ROYAL COLLEGE OF PSYCHIATRISTS

FACULTY OF LIAISON PSYCHIATRY NEWSLETTER

Contents

Welcome to the spring edition of the Liaison Psychiatry Faculty Newsletter.

This edition reflects, as usual, the depth and breadth of our speciality. Jim Bolton, chair of our Faculty provides an update on recent developments and the need for clear and strategic communication. He summarises the recommendations arising from the recent survey of the integrated care of long-term physical health conditions and medically unexplained symptoms.

We have included an invitation from Khalida Ismail to those interested in diabetes and psychiatry to gather at our next conference in Liverpool. There is a thoughtful piece about what makes us good leaders. Stephen Potts presents the emerging guidelines for those assessing altruistic donors, whilst we also learn what could help after ICU admission. This incredible versatility in our range of practice makes it more difficult to test outcome measures. Hence we are grateful to Anita Phung who presents the results of implementing and adapting FROM-LP at her hospital. Elena Baker-Glenn summarises the findings from a recent survey of Higher Trainees' experience in Liaison psychiatry, We hope you enjoy reading this edition.

May we draw your attention to the next Faculty Conference in May 2018 to be held on 16-18 May 2018 at the Liverpool .

In future, newsletter will be published and released thrice a year.

We are always looking for submissions, which are relevant to liaison psychiatry including reports on

service development, education, training, audits, conferences and events. Articles should be no more than one to two pages long. Please include your name, title, place of work and contact details. Please note that this is neither a peer review process nor a scientific publication but it gives a good platform to share good practice and ideas.

Please e-mail Stephanie Whitehead at Stephanie.Whitehead@rcpsych.ac.uk using "Liaison Faculty Newsletter" as the subject title. We would like to thank Stephanie Whitehead for her support in preparing this Newsletter.

Thanks to you all for your continuous support. We have had a fantastic number of submissions, so much so , that we are planning another edition in the summer!

We hope you enjoy the newsletter.

Well done Faculty!

See you all in Liverpool

Editorial Team

Liaison Faculty Newsletter

Dr Nora Turjanski

Dr Sridevi Sira Mahalingappa

CHAIR'S REPORT - DR JIM BOLTON

Thank you

My last Newsletter column was titled "Help!", largely because I am often requesting your assistance with various projects. This time I want to thank you for all your recent support. In particular, thanks to all of you who responded to the survey of English Liaison Psychiatrists' experiences of IAPT services providing interventions for patients with medically unexplained symptoms and long-term conditions.

The survey findings were used to support discussions by the Faculty Executive Committee and others about providing integrated care for these conditions. In particular, your input has informed a pending statement on this subject by the National Collaborating Centre for Mental Health to accompany their recently published *IAPT Pathway for People with Long-term Physical Health Conditions and Medically Unexplained Symptoms*. The executive summary of the results of the survey are elsewhere in this Newsletter and a full copy is available

on the Faculty pages of the College website.

Across the UK, Liaison Psychiatry continues to be engaged in many different projects and initiatives. We remain a speciality in demand, clinically, politically and by the media. Recently both Professor Michael Sharpe and Annabel Price, our Vice Chair, have had thoughtful articles on aspects of Liaison Psychiatry published in the influential Health Service Journal. These are worth reading and have provoked a lot of interest.

Recently I was asked to discuss the role of Liaison Psychiatry in the management of self-harm and suicidal ideation with the All Party Parliamentary Group on Suicide and Self Harm. With information from our lead representatives in Scotland and Wales, Stephen Potts and Tania Bugelli, I led a discussion with several MPs that caused them to question why Liaison psychiatry is not a mandatory service in all general hospitals. I hope that this discussion will provide more political backing for our campaign to become an accepted part of comprehensive healthcare and not an optional extra.

Currently we are developing the Faculty's Communications Strategy, together with colleagues from the College's Strategic Communications Department. We are planning a number of initiatives to raise the profile of Liaison Psychiatry with hospital colleagues and the general public. In the last Newsletter I asked for your help in developing a strapline for such a campaign and I am grateful to all those of you submitted suggestions. I will let you know more about the campaign later this year when I will be seeking your help again!

Finally, I hope to see many of you In Liverpool for our annual Faculty Conference. Nora Turjanski and Sridevi Sira Mahalingappa, our Faculty Communication Leads, have put together an enticing programme with something for everyone. I am also looking forward to visiting a city with such an interesting historical and musical heritage, being the birthplace of the Beatles. So, get your *Ticket to Ride* for a *Magical Mystery Tour* to Liverpool and we will be *All Together Now*, and for some there may even be the odd *Hard Day's Night* in the local bars.

