



# Innovation

Research and Development Newsletter



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Save the date: Research Forum 2020



Articles about recently completed research projects are marked with this symbol.

## Editorial issue 40 Innovation

Welcome to our 40th edition of Innovation. This newsletter spans more than a decade of providing you with articles about fantastic work done to improve the experience of our staff, service users and carers and the care we offer. All the back copies can be seen at [www.leedsandyorkpft.nhs.uk/research/publications/](http://www.leedsandyorkpft.nhs.uk/research/publications/)

I'd like to welcome three new research staff to the Trust: Brian Berry joined us into a new part-time role of Research Contract Manager late last year, Jon Stott joins our two other Academic Clinical Fellows and Sarah Trufhitt moves from Humber NHS Foundation Trust as a Research Assistant replacing Holly Taylor. You can read about Brian, Jo & Sarah in this edition. Congratulations to Holly who stays with us in a promoted role as Clinical Studies Officer. We were sorry to see Alicia Rodgers leave the Trust and wish her well in her new roles with the Clinical Research Network and in teaching. We will also be shortly welcoming Melissa Gretall as a Research Assistant who will cover Annalisa's maternity leave. We wish both Annalisa and Nafeesah all the very best for their births and maternity leave.

The R&D department are as busy as ever, working from home in the main and also supporting clinical services and COVID research studies in other trusts. As Sara Munro says 'I don't think there will ever be a research subject that is more important to the whole population'. We are assessing and reviewing studies that were 'paused' at lockdown and will re-open those that remain viable, along with new studies, when adjustments are agreed to ensure everyone's safety.

This newsletter contains summaries of the following completed projects:

- Computerised cognitive-behavioural therapy for depression in adolescents: 12-month outcomes
- Improving diagnosis and support for younger people with dementia: ANGELA study
- Dementia care mapping to reduce agitation in care home residents with dementia
- Results from the CoACTiON study
- FREED-UP - Upscaled
- Evaluation of the Smoke Free and Nicotine Management pilot project
- EMERALD, diabetes and serious mental illness

The usual funding deadlines are included.

Do get in touch if you want to send in an article or have any questions or suggestions about research in LYPFT.



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# COVID-19 and the Research and Development department

The coronavirus (COVID-19) pandemic has had an enormous effect on the Trust with staff working hard across all services to provide the best possible patient care during this time.

The Research and Development department is no exception to this and have had to make some significant changes. Like many across the nation, the Leeds and York-based teams left their offices mid-March, forwarding desk phones to their mobile phones and taking with them equipment to enable them to work remotely. Meetings and catch ups are now held using web-based platforms.

While several studies have temporarily closed to recruitment the team is still working on studies where follow ups have been changed to remote data collection and recruitment activity is continuing where this can be done virtually. The team also continues to assess new studies which have been adapted to open to comply with current guidance.

Following a call for volunteers from the Trust members of the team are supporting clinical services in the Trust such as taking bloods and delivering medication to patients who cannot attend clinics.

The UK's research community has rapidly developed several Covid-related studies opened in response to the pandemic. Members of the R&D team are supporting the Covid vaccine study in Hull and Sheffield and the CCP study in Rotherham.

The R&D team has opened the following studies and continues to be on standby to support its neighbouring acute trusts should they need additional resources to deliver crucial research

## Clinical Characterisation Protocol for Severe Emerging Infections in the UK (ISARIC\_CCP)

The purpose of CCP-UK is to study COVID-19 to better understand its spread and behaviour by analysing biological samples and data from patients across the UK who have tested positive for the virus. The Trust is involved in data collection only.

## Psychological impact of the Coronavirus (COVID-19) pandemic and experience: An international survey

This study aims to explore the psychological impact of COVID-19 pandemic. It is an international survey that will investigate cross-culturally what factors may support people's wellbeing.

The study is open to anyone over the age of 16 and is designed to explore the psychological impact of COVID 19. It will take approximately 15 minutes to complete online. Please follow this link <https://bit.ly/2SnQvg1>. The questionnaire will be repeated after six months.

