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From being different to making a difference: developing the role of clinical health psychological services in the public health arena

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CONTEXT STATEMENT

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Overview – mind and body



In developing a logo for the new Dental and Oral Therapy Psychology (DOT-P) Service I was drawn to an online image of the psi - the symbol¹ for psychology - found within the side view of two faces. I was moved by the image's ability to communicate a central theme of my ethos as a psychologist in the NHS: *that of the need to integrate body and psyche*. Physical health treatment is only one branch of the overall healing journey; a key component of my work described in these public works has been to incorporate and embed mental health support for patients experiencing physical health and traumatic conditions.

This logo has become the symbol of my journey through the Doctorate in Public Works. It has helped me, through a process of reflexivity, to step back and review the relevance and impact of my public works to the public domain. It has also guided me to a clearer understanding of my very personal motivations, dreams and disappointments which have all helped shape my standing today as a consultant clinical psychologist after twenty-two years of working in the NHS.

This context statement explores three areas of public works which I have instigated and developed in the NHS. I see all three not as discrete public works but interrelated, with a key aim to incorporate, foster and promote the emotional needs of patients, staff, and wider systems. A key aspect of achieving this has been to establish and nurture meaningful emotional encounters and relationships to support and help those in emotional distress, whether patients, colleagues, or teams.

¹ The symbol for psychology represents the twenty-third letter of the Greek alphabet, psi.

These three key parts are as follows. Part One is a reflection on my own personal and professional journey which includes the important timeline of my NHS career. Part Two is an in-depth exploration of the public works, and Part Three focuses on the impact of my public works in the public domain.

Given the organisational complexity of the NHS the reader is guided to the Appendices section where there is information relating to organisational charts, abbreviations and anonyms used in the NHS.

Abstract

Psychological therapists have a key role in providing care and transforming services in the NHS (National Health Service). I have always wanted to make a difference to those using, and working in, the NHS and from the onset of my professional career I have given the majority of my working life to working in public health settings. This context statement has given me the opportunity to step back and, with a reflexive stance, review the relevance and impact of my public works to the public domain. For Finlay (2013), reflexivity provides a window into the researcher's lived experience and through this collection of public works I will attempt to share with the reader my personal and deeply meaningful experiences related to my professional development.

I will provide a description and background to the three main public work projects I have undertaken related to expanding the role of psychology in physical health settings in the NHS. These are:

- The development of a regional Dental Psychology and Oral Trauma Psychology Service.
- The promotion of psychological mindedness and the psychological well-being of palliative care staff through the development of clinical discussion groups.
- The promotion of suicide risk assessment, management and training in palliative and end-of-life health settings.

I will then provide a more in-depth and critical analysis of the public works, making use of Leadbeater's (1997) concepts of effective entrepreneurship and leadership to demonstrate how I have made such an impact on my organisation and profession, and developed my own professional roles as a practitioner, manager and leader.

I will show how my public works have gone through a cycle of development (du Plock & Barber, 2015) in which I was able to successfully navigate through

different and challenging stages to achieve set goals and my growing vision for clinical health psychology in the NHS.

Part One: Personal and Professional Background

In Part One I will describe my personal and professional development as a clinical psychologist and psychotherapist working within the National Health Service (NHS)², and reflections arising from the writing of this context statement.

In evaluating my professional standing in the NHS, and within psychology and psychotherapy, I hope to provide evidence of how I have developed my career. I have developed from being an immigrant psychologist in 1999 who had never worked in the NHS before, to a British consultant clinical psychologist who now manages a fast growing Clinical Health Psychology Service, covering a vast area of London and Essex as well as having regional input to South East England. I will show how the projects that I have undertaken, and the publications and training I have provided, have helped to influence the promotion of psychology and psychotherapy in difficult to reach and unique patient groups, and in areas of key quality and safety for patients, carers, and staff alike. I therefore self-identify as a clinician and an organisational leader, qualities inherent in the profiles of Doctorate in Public Works students (du Plock & Barber, 2015).