Your Chair (and *The Fool on the Hill*),

Jim Bolton

Assessing altruistic donors - emerging guidance

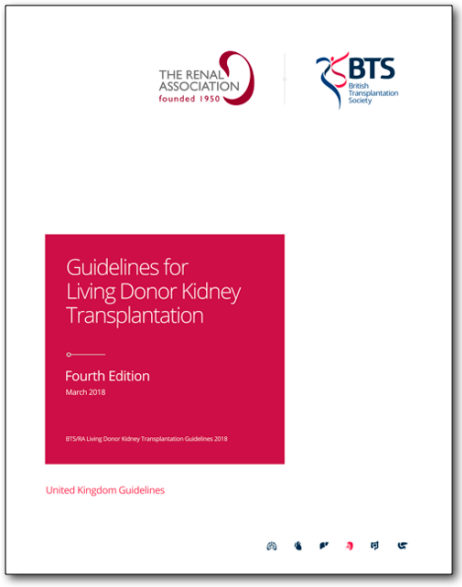
Dr Stephen Potts
Consultant in Transplant Psychiatry, Edinburgh

Transplant psychiatry is a small subdivision of liaison psychiatry. I think I am alone in pursuing it as my primary role, but other liaison psychiatrists see transplant patients as part of their portfolio of roles.

Those who see potential living organ donors will know that since so-called "altruistic" (aka non-directed)organ donation first became legal in the UK in 2006, the practice has grown rapidly and become well – established, making up more than 10 % of all live donations (and more in some centres). This may be partly responsible for the first recorded fall in the kidney transplant waiting list - which a charity promoting altruistic donation has pledged to abolish altogether.

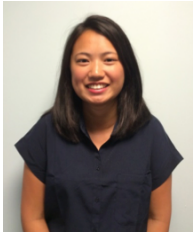
Transplant clinicians were initially wary, and the regulatory body (HTA) mandated a psychiatric assessment of all potential altruistic donors, though it was vague about details. Practice varied widely between units, and more so after the mandatory requirement was withdrawn in 2012, while clinical bodies such as BTS continued to recommend it.

In an attempt to guide those undertaking these assessments and their referring clinicians, an informal group of psychiatrists and psychologists from the UK and Ireland (with an observer from Germany) convened a meeting in London to produce consensus guidelines. These have now been incorporated in the latest UK guidance covering all aspects of live donor assessment and management.



The German connection lead to further meetings in Nuremberg and the US, and the production of multi-author international guidance, shortly to be published in the Journal of Psychosomatic Research.

It's been a long journey to this point, but I am sufficiently convinced it has been worthwhile to begin another, this time focussing on the subset of highly idealistic but perhaps also vulnerable donors. As altruistic donation has become more widespread and well publicised, transplant centres are fielding approaches from donors in their early twenties or even late teens. The range of views and variation in practice in this area is marked, and long term follow-up evidence only goes so far: but some attempt at consensus is clearly needed. Watch this space.



The Framework for Routine Outcome Measurement in Liaison Psychiatry - An Experience of Implementing the Recommendations

Dr Anita Phung, Dr Joseph Ramsay, Dr Stephanie Ewen, Dr Isabel McMullen
Department of Psychological Medicine, King's College Hospital,
South London and Maudsley NHS Trust, London

Background

There has been an increasing focus on outcome and performance measurement in liaison psychiatry services. Subsequently, the Framework for Routine Outcome Measurement in Liaison Psychiatry (FROM-LP) was established. Whilst there is increasing evidence for the economic benefit of liaison psychiatry services, evidence reflecting liaison services' outcomes and performance is lacking.

Aim

The aim of our quality improvement project (QIP) was to evaluate the performance and outcomes of the liaison psychiatry service at King's College Hospital (KCH), which involved developing, implementing and evaluating a systematic data gathering tool pertaining to the clinical workload of the liaison psychiatry service at KCH. This tool should routinely capture patient clinical information, administrative tasks, as well as integrating outcome measures as recommended by the FROM-LP.