More studies will follow but for further updates please visit the designated page on the website: [www.leedsandyorkpft.nhs.uk/research/covid-19-research-studies/](http://www.leedsandyorkpft.nhs.uk/research/covid-19-research-studies/)



# FREED-UP - Upscaled

Our research investigates the implementation and scaling of FREED (first episode rapid early intervention for eating disorders) from the service where it was developed to three other large NHS eating disorder services, including LYPFT. FREED is an innovative, transformative, early intervention care package for emerging adults presenting with an early stage eating disorder.

Our evaluation demonstrates FREED's effectiveness in reducing time from illness onset to start of treatment (duration of untreated eating disorder; DUED), reducing waiting times for assessment and treatment, and improving treatment uptake and clinical outcomes, in comparison to usual treatment in patients seen previously. For example, at 12 months, 53.2% of FREED-anorexia nervosa patients had returned to a healthy weight compared to only 17.9% of patients previously seen. Reductions in need for day/inpatient admissions (FREED 6.6% vs patients seen previously 12.4%) translate to considerable cost savings. Our findings replicate our previous single centre pilot data from the service where FREED was developed. Consistent with the early intervention literature, there is an expectation of fewer re-referrals and fewer chronic cases due to early achievement of full recovery.

The study shows that FREED is a robust intervention with replicable implementation results. Thus, it has demonstrated scalability, i.e. it can be successfully implemented into eating disorder services in different parts of the country and is ready for national roll-out. A key focus now is the continued scaling and implementation of FREED, so as to provide access to early, effective eating disorder care for all young people with eating disorders.

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# Dementia care mapping to reduce agitation with dementia

The EPIC cluster randomised control trial is a study of the quality of care for people with dementia in care homes. Interventions that can improve care outcomes are required. This study investigated the clinical effectiveness and cost-effectiveness of Dementia Care Mapping™ (DCM) for reducing agitation and improving care outcomes for people living with dementia in care homes, versus usual care.

## Design

A pragmatic, cluster randomised controlled trial with an open-cohort design, follow-up at 6 and 16 months, integrated cost-effectiveness analysis and process evaluation. Clusters were not blinded to allocation. The primary end point was completed by staff proxy and independent assessors.

## Setting

Stratified randomisation of 50 care homes to the intervention and control groups on a 3:2 ratio by type, size, staff exposure to dementia training and recruiting hub.

## Participants

Fifty care homes were randomised (intervention, n=31; control, n=19), with 726 residents recruited at baseline and a further 261 recruited after 16 months. Care homes were eligible if they recruited a minimum of 10 residents, were not subject to improvement notices, had not used DCM in the previous 18 months and were not participating in conflicting research. Residents were eligible if they lived there permanently, had a formal diagnosis of dementia or a score of 4+ on the Functional Assessment Staging Test of Alzheimer's Disease, were proficient in English and were not terminally ill or permanently cared

for in bed. All homes were audited on the delivery of dementia and person-centred care awareness training. Those not reaching a minimum standard were provided training ahead of randomisation. Eighteen homes took part in the process evaluation.

## Intervention

Two staff members from each intervention home were trained to use DCM and were asked to carry out three DCM cycles; the first was supported by an external expert.

## Main outcome measures

The primary outcome was agitation (Cohen-Mansfield Agitation Inventory), measured at 16 months. Secondary outcomes included resident behaviours and quality of life.

## Results

There were 675 residents in the final analysis (intervention, n=388; control, n=287). There was no evidence of a difference in agitation levels between the treatment arms. The adjusted mean difference in Cohen-Mansfield Agitation Inventory score was -2.11 points, being lower in the intervention group than in the control (95% confidence interval -4.66 to 0.44; p=0.104; adjusted intracluster correlation coefficient: control=0, intervention=0.001). The sensitivity analyses results supported the primary analysis. No differences were detected in any of the secondary outcomes. The health economic analyses indicated that DCM was not cost-effective. Intervention adherence was problematic; only 26% of homes completed more than their first DCM cycle. Impacts, barriers to and facilitators of DCM implementation were identified.

## Limitations

The primary completion of resident outcomes was by staff proxy, owing to self-report difficulties for residents with advanced dementia. Clusters were not blinded to allocation, although supportive analyses suggested that any reporting bias was not clinically important.

## Conclusions

There was no benefit of DCM over control for any outcomes. The implementation of DCM by care home staff was suboptimal compared with the protocol in the majority of homes.

