests agomelatine is often prescribed for patients who are among the most ill and possibly suffering a treatment-resistant depression. Despite such severity of illness, 60% remained on treatment at week 12. Agomelatine may also be beneficial in the treatment of less severely ill patients who have not failed to respond to other antidepressants. Similar data from less severely ill patients are required to inform if the drug is efficacious in such patient groups.

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R & D

# 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.**

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### 100th birthday of the Medical Research Council

To celebrate the 100th birthday of the Medical Research Council, the MRC Clinical Trials Unit (CTU) has put together a series of short films exploring the role of clinical trials, the role of the CTU, and how trials are developed and carried out.

**The Gold Standard:** What are randomised controlled trials and why are they important? Randomised controlled trials are regarded as the 'Gold Standard' for testing whether new treatments work. This short film from the Medical Research Council Clinical Trials Unit explains what they are, and why they are important.

**The MRC Clinical Trials Unit:** What is the MRC CTU and what does it do? The MRC Clinical Trials Unit is a centre of excellence for clinical trials, meta-analysis and epidemiological studies. This film explores the type of work the MRC CTU does, and what sets it apart from other trials units.

**Pieces of the Puzzle:** Where do ideas for clinical trials come from? with examples from cancer and HIV research. The MRC Clinical Trials Unit: How do we turn an idea into a trial? Having an idea for a trial is just the start of an often lengthy process for developing a trial. This film describes that process.

**The MRC Clinical Trials Unit:** Running a safe trial The safety of participants is a priority for those involved in running trials. This film explains some of the mechanisms in place to ensure that trials keep participants safe, and are successful.

**The MRC Clinical Trials Unit:** Sharing the results of trials Once we have the results of a trial, we need to make sure that the results are made known to a variety of audiences, including doctors, trial participants, others with the condition, and policymakers. This involves more than just presenting at conferences and publishing journal articles. This film explores how two very different trials have tried to make sure their results are shared with everyone who needs to know.

**The MRC Clinical Trials Unit:** How have our trials made a difference? The aim of trials is not just to answer a scientific question, but for the results of these trials to make a difference to how patients are treated in the real world, improving survival and quality of life. This film looks at how some of MRC CTU's cancer, HIV and TB trials have made a difference.

**Please find the link below:**
http://www.ctu.mrc.ac.uk/news_and_press_releases/news_archive/centenaryfilms_24072013.aspx