1. My reflexive journey

‘Nonetheless, the questioning continued and somewhere I knew it was time to face my past that I had kept neatly locked inside for over a decade.’ (Kumar, 2017, p. 3026)

The Doctorate in Psychotherapy by Public Works (D. Psych) requires that the context statement be submitted as a ‘reflexive audit of the public works’ (Metanoia Institute, 2020). Reflexivity is a key aspect of qualitative research, with its practical foundation in phenomenology and hermeneutics (Walsh, 2003). As Langdridge notes:

² Due to the specific terminology found within NHS and medical settings, the reader is guided to the definitions section of Appendix 1

'Reflexivity literally means to bend back on oneself... and is described as the process in which researchers are conscious of and reflect about the ways in which their questions, methods and own subject position might impact on the psychological knowledge produced in a research study.' (Langdridge, 2007, p.58)

Hermeneutic phenomenologists³ argue that researchers cannot help but bring themselves into the research they undertake, they are an intrinsic part of their research, deeply influencing and being influenced by the research project (Finlay, 2012). For Finlay, reflexivity therefore provides a window onto the researcher's lived experience where inter-subjectivity is not only accepted but embraced (ibid).

Reflexivity as a hermeneutic methodology therefore follows a process of discovery, in which the implicit aspects and meaning of this lived experience need to be brought to awareness and made explicit (Finlay, 2012; Goble & Yin, 2014).

My journey leading up to and through the Doctorate in Public Works process has been a deeply personal and meaningful period of self-reflection. In this regard, it has brought illuminations of my own unresolved struggles, and the personal motivations which have driven my public works. This parallels my self-reflective stance in my role as a psychologist and psychotherapist, and in particular the value I have found in attending clinical supervision and my own personal psychotherapy.

Djuraskovic and Arthur (2010) note how any study based on personal experience requires revisiting past trauma, vulnerabilities, and unresolved issues. When I met with Dr King, my academic advisor, I mentioned how I felt I was re-discovering myself professionally and personally through this doctoral journey. Dr King provided me with insight into Moustakas' (1990) approach to heuristic enquiry, which emphasises the researcher's intimate personal connection to his or her work. This was an 'a-ha' experience for me as I recognised how unconsciously engaged I

³ Hermeneutic phenomenology is a qualitative research methodology that arose out of, and remains closely tied to, phenomenological philosophy (Goble & Yin, 2014)

had been, and how my own self has been re-awakened through this process of heuristic self-inquiry (Sela-Smith, 2002). Heuristic inquiry is a form of phenomenological and hermeneutic inquiry aimed at uncovering a phenomenon that arises from a deeply personal experience (Douglass & Moustakas, 1985) and has the power to transform the researcher (Moustakas, 1990). My personal experiences of tragedy and suffering have always been close to my heart, and my interest in psychoanalysis and work as a psychotherapist has encouraged me to constantly reflect and recognise my own self and history in my private and professional life. An essential component of psychoanalytic thinking is the awareness of the unconscious, and that motivations within the self may be driven by hidden, but powerful inner processes. The heuristic approach therefore fits well for me as, similar to psychoanalysis, it is focused on unravelling that which is covert and requires ‘digging deep’ to get to greater awareness and understanding. As Sela-Smith notes:

‘...the researcher, who is also the participant, engages in self-dialogue to get deeper into the personal question and remains open to intuition to connect with tacit knowledge, the root of the problem or inquiry’ (Sela-Smith, 2002, p. 53).

Douglass and Moustakas (1985, p. 49) similarly note that: *‘...this tacit knowing operates behind the scenes, giving birth to the hunches and vague, formless insights that characterize heuristic discovery.’* It leads to a process of indwelling, what Moustakas (1990, p. 24) terms the *‘heuristic process of turning inward to seek a deeper, more extended comprehension of the nature or meaning of a quality or theme of human experience.’*

Although I had awareness that my own personal history had intrinsically led to my interest in key areas of my public works, on reflection I can see how much of this I had approached on an intellectual level. I could begin to recognise that a part of me had remained cut-off from the full immersion into my inner self. I recall the evening after my initial interview at Metanoia Institute - I suddenly felt a deep sense of sadness and an intense and vivid awareness of my disfigurement. It was a feeling that I had not experienced for a long time, and it then dawned on me how my tenacity in not giving

up on the development of psychological support for the maxillofacial service was possibly related not only to my ambition as a strategic lead, but also to a deeper wish not to give up on myself, and on my own healing through this external process. Sela-Smith has posited in this respect that if the researcher is not completely immersed in the inquiry, it *'will lack integrity... and [the researcher] will not be able to live the question in his or her waking, sleeping and dreaming'* (Sela-Smith, 2002, p. 66).

I could now recognise that I was immersed in the project and that links and ideas that I had not previously considered were entering my awareness.

Moustakas (1990, p.63) outlined that the process of heuristic inquiry follows a systematic process of movement through six phases which require the researcher to *'remain internally focused and dwell within the feelings of the tacit dimension, allowing the six phases to unfold naturally by surrendering to the self-inquiry'*.