This project was funded by the National Institute for Health Research (NIHR) Health Technology Assessment programme and will be published in full in *Health Technology Assessment*; Vol. 24, No. 16. See the NIHR Journals Library website for further project information.

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# Results from the CoActiON study

The results of the CoActiON study (Cultural Adaptations in Clinical Interactions) were published recently in the International Review of Psychiatry. This was a multi-site survey study to assess what cultural adaptations are made by clinicians in different settings. The aims were to identify what interactions that are culturally influenced are used by clinicians in England and how these interactions are experienced by patients who are from a Non White Western Background.

Those who completed the surveys were clinicians working in Mental Health in 25 areas of England and patients in those areas who were of a Non White or non Western background. A total of 2805 participants took part in the study between 1 April and 30 June 2018, 87% (2440) Clinicians and 13% (365) Patients; 41 participants were recruited in LYPFT. Questionnaires were written in English and support was available from carers or staff members for those who needed it. Only those with capacity and those willing to complete the questionnaires took part.

Participants generally came from NHS community mental health teams or inpatient services. The most common role for clinicians was that of nurse with most clinicians working 1 – 5 years in their role. Most patients had been with services for over 10 years. In terms of gender, those that completed the questionnaires were mainly female clinicians and male patients (55%). The majority of the clinicians were white and a majority reported they had less than 40% of their practice population from minority cultures. 67% of the patient participants spoke English as their first language.

The results of the questionnaire when analysed showed that often the opinions of the clinicians and the patients differed except to most often agree that a culturally specific assessment tool was never used and that levels of acculturation were most of the time or always considered. Disagreement though was recorded around other factors (whether the setting of interaction was culturally appropriate, whether preferred language, migration history, barriers to accessing services, influence of religion, alternative pathways to care and cultural values relating to goals and social support networks were discussed). Clinicians most often felt these factors were always or most of the time taken into account, but patients felt that they were rarely or never taken into account. So a disconnect was shown to exist. Other questions given solely to clinicians showed that they considered the areas of cultural importance mentioned 'most of the time' or 'always' and most felt they were attending to cultural needs. In comparison those questions just answered by patients showed the majority of patients received care from someone of a different cultural background and that 'often' their cultural needs were not met, however some reported that their cultural needs were addressed.

Using some statistical tests on the answers to the questionnaires it was possible to see that Clinicians are more likely to feel cultural needs were being met if they had been working in their role for more than 10 years, had specific training to work with cultural groups and they had a high percentage of their patients came from minority cultural groups.



The results of this study are in line with other research done previously showing a disconnect between how clinicians rate their communications skills and how patients report as not satisfactory. This study shows that within the sphere of cultural competence the clinicians' assessment of their perceived cultural competence and the patients' view that their cultural needs are not being met points to a disparity between the two view points. This must be addressed going forward.

This research was funded by the Pakistan Association of Cognitive Therapists (PACT) and sponsored by Southern Health NHS Foundation Trust. The Chief Investigator was Professor Shanaya Rathod. The full article can be read here:

<https://doi.org/10.1080/09540261.2020.1750818>

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# EMERALD: improving diabetes outcomes for people with SMI

Severe mental illness (SMI) refers to a group of illnesses, such as schizophrenia or bipolar disorder, that greatly interfere with life activities. People with SMI experience poorer health, often dying 15 to 20 years earlier of preventable or manageable conditions. Diabetes contributes significantly to this, being two to three times more common in people with SMI. There are several reasons for this, including the individual's mental illness, its treatment, lifestyle (e.g. lack of exercise, smoking) and poverty. We wanted to learn more about how SMI interacts with diabetes and how having both conditions influences healthcare use.

In the EMERALD study, we looked at general practice records from large numbers of patients across England between 2000 and 2016. We also interviewed people with SMI and diabetes, their family members/supporters and healthcare professionals from across the North West, and Yorkshire and the Humber. We then held workshops with stakeholders to help us further understand our findings.

The study has been led by Dr Najma Siddiqi from the Department of Health Sciences at the University of York, supported by expertise from a number of university and Trust partners including LYPFT. Throughout the EMERALD project we have also been guided by our patient and public involvement group, DIAMONDS Voice. We are very grateful and privileged to have such a dedicated and knowledgeable group supporting this work.