Standards

The FROM-LP recommends several measures to evaluate outcome and performance including Identify and Rate the Aim of the Contact (IRAC), Clinical Global Impression Improvement (CGI-I) scale, patient satisfaction scale, friends and family test, referrer satisfaction scale and CORE-10. Our QIP used measures 1 and 2 in evaluating outcome and performance of the liaison psychiatry service at KCH.

Methods

A digital whiteboard displayed a purpose-built spreadsheet which was used to facilitate three daily liaison

psychiatry team meetings. The spreadsheet was used as an essential clinical tool, tracking the department's caseload and patient management plans. Administrative details, including referrer, reason and urgency for referral and outcome measures, including IRAC, CGI-I, were routinely completed as part of clinical handover.

The department's caseload during two months (February and May) was audited, enabling us to describe and analyse the department's referrals, workload and performance. Referrals were completed electronically. Patient and referral details were entered onto the liaison psychiatry caseload spreadsheet in real time and any missing data was entered retrospectively following discharge of the patient. Data collection included referral date, referring team, reason for referral, urgency of referral (as determined by referrer), response time to referral, diagnosis, brief risk and child risk screen, IRAC, CGI-I and discharge date.

Microsoft Excel was used for data analysis which involved calculating the cumulative frequency or mean.

Results

A total of 146 inpatient referrals were received in February (n=61) and May (n=85).

The majority of referrals came from acute medicine (43.15%), other medical specialties (20.55%) and trauma (13.01%).

The main three reasons for referral were for low mood (34.25%), self-harm (27.40%) and psychosis or mania (21.92%).

The IRAC classification allows responding clinicians to categorise the aim of referrals. The main three IRAC classification were for assessment and diagnosis or formulation (46.58%), for assessment and management of risk (30.82%) and for providing guidance and advice (8.90%).

The CGI-I score allows clinicians to rate patients' global clinical improvement. The CGI-I score showed that on average, patients had experienced some improvement (2.90) following liaison psychiatry input.

Discussion

By using the CGI-I score, we were able to demonstrate that on average, liaison patients experienced 'minimal improvement'. Although the CGI-I score is a validated outcome measure for liaison services, we believe that it has some significant limitations. For example, it is subjective and appears to have significant inter-rater variability; psychiatry liaison patients are normally only under the liaison team for a brief time which often does not allow any significant improvement to be observed; and CGI-I does not seem to reflect the impact of many of the liaison psychiatry department's roles, such as offering advice to other clinical services, assessing mental capacity and assessing and managing risk. For these reasons we believe that other outcome measures should also be included, perhaps those which use service user satisfaction surveys (e.g. patient and referrer satisfaction scales) or CORE-10.

Recommendations to local Liaison Psychiatry services
More than half of all referrals came from the acute medicine and trauma departments. We recommend that future or quality improvement interventions, aimed at improving other clinicians' understanding and use of liaison services, could be focussed on these clinician groups.

As well as this, more than half of all inpatient referrals were due to low mood or self-harm. We believe that this reflects, in part, the anxiety that these presentations can cause in treating clinicians. We recommend that future training or quality improvement interventions could focus on these types of presentation.

Psychiatry liaison services are increasingly recognised as an essential part of acute hospital care but demonstrating workload throughput and performance for these services has often been challenging.

By implementing a routine clinical and performance measuring tool incorporating suggestions from the FROM-LP we have successfully created data on the volume and nature of our department's workload. However, it was not possible to implement all the measuring tools recommended by the FROM-LP, which highlights the ongoing challenges of evaluating liaison psychiatry services.

Moving forward, we expect that developing this tool will enable an evidence-based allocation of resources, improving outcomes for service users.

Dr Anita Phung

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A Pilot Study Delivering EMDR for Post-ICU Patients with PTSD

Tom Hulme, Clinical Nurse Specialist, CBT & EMDR Therapist

Introduction

More and more patients in intensive care units (ICU) are surviving their critical illnesses due to advances in medical care (Warlan & Howland, 2015). This has led to an increased awareness of the psychological sequelae of these episodes of care, particularly post-traumatic stress disorder.