For Moustakas (1990, p.27), the beginning phase of heuristics is termed *Initial Engagement*, and its task is 'to discover an intense interest, a passionate concern that calls out to the researcher, one that holds important social meanings and personal, compelling implications'. As Djuraskovic and Arthur (2010, p.1577) note, during this phase, the researcher immerses into 'extensive self-exploration in order to discover the tacit knowledge and ultimately arrive to the research question'. My initial engagement and interest in the relationship between the body and mind began many years ago with my personal experience of being a craniofacial patient; it continued through my professional and personal life, where it was sparked during different periods of time. I felt compelled to continue exploring the area of integrated health, and this brought me into the second of Moustakas phases, *Immersion*. According to Moustakas (1990, p.28) the researcher becomes at one with and must live the research question. To be fully connected with the question, the researcher engages in 'spontaneous self-dialogue and self-searching, pursuing intuitive clues and hunches, and drawing from the mystery and sources of energy and knowledge within the tacit dimension'. As I was becoming rapidly immersed with the question of how our physical bodies can impact on our

emotional lives, I began a journey of reviewing my own self and the world around me. I noticed that being immersed with the question was often fraught with its own challenges: I could sense my own resistance at times, especially to staying so deeply connected to such personal material. It was a challenging process, as it brought to the fore many unresolved feelings and struggles. I felt as though I was living and breathing topics of deep personal meaning.

I noticed, however, that following this process of deep immersion, I began to explore areas outside of psychology and work. I invested in holidays and fell in love with the beauty of Greece and Spain. In retrospect, I can now see how this gave me a period of needed release from the intensity of the process of immersion in my research interests. It links closely to Moustakas third phase of heuristics, *Incubation*. During this phase, the researcher moves away from intense immersion with the question and becomes more detached from it. As Moustakas (1990, p.29) notes: ‘the period of incubation allows the inner workings of the tacit dimension and intuition to continue to clarify and extend understanding on levels outside the immediate awareness’.

This period seemed relatively short lived for me though, as the initial engagement phase was so deeply personal and meaningful; furthermore my continued work in the area, and close contact with others with similar conditions never truly separated me from the topic. I noticed that the period of incubation came to an end when I started working more intensely on the funding applications for NHS England. I became increasingly excited to explore and develop projects again, with a sense of focus and determination. It was as though the tacit, very deeply emotional experiences were now coming to the fore again and helping to shape my wider view of clinical health psychology.

Moustakas (1990) notes that as the researcher becomes more receptive to the tacit dimension of knowledge and intuition, the fourth *Illumination phase* unfolds. Djuraskovic and Arthur (2010, p.1578) discuss how this phase continues to allow for ‘mysterious workings of the tacit knowledge’ and that it involves a breakthrough, in which new and modified discoveries continue to unfold. I recognise that it was during this phase that my breakthrough occurred, with my decision to formally apply for the

Doctorate in Public Works. I began to discover and explore new interrelated themes related to my public works with excitement and enthusiasm.

This period was followed closely for me by the fifth phase of the heuristic enquiry, *Explication*. This phase refers to the process of deep examination and disclosure of themes and qualities that have surfaced during the illumination phase (Djuraskovic and Arthur, 2010; Moustakas, 1990). This was highlighted for me when I wrote the first draft of my context statement and submitted it for review. I began to see overarching connections and themes in my public works, and began to share these in the written form. It was deeply freeing and meaningful, as inner tactic workings seemed to now truly unfold and make sense as they were explicated in the written form. It was as though the wider, more panoramic view that Sela-Smith (2002) described in her works, was now becoming an exciting and overt reality through the context statement.

Sela-Smith (2002) notes that if the researcher has surrendered to the heuristic self-search, and the first five phases have naturally unfolded, Moustakas final phase of *Creative Synthesis* will spontaneously emerge. This phase was very meaningful and satisfying as it brought for me a deeper understanding of my projects in a synthesised form. I could now step back and see the more panoramic picture. For Moustakas (1990), this phase represents the final integration of the data and qualities and can be presented in many different forms (Moustakas, 1990). It was at this point that I felt ready to present my public works in its final and complete written form as the context statement.⁴

Moustakas' six phases of heuristic enquiry have been a deeply moving journey and creative process for me, which have culminated in my transformation, both personally and professionally.

⁴ Hiles (2001) has pointed out that there is in fact a seventh phase to Moustakas approach, which is often overlooked or taken for granted by other researchers. This is termed the *Validation* phase. For Hiles (2001), the Validation phase is two-fold, involving a process of self-validation as well as external validation.