The EMERALD study has now been completed and we have submitted a detailed report of the research to our funder, the National Institute for Health Research (NIHR). We are currently focusing on preparing and sharing our findings with a variety of audiences: people with SMI and their supporters, people who make decisions about healthcare, and other researchers. We plan to publish the results of our research in academic journals in the near future and we are exploring other opportunities to share this important work.

We would like to thank patients and staff from Leeds and York Partnership NHS Foundation Trust, along with the other mental health trusts and GP practices, for participating and generously giving their time to support the project.

This summary presents independent research funded by the NIHR under its Health Services and Delivery Research (HS&DR) Programme (Grant Reference number 15/70/26). The views expressed are those of the study team and not necessarily those of the NIHR or the Department of Health. For further information on the EMERALD study or to explore opportunities to share the work, contact details can be found below.

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**emerald.**

Understanding risk factors for diabetes  
and the experience of diabetes healthcare  
for people with severe mental illness.



# Improving diagnosis and support for younger people with dementia: ANGELA study

The Angela Project was a three-year research study carried out by the universities of Bradford, Northampton, Surrey and UCL, funded by the Alzheimer's Society, and in partnership with Dementia UK and YoungDementia UK.

It was the largest study of young onset dementia ever carried out in the UK and was designed to look at how post-diagnostic support for people living with young onset dementia and the accuracy of diagnosis, can be improved.

The study was dedicated to Angela who was diagnosed with dementia at 51 years of age. She had symptoms for three years before getting a confirmed diagnosis. Many other people experience diagnostic delays like Angela.

During the study, views were gathered from professionals and over 230 people living with, or caring for, someone with young onset dementia making it the largest study of its kind. 500 sets of case notes were audited, 22 of which were recruited in LYPFT, the team talked to commissioners and service providers to understand more about what helped and hindered them in providing young onset dementia services.

The survey also looked at good practice and what needs services that provided good services met, as well as the barriers and facilitators to good practice in post-diagnostic support for younger people.

The Angela Project team has collated some of their key findings and recommendations to create a publication, Good Practice in Young Onset Dementia - Improving diagnosis and support for younger people with dementia. You can download a copy here or request paper copies via this form.

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# Evaluation of the Smokefree and Nicotine Management pilot project

The Evaluation of the Smokefree and Nicotine Management pilot project was approved by LYPFT's Board in July 2019 and commenced in all inpatient settings of the Newsam Centre on 2 September 2019. Key changes made to the existing policy for the purposes of the pilot are:

- Recommendation of varenicline for service users in eligible care pathways
- The introduction of e-cigarettes as a quitting or abstinence aid
- The repurposing of designated smoking areas, to designated vaping areas in external areas of the Trust grounds.

The paper details findings of the evaluation using the measures agreed in the pilot proposal; recommendations and their rationale are made based on the evidence emerging from the pilot. Key findings from the data evaluation are as follows:

- Implementation of the Newsam pilot has associated costs. The new, added cost of supplying e-cigarettes to service users can be predicted; however other Trust expenditure such as smoking related fire damage is more difficult to predict and is likely to need a longer period of evaluation.

- Incidents as reported via Datix relating to the pilot did not significantly increase; however complexities in some areas of the pilot site in order to prevent and manage incidents were identified and are discussed in a more detailed paper.
- Staff and service users gave positive feedback about the health and wellbeing effects of the pilot; however the delivery model is viewed as restrictive, particularly by service users.

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# New toolkit launched to support delivery of health services research

The National Institute for Health Research (NIHR) has launched a new toolkit for researchers, to help them deliver the high quality health services research that the NHS needs.

The Health Services Research (HSR) Toolkit is a national resource which brings together ideas, guidance and support in one place.

The NIHR funds and supports the set up and delivery of a wide range of research studies that deal with the development of health services. The HSR Toolkit has been launched by the NIHR Clinical Research Network (NIHR CRN), which provides researchers with the practical support they need to make clinical studies happen in both the NHS and the wider health and social care environment.

The toolkit is for researchers who are interested in or already delivering research with a focus on improving the quality, accessibility and organisation of health services, and as such is applicable to a number of different clinical specialties.

Professor Peter Bower, NIHR National Specialty Lead for Health Services Research, said: "Health services research is critical for an NHS that is effective, efficient and centred on patient need.