Post-traumatic stress disorder (PTSD) is defined as a severe anxiety disorder that occurs when a person is exposed to actual or threatened death, serious injury or sexual

violence. The exposure can be direct, witnessed or indirect, e.g. by hearing of a relative or close friend who has experienced the trauma. Symptoms include:

- intrusive thoughts or memories about the trauma
- nightmares related to the traumatic event
- flashbacks where the person feels like the event is happening again
- avoiding thoughts or feelings connected to the traumatic event
- avoiding people or situations connected to the traumatic event
- negative thoughts or beliefs about one's self or the world which are related to the trauma
- a distorted sense of blame for one's self or others related to the event
- being stuck in severe emotions related to the trauma (e.g. horror, guilt, shame, sadness)
- severely reduced interest in pre-trauma activities
- feeling detached, isolated or disconnected from other people
- difficulty concentrating
- irritability, increased temper or anger
- difficulty falling or staying asleep
- Hypervigilance
- being easily startled

(American Psychiatric Association, 2013)

A diagnosis of PTSD can only be made if the person continues to experience pervasive symptoms for at least one month after the traumatic event.

According to previous studies, PTSD affects between 8% to 27% of ICU patients (Wade et al, 2013), compared to 6% to 8% of the general population (American Psychiatric Association, 2013; Pietrzak et al, 2011).

Eye movement desensitisation and reprocessing therapy (EMDR) is recognised by the World Health Organisation (2013) and the National Institute for Clinical Excellence (2005) as an effective treatment for PTSD.

Aim

To deliver a time-limited, evidence-based treatment for PTSD in order to demonstrate positive health outcomes for this patient group.

Methods

The pilot clinic started on 1st June 2016 and ran for 11 months. One of the liaison psychiatrists would visit the intensive care unit each week in order to identify possible high-risk patients for PTSD. As a formal diagnosis of PTSD cannot be made within the first month following the trauma, the psychiatrist's role was one of offering support, validation and normalising of their symptoms.

In order to screen these patients after the one month cut-off period, both the patient and their GP were sent an Impact of Event Scale - Revised (IES-R) along with a covering letter, explaining that if they were still experiencing symptoms, they could contact the clinic directly in order to be offered an assessment.

The IES-R is a 22 item self-report measure of current subjective distress in response to a specific traumatic event (Weiss & Marmar, 1997). The patient answers each question using a 0 to 4 Likert scale: 0 (not at all), 1 (a little bit), 2 (moderately), 3 (quite a bit) and 4 (extremely). A total score of 24 to 32 indicates that PTSD is a clinical concern. Those with these scores who do not have full PTSD will have partial PTSD or at least some of the symptoms. A score of 33 and over represents the best cut-off for a probable diagnosis of PTSD.

Results

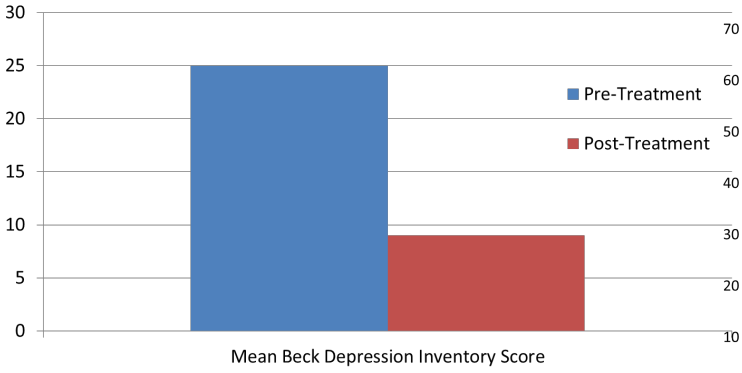
Despite sending out over 800 letters to ICU patients and their GPs over the course of 11 months (n = 817), responses were low. Based on the evidence that PTSD affects between 8% to 27% of ICU patients (Wade et al, 2013), we would have expected to see between 65 and 220 patients. In fact we only received 29 responses. Of those, 14 met the diagnostic criteria for PTSD based on their IES-R score. 8 did not return the IES-R after making the initial contact. 5 did not meet the criteria for a PTSD diagnosis based on their IES-R score. The remaining 2 people decided that they lived too far from the hospital to engage in therapy. Of the 14 people invited into therapy, 3 dropped out before completing treatment and 1 decided not to proceed after the initial history taking. This left 10 people who completed therapy.