1.1 Research methodology: towards a ‘mixed methods’ approach

It is important for me to contextualise my research within my wider ontological and epistemological⁵ world-view. Mertens has noted in this respect that, ‘...*a researcher’s philosophical orientation has implications for every decision made in the research process, including the choice of method*’ (Mertens, 2015, p.7). The most prominent of these philosophical orientations are generally described as objectivist/positivist and interpretivist/constructivist (ibid).⁶ Whereas the former is associated with quantitative research, the latter is related to qualitative research.

I have never felt that it is possible to produce the neutral and value-free information as required by a positivist approach and this, coupled with my belief in the value of subjectivity, has naturally drawn me more to the constructivist philosophies.

However, as I struggle with absolute truths, I have been less concerned about needing to take a ‘side’ in the philosophical debates about research paradigms. I have always believed that true reflexivity is about taking a critical stance to all information and considering a variety of alternatives. I have found the work of Maxwell (2011) helpful in this regard. Maxwell has cautioned on the risks of adopting a single ‘definite’ paradigm and has noted how ‘*we need multiple lenses to attain more valid, adequate, in-depth knowledge of the phenomena we study*’ (Maxwell, 2011, p. 9). He similarly notes how ‘*different situations and research problems may require different*

⁵ Ontology refers to beliefs about the fundamental nature of reality, whereas epistemology refers to how knowledge is obtained (Crotty, 1998). Both act as the foundations of our approach to a research question and range from positivist stances to interpretivist stances (Mertens, 2015).

⁶ From a Positivist/Objectivist perspective, knowledge is viewed as objective, generalizable and value-free where a researcher is able to distance self from research, whereas from an Interpretivist/Constructivist perspective knowledge is viewed as subjective, where a researcher immerses themselves fully in the process (Hanago, 2019).

*sets of assumptions and models, as well as different combinations of methods...*⁷ (ibid, p. 8).

This ‘multiple lenses’ approach has drawn me to identify more closely with a third paradigm documented in research, that of pragmatism⁸. Pragmatism as a research paradigm recognises that no single view of the world provides the full picture and there may be multiple realities (Saunders, Lewis, & Thornhill, 2012). Pragmatist researchers believe in a flexible and contextual approach to methodology, *‘rather than two opposing and mutually exclusive poles of either objectivity or subjectivity’* (Kausik & Walsh, 2019, p.6). They also choose their approach by how well that choice results in anticipated or desired outcomes (Tashakkori & Teddlie, 2008), and as Kausik and Walsh note, *‘...as a research paradigm, pragmatism orients itself toward solving practical problems in the real world’* (Kausik & Walsh, 2019, p.4).

The pragmatist paradigm supports researchers to find a methodological approach that works best for the particular research problem that is being investigated and lends itself well to a mixed methods approach (Morgan, 2007)⁹. Mixed methods is a research approach whereby researchers collect and analyse both quantitative and qualitative data within the same study (Shorten & Smith, 2017). This is done via a process termed mixed triangulation (Risjord, Moloney, & Dunbar, 2001; 2002). The aim is for the methods to build on each other and interlink, to gain a more comprehensive and enriched understanding of the research question (McEvoy & Richards, 2006). By diverging the results of different methods, its strength and accuracy is seen to be enhanced (Risjord *et al.*, 2001; 2002). For example, I have used

⁷ This interest in a multitude of models has also formed the basis of my psychotherapy training, where although predominantly interested in psychodynamic theory and therapy I have found it helpful to be trained in an integrative approach.

⁸ The philosophical foundations of pragmatism have their foundation in the work of scholars such as John Dewey (1859–1952).

⁹ The pragmatic paradigm has emerged as one of the underlying philosophical frameworks for some advocates of mixed methods research, although not all advocates of mixed methods identify their approach with the specific philosophy of pragmatism (Kausik & Walsh, 2009; Morgan, 2007).

qualitative methods such as open-ended interviews, to help to illuminate and expand on information provided in quantitative standardised questionnaires. Shorten and Smith note, in this respect, that mixing ‘...enables researchers to seek a more panoramic view of their research landscape, viewing phenomena from different viewpoints and through diverse research lenses’ (Shorten & Smith, 2017, p.70).

A mixed methods approach does have its limitations. Zhang & Creswell (2013) note that mixed methods research can, at times, lack a clear description of how the mixing, or integration, of the qualitative and quantitative elements was achieved. They also go on to report that health related studies in particular may lack an in-depth and detailed description of why specific mixed methods were considered (ibid).