"However, there are challenges to delivering good quality health services research and the new HSR Toolkit is designed to help researchers navigate these and support them to deliver their health services research studies successfully.

"The new toolkit will feature blogs on key health services research issues, links to the latest guidance on best practice, and case studies of innovative ways of delivering high quality health services research."

Visit the HSR Toolkit to read the latest blog on how the NIHR CRN helped to deliver a health services research study designed to improve care for patients with lower back pain <https://sites.google.com/nih.ac.uk/hsrtoolkit>.



# Hello my name is...

## Jonathan Stott

I'm a doctor in my first year of training as a Child Psychiatrist. I was formally a Science Secondary School teacher and was motivated to retrain having worked with students struggling with mental health difficulties in the school environment.

During my training as a junior doctor I was fortunate to work with the Trust's Child Orientated Mental Health Intervention Centre team in York led by Professor Barry Wright. I thoroughly enjoyed helping to deliver Cognitive Behavioural Therapy interventions to children with phobias as part of the Alleviating Specific Phobias Experienced by Children trial (ASPECT). This work stimulated an interest and enthusiasm to combine my clinical practice with a research role.

I was pleased to gain an Academic Clinic Fellowship in August 2019. I am currently developing a school-based taste exposure intervention and aim to test its effectiveness in treating children with possible Avoidant Restrictive Food Intake Disorder.

I look forward to working with the LYPFT's Research & Development team and am grateful for the welcome and support I have already received.

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## Brian Berry

If you visit St. Mary's House, after the lockdown, you may see me. I am the Research Contracts Manager for the Research and Development department. I am entering my fourth year with the NHS. Currently, I spend one day a week, typically a Thursday, working at LYPFT and my remaining time is at Leeds Teaching Hospitals Trust, performing the same role.

When you meet me you will immediately notice my accent. It is a mid-western American accent from Wisconsin and South Dakota. While living in South Dakota, I was supply teaching using my BSc in psychology from the University of South Dakota and several masters' degree credits in counselling teaching at alternative education sites in mental health setting, teaching children with violent disruptive behaviours, those in juvenile corrections including gang members, and when not

teaching at alternative education site, I spent a lot of my time teaching maths. After a life-changing event, my spouse decided to return to the UK and this resulted in a career change for me, from teaching to Information Technology (IT).

My UK IT experience is IT change management / project management; meaning I managed teams, people, suppliers, and things to deliver IT system. This involved reviewing software licensing agreements, reviewing supplier agreements, and spending time reviewing how IT systems manage data. During my time in IT, I took a career break to obtain my law degree and work in conveyancing, selling and buying of property. After about a year conveyancing, I discovered my interest lay more in project management and I returned to IT project management.

# Hello my name is...

Just over three years ago I started working for the NHS. First in IT and then a career transition to Business Manager. During my time as a Business Manager I developed connections with a local Leeds school with interests in health careers. My work with the school culminated in being a feature speaker for the Westminster Employment Forum discussing the UK Career Strategy.

In my current role, I review and negotiate research agreements. While at LTHT I also, work with the Business Development team reviewing confidentiality agreements, site visit agreements, and advise on improving new business processes.

Finally, in my spare time I am active with my shul (Jewish synagogue), spending time with my Dalmatian Einstein, and reading history.

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## Sarah Trufhitt

I recently joined the Trust's Research and Development Team as a Research Assistant.

Prior to this, I worked at Humber Teaching NHS Foundation Trust as a Research Assistant on a variety of National Institute for Health Research studies in dementia and mental health. Alongside this I have been undertaking a part time Clinical Research Masters at the University of Sheffield. Within the masters I have worked with a Consultant Clinical Psychologist to design a research project for children with eating disorders, an area I am passionate about researching in. I have additionally worked as a Clinical Trials Assistant in Paediatrics which I thoroughly enjoyed and got to work on a range of drugs studies to help children.

I completed my BSc in Psychology at the University of Hull which included my dissertation on: the effect of transcranial direct current stimulation (tDCS) on body image perception in anorexia spectrum disorders. I have volunteered in eating



disorders for a local Hull charity, SEED, as well as Beat, the national eating disorder charity. I am also passionate about supporting a wide range of mental health and neurodegenerative disorders.

I am looking forward to working across LYPFT to deliver a wide range of National Institute for Health Research studies.