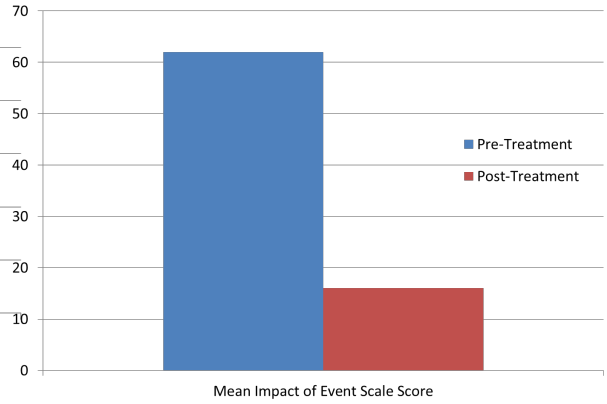
The 10 patients who completed therapy showed significant improvements. Their mean IES-R score reduced from 62 (severe PTSD) to 16, indicating minimal symptomology. Their mean Beck Depression Inventory II (BDI-II) (Beck et al, 1996) score reduced from 25 (moderate depression) to 9 (normal symptomology). The mean number of treatment sessions was 5.

817 letters to patients/GPs. Of the 29 responses:

- 14 met criteria for PTSD based on their IES-R score
- 8 failed to return IES-R
- 5 did not meet criteria for a diagnosis of PTSD
- 2 with PTSD diagnosis unable to attend BRI weekly, so advised to attend their local psychological therapy service
- Therefore 14 patients invited into therapy:
- 3 dropped out after 1-2 sessions and 1 decided not to proceed at all

- 10 completed treatment:
- Mean IES score went from 62 to 16
- Mean BDI score went from 25 to 9
- Mean number of treatment sessions = 5





Conclusion

This pilot study has demonstrated very good outcomes in delivering EMDR therapy to ICU patients with significant PTSD.

One drawback was the low numbers who took up the offer of therapy, despite there potentially being a much greater number based on previous research and despite sending out over 800 invitation letters. Therefore any future initiative should look at how these numbers could be improved, although it was also acknowledged that any prospective patients cannot be forced to undertake therapy.

One possible reason for these low numbers may have been that due to their PTSD symptoms, patients were reluctant to return to the scene of their previous trauma, e.g. ICU, due to the associated overwhelming re-experiencing symptoms and distress. One consideration could be to offer out-patient clinics away from the hospital site or even in the patients' homes.

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Integrated care for long term physical health conditions and medically unexplained symptoms: a survey of Liaison Psychiatry services

Summary

The Five Year Forward View for Mental Health lays out plans for an expansion in Improving Access to Psychological Therapies (IAPT) services to provide treatment for patients with medically unexplained symptoms and long term physical health conditions (MUS/LTCs). IAPT will be integrated into existing primary and secondary care pathways and services. This survey aimed to explore the experiences of Liaison Psychiatry and Psychological Medicine services in working with IAPT in the management of patients with MUS/LTCs, particularly in the general hospital setting.

Of the 40% of English acute hospitals from which information was obtained, the experience was of variable and limited provision of IAPT services for patients with MUS/LTCs. At least one quarter of community IAPT services had no such provision. Only three examples of IAPT services providing in-reach into a general hospital were identified.

IAPT is only one component of a comprehensive integrated care pathway for patients with MUS/LTCs, providing a high-volume service for patients of low complexity. Liaison Psychiatry services have expertise in the assessment and management of complex cases, such as those with complex co-morbidity, personality difficulties and high levels of risk related to patients' physical or mental health. Liaison Psychiatry can also provide training and supervision for other staff.

Establishing IAPT as competing in-reach services into hospitals that already have established psychiatry and psychology services is unlikely to be effective and will not provide integrated care. Existing Liaison Psychiatry, Psychological Medicine and Clinical Health Psychology services provide a basis of expertise and experience on which to build fully integrated services for patients with MUS/LTCs.

Recommendations

- Liaison Psychiatry expertise is essential within integrated services for the assessment and management of complex cases of patients with MUS/LTCs. A truly integrated care pathway for MUS/LTCs cannot be delivered solely by IAPT if it is to meet the needs of all patients.
- Liaison Psychiatry staff play a key role in the education and training of both frontline medical and nursing staff and IAPT staff in the recognition, assessment and management of MUS/LTCs.
- Clinical Health Psychologists are skilled in providing psychological care to complex patients and cannot be simply replaced by IAPT.
- Commissioners may benefit from education and support in how best to establish effective and capable integrated care for patients with MUS/LTCs.
- Commissioners need to be aware of existing services for the treatment of MUS/LTCs before they commission additional or new services.
- Existing Liaison Psychiatry services can provide a basis for the establishment of an integrated care pathway for MUS/LTCs, particularly in secondary care, but also in primary care. A comprehensive service requires the expertise of IAPT, Clinical Health Psychology and Liaison Psychiatry.