Teddlie & Tashakkori (2003) discuss how a mixed methods approach requires expertise in designing and implementing both the qualitative and quantitative phases, and that this requires a researcher who is particularly experienced in both methodologies. Collins, Onwuegbuzie & Sutton (2006) note, in this respect, how a researcher with more of a qualitative orientation may find it more difficult to design the quantitative component of a mixed-methods study than a researcher with a more quantitative orientation, and vice versa. Moreover, the mixed method of research is often noted in critical review to be more time and resource consuming than any other method of research due to its duplicity content, which can create delays and financial challenges to the projects (Halcolm, 2018; Teddlie & Tashakkori, 2003).

Moustakas’ hermeneutic approach also has its specific limitations. Djuraskovic and Arthur (2010) describe a potential conflict within Moustakas approach; its greatest strength, i.e. the ability to allow the researcher to be a full participant in the study, can also be one of its greatest risks. The importance of the researchers subjective experience of the phenomenon in question, increases his/her bias to the study. It is difficult to step back from intuitive work that is so inherently linked to oneself (ibid). Moustakas’ internal frame of reference, as discussed by Djuraskovic & Arthur (2010)

and Sela-Smith (2002), can make it difficult for the researcher not to contaminate the results of the study with such personal involvement.

I noticed this in analysing the themes of some of my patient's experiences with craniofacial conditions; their stories resembled my own and in a way that made it challenging to always keep a boundary between myself and their experiences. Similarly, I can recognise that my enthusiasm and energy went into particular areas of clinical health psychology that were of deep personal meaning and relevance; it has left me wondering whether by doing this, I neglected other areas of clinical health psychology that might have benefitted from such intensive study and investment of time.

Another limitation is discussed by Sela-Smith (2002). She proposes that there is an ambivalence that is present in Moustakas' writings on heuristic inquiry, where he moves from the experience of his own self-search to the observation of an experience. She notes that unless the researcher acknowledges and can stay with the depth of pain in facing his or her own inner world, it can lead to resistance to the research process¹⁰. Sela-Smith (2002) formulated what she terms Heuristic Self-Search Inquiry (HSSI) as a response, and way to manage, what she sees as the limitations of Moustakas' method.

The limitations to the practicality of Moustakas' heuristic approach have also been noted (Djuraskovic & Arthur; Sela-Smith, 2002). The focus on the individual's uniqueness in the heuristic approach makes developing a set of criteria for co-participants, such as time commitments, a contraindication to the method. If research input from co-participants is to be authentic, Sela-Smith (2002) emphasises that it should follow the same principles that the researcher applies to his or her own work. Taking into account the limitations of the mixed methods and heuristic approach, it is my hope that this reflexive audit will enable me to obtain a more 'panoramic' view of my public works and their contribution to my organisation and profession.

¹⁰

1.2 Early influences

I was born with a craniofacial condition called *Microtia Atresia*, which resulted in the absence of an external ear, ear canal and unilateral complete hearing loss. I was a sensitive child, and I can remember feeling self-conscious from an early age. I stood out as being different and was treated differently. My hair was kept long to disguise my ear, which brought with it its own set of problems. Although my long hair hid my ear, it also signalled me out as looking unusual, especially for a boy. I also had difficulties with co-ordination and sensory-motor functioning which made me struggle with sports. Apartheid South Africa tended to follow strict gender roles, and masculinity was primarily associated with strength, ‘short back and sides’ hair, and robustness in physical activities. I began to get singled out for my long hair and my ‘softness’, which was framed as femininity and weakness.¹¹

Life was not easy for me as a child and I was subjected to constant bullying which continued into my mid-adolescence. My parents tried to shelter me as best as they could, but the potential for suffering in life hit me hard from an early age. I think that this made me turn to my inner world from early in life where I found comfort in books and my imagination. I remember having a rich inner life in which I rescued and helped those who were vulnerable and alone. I have been able to recognise through my own psychotherapy that I was also possibly trying to rescue my own vulnerable and lonely part, the outsider.

1.3 The outsider

Oliker (2012) notes how there can be a number of scenarios that result in an individual being caught in a state of ‘outsiderness’, such as a child who is physically and/or emotionally different to others. Social exclusion theory has developed from this perspective and describes the adverse impact of being marginalised and excluded from full participation in a variety of areas of life (Young, 2000). The need to belong is one

¹¹ There is a body of literature and research that is dedicated to the understanding of the impact of traditional gender roles and masculinity, such as the work of Bem (1981).

of the core human motivations and the experiences of exclusion and rejection in childhood can have powerful and long-lasting effects on emotional and physical development (Baumeister & Leary, 1995). Over the years I have been able to reflect on how my own experiences of being in the position of an ‘outsider’ have intrinsically shaped my self-image and life perspective.¹²

1.4 Healthcare and NHS journey

One of the most significant encounters in the healthcare service I experienced was as a patient, when I went for a prosthetic ear fitting at my local dental hospital in South Africa. I was seventeen and filled with hope that I could eventually have two ears. What I never expected was the degree of emotion I would feel as I sat in the clinic chair having the examination for the suitability for the procedure. I remember the kindness of the clinician as he explained the limitations of the procedure. My ear had been reconstructed too much for the prosthetic ear to fit properly. I was left devastated. I began to cry, as I realised that my hope to look ‘normal’ had again been dashed.