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# Thoughts of a Patient Research Ambassador

We are living in a 'new world'. The phrase I use so often, 'today's research is tomorrow's treatment' has never felt so profound and the world has never come together with such single-minded focus on one research question – how to find a treatment for COVID19.

My concern is that the pandemic is reinforcing some of the myths about health research - that it is far removed from our everyday lives and that we are all sitting here powerless waiting for the day when a man in a white coat will emerge from a laboratory triumphantly clutching the vaccine that will save us all.

The fact is that health research has been and always will be a collaborative effort. It is about all of us and without our participation and involvement there would be no research.

To engage people with this message, I believe we must show that research is 'relatable', 'relevant' and 'reforming'.

If you wonder how we can make research 'relatable' look in your medicine cabinet and realize that it was people just like you and me who helped researchers resolve your headache, and when you talk to your therapist realize that it was people just like you and me who helped researchers heal your heartache.

We must ensure that research is 'relevant' to people's lives so they can make an informed decision about whether to take part.

This means that the information must be accessible. The most brilliant research study can struggle if it is housed in medical jargon and fails to communicate with those it needs to reach.

We must use Patient and Public Involvement (PPI), harnessing the lived experiences and expertise of patients, the public and carers, and work with researchers to shape research and create a language that will reach the people it needs to serve.

We stayed at home to 'save lives' – now people need to understand that they can take part in research and we may just save the world.

I believe we all have a right to know of the difference we can make. A sense of contribution goes to heart of who we are and in saving others we so often save ourselves.

COVID19 is creating a parallel mental health pandemic, worsening the pain of those with pre-existing mental health issues but also weaving new layers of suffering in the grief and trauma experienced by so many, including health workers.

It is through mental health research that together we will explore the fabric of our fears, share our deepest experiences and create the resources that will help us all to navigate the path back to ourselves.

We can all contribute by taking part. There are already online questionnaires with inbuilt patient information sheets and consent forms. Interviews and focus groups may soon be done with social distancing or through video calls as mental health research carries on.

We will all have 'lived experience' but the experience we have lived will be different. COVID19 has disproportionately affected black and ethnic minorities, those with underlying health conditions, older people and areas of high social deprivation. Groups not mutually exclusive, but all underserved in research.

The reasons may lie in the perception of research as remote from their lives, or for some, a historical mistrust of research that betrayed them. Only by working with communities can we rebuild perceptions and trust from the ground up to make research relatable and relevant – we must find the language to reach them and the compassion to serve them. We can and must start the conversation.



When research becomes relatable and relevant it has the potential to become 'reforming' – to drive social policies and create real change. 'Born in Bradford' is one of the biggest studies in the world with 30,000 Bradfordian participants contributing to research into areas such as mental health and air pollution that have led to changes in public transport and green spaces - "together we have shown how communities across our city can join hands and become a living network of citizen scientists" (Dr. Rosie McEachen and Professor John Wright).

I attended my Uncle's funeral this week, a military veteran, his last battle was with COVID19. 16 of us cried together sat on chairs 2 metres apart. We have joined hands with a living network of grief – of potential citizen scientists who all have the right to be heard.

I believe that some of the research emerging from this pandemic may be reforming, we may reshape our mental health system to be more trauma focused, we may find ways to retain our connectedness and compassion. But we all have to play our part, and in order to do that we have to understand that we can.

This is the people's pandemic. We have co-experienced it and we must co-produce the solutions.

In memory of Sid Watson 1922-2020

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# Computerised cognitive–behavioural therapy for depression in adolescents: 12-month outcomes

Computerised cognitive–behavioural therapy (CCBT) in the care pathway has the potential to improve access to psychological therapies and reduce waiting lists within Child and Adolescent Mental Health Services, however, more randomised controlled trials (RCTs) are needed to assess this.

## Aims

This single-centre RCT pilot study compared a CCBT program (Stressbusters) with an attention control (self-help websites) for adolescent depression at referral to evaluate the clinical and cost-effectiveness of CCBT (trial registration: ISRCTN31219579).