Dr Jim Bolton

Chair of the Royal College of Psychiatrists' Faculty of Liaison Psychiatry

April 2018

Humanities and leadership in Psychiatry

Dr Ahmed Saeed Yahya (Speciality Trainee in Psychiatry), Dr Jude Chukwuma (Consultant Psychiatrist) and Dr Nisha Shah (Consultant Perinatal Psychiatrist)

About the authors

Dr Yahya is a Specialist Registrar in Psychiatry who is currently based at East London NHS Foundation Trust. Dr Jude Chukwuma is a Consultant General Adult Inpatient Psychiatrist who is based at Barnet, Enfield and Haringey NHS Trust. Dr Nisha Shah is Consultant Perinatal Psychiatrist who is based at North East London NHS Foundation Trust.

Introduction:

Leadership can be defined as the art of motivating a group of people to act towards achieving a common goal (Sharma et al 2013). There is increasing attention paid to medical leadership- with particular emphasis on developing the necessary competencies during both core and speciality psychiatry training. The General Medical Council suggest that leadership skills are a core requirement for doctors (Brown et al 2013). The NHS institute for Innovation and Improvement states

that doctors have a responsibility 'to contribute to the effective running of healthcare organisations' (Brown et al 2013).

The Royal College of Psychiatrists has made great effort to address the five domains of the medical leadership competency framework in their postgraduate training curriculum. The five domains include: demonstrating personal qualities, working with others, managing services, improving services and setting direction. These can all be tracked in the current curricula. Within the curriculum there is also a supplementary focus on the development of personal qualities and working with others. Brown and Brittlebank 2013 highlight that successful healthcare organisations have been built on by the continued engagement and leadership of medical staff. It is the responsibility of all trainers and educators in Psychiatry to emphasise the importance of developing these skills and producing the best medical leaders.

Psychiatrists are particularly well suited as leaders. The skills they acquire during their training include good communication and interpersonal skills. They focus on listening to patients and other stakeholders, and promoting a multidisciplinary patient-centred approach to meeting the individual patient's needs and managing risks. Psychiatrists are self-aware and self-reflective.

Discussion:

Warren Bennis who was regarded as a pioneer of the contemporary field of leadership studies reported that a key quality of a good leader is someone that is well communicated (Kirby 2014). This is an area which we wish to explore further in this short article. Although Psychiatrists have a huge array of skills which would constitute a strong leader, we examine whether additional training around the humanities, would augment their already diverse skill set. The humanities focus on building skills in both written and verbal communication. Most importantly they teach the individual to critically explore and ask questions about their working environment.

The benefits of the humanities is apparent in the cross disciplinary work of both philosophy and psychiatry. This area has contributed immensely to clinical practice and management. Professor Bill Fulford who is an eminent Psychiatrist and philosopher has noted key developments in patient- centred practice, new models of service delivery, neuroscience search, psychiatric education and the organisational basis of Psychiatry as an international science-led discipline (Fulford et al 2004).

In 2015 the British council surveyed the educational backgrounds of 1,700 leaders across thirty countries. Participants were involved in various fields from corporate, government to non-profit organisations. The research found that fifty five per cent

of these leaders had either a humanities or social sciences degree (Blochinger 2015). Dr Cruikshank who is the dean for humanities at McMaster University (Canada) reports that the subject area helps to develop creativity, persuasive and rational arguments; it helps to communicate these ideas and teaches one to think both constructively and critically.

Curiosity and empathy are key components of a strong leader and have been ranked by business executives as key components for success. Dr David Brendel is a leadership development specialist and a Harvard trained Psychiatrist. He has written about the benefits of 'Humanity subjects.' A large portion of time is dedicated to reading the 'great works' of the past. These can promote a person's ability to imagine and understand the perspective of others. Developing the theory of the mind has been introduced as an area of research linked to leadership. A seminal study from 2013 suggested that the reading of high quality literary fiction enhanced theory of mind skills. Literary fiction challenged and refined a reader's capacity for empathetic curiosity (Brendel 2015).

An article by the Economist highlighted the benefits of reading the great texts from Western and Eastern philosophy. It was suggested that business leaders would gain skills from this literature and apply this to their business models (Brendel 2015). From personal experience these works are very complex. However, those with backgrounds in the Humanity subjects feel a lot more at ease reading these texts and applying key skills derived from these to their practise.