The clinician did something important for me; he did not avoid my tears but sat with me and listened as I shared with him my feelings, worries and my broken dreams. Although the prosthetic ear could never be fitted, what did last from this encounter thirty-five years ago was my impression of how supported I felt by that one clinician in a hospital full of strangers in white gowns. It made me feel less alone in that moment of suffering, and I became aware of the powerful potential of a compassionate and therapeutic encounter.

Brant (1994) succinctly describes how in listening to another’s past, we become witness to it, we walk with a person through their pain, reducing their sense of isolation. There was no psychological support retrieved from this dental school, but

¹² I will be looking in more depth at the impact of my disfigurement and social exclusion in Part Two, in relation to my interest in developing the maxillofacial service.

I did have someone to listen to me and that made the world of difference. I do realise, however, that I also needed something beyond that compassionate encounter. The prosthetics fitting had stirred so much unresolved pain, and as much as my ear needed to be ‘fixed’ so did my emotional life. There was nothing available within the specialist route of psychological interventions for appearance-related distress, and this is something that I can remember as a key experience which stirred my interest in researching psychological support for craniofacial conditions.

1.5 My professional NHS journey: an introduction to my timeline (see Appendix 2)

I qualified as a clinical psychologist when I was twenty-five and began to work in a public health setting in South Africa. Since moving to England I have worked in the same NHS Trust for over two decades. I started by working on the Psychiatric Intensive Care Unit (PICU) part-time, whilst setting up community mental health psychology clinics for patients discharged from acute mental health services. My initial contribution in psychology was to bring psychological practice more to the fore in acute psychiatric settings. From this early onset I was already working in a less common area of psychology.

At this time, acute inpatient mental health units often had a predominantly medical model approach, with sparse and limited psychological input. I could see the unmet needs of patients who found themselves involuntarily committed to hospital with a predominant model of medication and physical containment. I was lucky to join a PICU part-time where the clinical lead, a psychiatrist, was focused on innovative practice and encouraged me to broaden the view and treatment of detained patients to include crucial psychosocial factors.

I was one of the first UK clinical psychologists to be appointed as an executive member of the National Association of Psychiatric Intensive Care Units (NAPICU), and was afforded the opportunity to present at local and national conferences on the role of psychology in PICU settings. I was invited by Cambridge University Press to

write a chapter on psychological care in the first PICU textbook and have now written in three editions. While developing the role of psychology on the PICU I noticed that some other acute wards continued to treat ‘medical symptoms’ rather than emotional distress. I recognised that a key component of my role as a psychologist was therefore not only to work clinically, but it was also *to help change organisational practice* and, in particular, how mental health was viewed on a wider, systemic level in the NHS.

As part of my role as lead psychologist on a PICU I spent time working on the psychological aspects of risk management. I had discussions with members of the North East London Foundation Trust (NELFT) Risk Assurance Group, and it became apparent that there was no clinical group overseeing the cases of suicide in the Trust. In 2010, I agreed to assist in the development of such a group, termed the Clinical Risk Advisory Group (CRAG). This group was made up of a multidisciplinary team of clinicians and was the first to be chaired by a psychologist. The key purpose of the group was to overview suicides reported to the Trust, and to capture clinical themes and trends that emerged (Kingsley, 2010). I chaired the CRAG successfully for three years, and during this period important developments occurred in my professional career. I began to give more extensive presentations on the risks of suicide and was invited to be a member of the NHS National Patient Safety Agency (NPSA) in developing suicide prevention toolkits. I was also invited to form part of a working group set up by Dr Richard Graham at the Tavistock and Portman NHS Trust to assess digital/ online risks of suicide, and was approached by NELFT to develop a Clinical Risk Policy for the Trust.