## Method

The trial ran within community and clinical settings. Adolescents (aged 12–18) presenting to their primary mental health worker service for low mood/depression support were assessed for eligibility at their initial appointment, 139 met inclusion criteria (a 33-item Mood and Feelings Questionnaire score of  $\geq 20$ ) and were randomised to Stressbusters ( $n = 70$ ) or self-help websites ( $n = 69$ ) using remote computerised single allocation. Participants completed mood, quality of life (QoL) and resource-use measures at intervention completion, and 4 and 12 months post-intervention. Changes in self-reported measures and completion rates were assessed by group.

## Results

There was no significant difference between CCBT and the website group at 12 months. Both showed improvements on all measures. QoL measures in the intervention group showed earlier improvement compared with the website group. Costs were lower in the intervention group but the difference was not statistically significant. The cost-effectiveness analysis found just over a 65% chance of Stressbusters being cost-effective compared with websites. The 4-month follow-up results from the initial feasibility study are reported separately.

## Conclusion

CCBT and self-help websites may both have a place in the care pathway for adolescents with depression.

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# National Institute for Health Research (NIHR) funding opportunities

The NIHR Clinical Research Network Portfolio is a database of studies that shows national clinical research study activity. Clinical trials and other well-designed studies involving the NHS, funded by the NIHR, other areas of government and non-commercial partners are automatically eligible for portfolio adoption. Studies that are adopted on to the portfolio can access infrastructure support and NHS service support costs to help with study promotion, set-up, recruitment, and follow-up.

The Research Design Service ([www.rds-yh.nihr.ac.uk/](http://www.rds-yh.nihr.ac.uk/)) provides guidance and support that you will need to access when making an application for NIHR funding. They also provide funding to enable service users, carers and the public to contribute to the development of your research bid.

Funding stream	Deadline
Efficacy and Mechanism Evaluation (EME)	Injuries, accidents and urgent and emergency care themed call 20 Aug, 1pm
Health Services and Delivery Research (HS&DR)	Injuries, accidents and urgent and emergency care themed call 10 Sept, 1pm
HTA Commissioned Calls	Injuries, accidents and urgent and emergency care themed call 2 Sept, 1pm

## Funding streams:

- Efficacy and Mechanism Evaluation (EME):** Researcher-led and aims to improve health/patient care. Its remit includes clinical trials and evaluative studies.
- Health Services and Delivery Research (HS&DR):** Funding research to improve the quality, effectiveness and accessibility of the NHS, including evaluations of how the NHS might improve delivery of services. It has two work streams, researcher-led and commissioned.
- Health Technology Assessment (HTA):** Funds research to ensure that health professionals, NHS managers, the public, and patients have the best and up-to-date information on the costs, effectiveness, and impacts of developments in health technology.
- Invention for innovation (i4i):** Funds research into advanced healthcare technologies and interventions for increased patient benefit in areas of existing or emerging clinical need.
- Programme Grants for Applied Research:** To produce independent research findings that will have practical application for the benefit of patients and the NHS in the relatively near future.
- Public Health Research (PHR) Programme:** Funds research to evaluate non-NHS interventions intended to improve the health of the public and reduce inequalities in health.
- Research for Patient Benefit (RfPB):** Generates research evidence to improve, expand and strengthen the way that healthcare is delivered for patients, the public and the NHS.

For further details about funding opportunities through the NIHR, visit:

[www.nihr.ac.uk/about-us/how-we-are-managed/boards-and-panels/programme-boards-and-panels/](http://www.nihr.ac.uk/about-us/how-we-are-managed/boards-and-panels/programme-boards-and-panels/)

  
**National Institute for  
Health Research**

# Contact us R&D

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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## SAVE THE DATE: Research Forum 2020

**Date: Thursday 12 November 2020**

The Research Forum is an all-day event hosted by Leeds and York Partnership NHS Foundation Trust's Research and Development and Library and Knowledge Services Teams. Its purpose is to showcase some of the research that our Trust and academic staff have completed in previous years.

The Forum is held in November, in part to coincide with the completion of the projects from the Doctorate in Clinical Psychology course at the University of Leeds. Around 90-100 delegates generally attend, including service users, carers, nurses, allied health professionals, psychologists, academics, researchers and psychiatrists.

The projects are presented either in plenary or workshop sessions by the researchers or in poster form. There are typically 15-20 posters and these will be judged by delegates attending the event, with prizes awarded for 1st and 2nd places.

Due to the current crisis this event will take place as a webinar. More information to follow.

**This is a FREE all-day event.**