Conclusion:

Psychiatrists are equipped with key leadership skills and already make great leaders. They possess a unique complement of attributes for their role. However, the beauty of psychiatry is the willingness to embrace and accept other modalities of practice. The breadth of the speciality is huge and there is presently an increasing link between psychiatry and the arts. In this article, we briefly discussed how being more open to the humanities can develop us in our respective careers and in our role as medical leaders. We argue that the integration of humanities to postgraduate medical education can enhance the acquisition of leadership skills. In psychiatry, a lecture or a group discussion led by a philosophy academic in our respective trust academic afternoons may contribute greatly. This resource is being utilized in the commercial world and may prove worthwhile in medical education and medical leadership.

There has been no financial support for this work. There has been no conflict of interest. There are no disclosures to be made.

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Diabetes and Liaison Psychiatry Working Group

The rising tide of obesity and diabetes, the complexity of cases we are seeing in the liaison and primary care setting, and increasing acknowledgement that there are interactions between mind and body in diabetes means it's time for a diabetes and psychiatry working group!

The Liaison Faculty Executive is formally supporting setting up a working group in Diabetes Liaison Psychiatry (DLP). The aims of this group are to:

1. Build a critical mass of liaison psychiatry experts in diabetes

2. Synthesize the evidence base for different models of integrated care for diabetes

3. Generate consensus on key performance indicators of liaison psychiatry in diabetes

4. Network with Diabetes UK/ABCD/RCPs (London & Edinburgh), NHSE, NHSScotland

5. Developing proforma for business cases for commissioning liaison mental health models into diabetes pathways

6. Develop training and educational programmes for diabetes professionals

7. Identify and promote key areas and gaps in diabetes and mental health research

8. Foster interest and mentor medical students and trainee doctors

We plan to hold our inaugural meeting at the Liaison Faculty conference on:

Thursday 17.05.18 12:30 – 1 pm

This is during the lunch break. There will be time to get your lunch and bring it to the meeting. As you can see from the conference programme, Dr Partha Kar, NHSE Associate Director for Diabetes will be presenting early in the morning and taking questions and answers during his talk.

Please email Stephanie.Whitehead@rcpsych.ac.uk if you are interested and please forward to colleagues who are or want to work in this field.

Do contact Professor Khalida Ismail or Dr Luke Solomon if you want to have an informal chat.

Otherwise in the meantime, we look forward to seeing you in Liverpool with your 'diabetes hats'.

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Survey of Higher Trainees' Experience in Liaison Psychiatry

Thank you to all trainees who took part in the higher trainees' survey last year.

A survey was undertaken to look at the experience that trainees are obtaining in liaison psychiatry following the introduction of the 2016 curriculum. The survey was conducted using Survey monkey; it was sent out by email on 2 June 2017, and responses were collected for 2 months. A total of 27 responses were obtained from the survey; the majority (22) of the responses were from England

Some posts included experience with CRHT, some posts had outpatient experience, the majority of posts had some ED experience, but there were a few

posts that did not have experience on the medical and surgical wards. Trainees were all able to access a range of experience in their liaison post, although some were accessing training opportunities from a different team to ensure competencies were met.

Less than half of the trainees were seeing a patient for psychotherapy within a liaison psychiatry setting. However, the majority of people were able to apply psychological skills to patients that they saw.

Concerns were raised about the number of WPBA required in comparison with other specialties.

Less than full time trainees flagged up particular challenges with the requirement to rotate every 12 months where they are unable to complete an endorsement. They have also found that they are expected to take on full time work, but do so in reduced hours.

The issues outlined are being raised and addressed within the College and we are grateful for ongoing feedback where there are concerns about training posts in liaison psychiatry. We are also keen to hear from people about positive training experiences and where things work well!

Dr Elena Baker-Glenn, TNC Chair 2016-17, Liaison Faculty

Dr Thirza Pieters, SAC Chair, Liaison Faculty

Dr Hannah Driver, PTC rep 2016-2017, Liaison Faculty

ROYAL COLLEGE OF PSYCHIATRISTS' FACULTY OF LIAISON ANNUAL CONFERNCE 2018 WILL BE IN LIVERPOOL on May 16 - May 18.

More details about the conference can be found on the Faculty Website.

https://www.rcpsych.ac.uk/traininpsychiatry/conferencestraining/conferencesandcourses/may16_liaison2018.aspx

Hope to see you at the confernce!