1.6 A step forward: an introduction to a maxillofacial service

From the onset of my role in acute psychiatric settings I was interested in a more holistic view of patients and health treatment, including the co-existing relationship between the body and psyche. My own physical health condition and being a carer of loved ones with physical illnesses helped shape my interest in the specialist area of clinical health psychology. This area of psychology is directly interested in how physical illness and mental health are closely intertwined and need

to be considered equally in the treatment of health conditions (British Psychological Society, 2020).

My interest in clinical health psychology resurfaced after I underwent further reconstructive surgery to my ear, this time in the UK and through the NHS in 2004. Although the physical result of the surgery was of a high standard, I found the emotional component to my treatment to be extremely poor, especially my treatment by the surgeon. I now had two quite opposing experiences of treatment - my experience in adolescence of being cared for and understood during the prosthetics screening, and my experience of being treated like an object during the later surgery. It was this latter experience that gave me the impetus to explore what was available psychologically for patients with craniofacial conditions in North East London.

It was at this time that I contacted Whipps Cross Hospital and was directed to the lead maxillofacial consultant surgeon, Mr Nayeem Ali. I contacted him by phone and was excited to hear that he was passionate about expanding the psychological care of his patients. We met several times and enthusiastically shared ideas. Mr Ali introduced me to the area of orthognathics¹³ which made up the predominant group of patients in this service and although we came from different professional backgrounds we both shared a vision - to create and develop psychology in the maxillofacial service. It was the beginning of a long journey with many challenges, hopes and disappointments, in which we persevered with our shared goal. As Mr Ali has noted:

'It was serendipity then that Marc Kingsley walked into my department one afternoon. Marc explained his role as a clinical psychologist and also his interest in how this can be applied to the face and patients undergoing facial surgery. We found we were immediately on the same page. After arranging an honorary contract Marc started coming to my clinics to better understand the journey and experiences of orthognathic patients. Psychological support services for this patient group was

¹³ Orthognathic surgery is a specialist branch of oral and maxillofacial surgery / orthodontics. It involves modification and re-alignment of the jaw area for functional and aesthetic improvement (Kingsley, Royan & Taylor, 2015).

scarce enough, but our model brought all parties together in an MDT format which I believe was unique, certainly at that time.’ (See Appendix 6).

Attending the weekly maxillofacial service was a significant milestone in my professional and personal life. I found it riveting to be working in an area of such interest, even if only once a week, and embraced this with enthusiasm. I sought out experts in the area of craniofacial conditions and managed to meet up with James Partridge, the founder and chief executive of *Changing Faces*¹⁴. I was introduced to the *Changing Faces* model of psychosocial management which not only provided specialist psychological interventions for people with facial disfigurements, but also challenged societal interpretations of ‘normality’ and attractiveness. I also formed links with and visited the Centre of Appearance Related Research (CARR) at the University of West England and attended conferences specific to appearance-related distress.

I noticed however that during this time my mood had become lower, and my own self-consciousness about my ear seemed even more apparent. I can recognise in retrospect that this intellectual pursuit had triggered deeply personal experiences, and I was embarking on a journey to self-discovery as outlined by heuristic reflexivity (Kumar, 2017; Moustakas, 1990). As Moustakas notes in this respect:

‘All heuristic inquiry begins with the internal search to discover, a passionate desire to know, a devotion and commitment to pursue a question that is strongly connected to one’s own identity and selfhood’ (Moustakas, 1990, p.15).

I became aware of the emotional responses I was experiencing when attending the maxillofacial clinic. For example, I can remember my first invitation to join an outpatient’s clinic. I stood in a sterile, white room with a bright light facing onto a young patient who was lying on a dental chair. The orthodontist and oral surgeon were

¹⁴ *Changing Faces* is a leading UK charity devoted to the support of patients with a diverse range of facial disfigurements.

in loud, animated conversation about the patient's jaw occlusion, whilst using instruments to look inside her mouth. They overtly described the severity of her 'deformity', bringing in students to look. I later spoke with the patient who was able to share with me how self-conscious she had felt during this encounter, and how her underlying negative beliefs about her face had been brought to the fore.

It struck me how the patient's experience of hearing the word 'deformity' in front of a whole group of strangers had not been considered by the clinicians, or of how being viewed in such a clinical manner, with strangers staring at her, could have contributed and reinforced any deeply held beliefs that she held about being different or 'deformed'. This encounter also made me aware of how I felt when people looked at my disfigurement, and how there had been times when I felt similarly to the patient in the chair. It was unsettling and painful but helped me to recognise how much work needed to still be done within myself and externally in changing practice.

1.7 A turning point: redundancy and appointment as Care Pathway Lead for Clinical Health Psychological Services

In 2012 I was unexpectedly made redundant. It was a stressful period and coincided with a deterioration in my sister's physical health to that of an end-of-life diagnosis. During this period, a job became available as the Care Pathway Lead for Clinical Health Psychology for NELFT. This was a big move for me to consider - although I was already involved in working within physical health settings, the extent until now had been minimal. At this stage in my career I had no experience of setting up and running an independent service. I had never managed staff, nor considered writing business cases. I was also suffering as I watched my sister's health deteriorate and wondered if I would have the resilience to face patients with similar conditions. I remember my interview for the clinical health Care Pathway Lead well, as one of the first questions I was asked was how I was going to try and develop more psychological services with commissioners! I knew I had a survival instinct and passion, and with these two qualities I hoped that I could venture into this new area of clinical work and period of my life. I did get the job and have been working in this role since 2013.

I gained a further promotion in 2019, to that of Strategic and Clinical Lead for Clinical Health Psychological Services (CHPS) at NELFT. I line-manage and clinically supervise 16 members of staff. These are all psychological practitioners and include clinical and counselling psychologists, psychotherapists, and counsellors. I also help co-ordinate the trainee/ student programmes for our service and have encouraged the development of trainee placements for counsellors and psychotherapists within NHS settings. This has included developing a training link with Metanoia Institute, North Thames clinical psychology doctorate courses, and the University of Hertfordshire.

I am responsible for the strategic development of the service, including the expansion of clinical health psychological services to traditionally poorly-represented medical areas. This means that I often write up business cases (which in themselves can be a large piece of work, including literature reviews and financial budgets) in order to try and support the development of psychological posts. I work closely with commissioning groups including NHS England (NHSE) and have provided several presentations and workshops on the value of psychological therapy for patients within acute hospitals and community health settings. I am a budget holder for my service - a big responsibility in that future psychological development and jobs are often discussed with me on a regular basis. This is especially challenging in periods where the NHS has determined to make 'efficient savings'.

1.8 A re-introduction to the Orthognathics Service and dental psychology

As a key component of my new role as the Clinical Health Psychology Lead was to expand psychological cover into physical health settings, I had an opportunity to re-connect with my colleagues in the Orthognathics Service at Whipps Cross Hospital. In Part Two, I will demonstrate in more detail how this reconnection led to a pilot study, which eventually resulted in the development of a fully-funded NHSE commissioned service for orthognathics and the broader dental psychology service,

1.9 An introduction to working with palliative and end-of-life cases

My professional exposure to palliative care¹⁵ and end-of-life work happened quite quickly. Within a month of commencing my new role in clinical health psychology I was introduced to the oncology and haematology team in a busy hospital and began to take on a small caseload. From the onset it became apparent to me that working so closely with death and dying would have a significant impact on my professional and personal life. I found myself exposed to unyielding suffering; the whole experience felt quite overwhelming at times as I had just recently witnessed my sister's passing from a palliative condition. It had been devastating to witness her decline, and even more difficult for me not to provide a solution or offer her the hope she so desperately needed.

I was now in a parallel position as a therapist on an oncology ward with patients and their families approaching me. The helplessness and suffering felt tangible, both around and within me. The despair that patients brought to me was heart-breaking, examples included those of a young lady who was not ready to give up on her life as she desperately wanted to experience love; and a mother with advanced cancer who carried on fighting as she did not want to leave her daughter who suffered easily from life's difficulties. I soon realised that therapy in the area of palliative care and end-of-life was often different to other areas of mental health. I could not challenge some of the beliefs or anxieties brought to me, or offer solutions - they were real, brutal, and frightening.

Literature on the experiences of clinicians and especially therapists working within palliative and end-of-life care remains limited. However there is a recognition of the helplessness and resurfacing of personal suffering and loss that may be evoked at any time when treating and managing dying patients and their families (Katz,

¹⁵ Palliative care involves active holistic care of people that live with an advanced and progressive illness and approach end-of-life. (Dacre *et al.*, 2015).

Johnson, & Neimeyer, 2016; Meier & Beresford, 2006; Wenzel, Shaha, Klimmek, & Krumm, 2011). The inevitability of my own past, and especially that of facing my own personal history of tragedy and suffering came to the surface with a greater intensity once I started in this new role. I found myself thinking not only of my sister's recent death, but also of my earlier experiences of witnessing my father's, and later my mother's, suffering, deterioration, and death. Memories flooded back to me. I could see similarities in my clinical work with my own journey as a son and brother in facing the inevitability of the ending and loss of precious relationships, and the helplessness and anguish felt in the face of this suffering. What hit me, as it did so many of my patients and their families, was the unfairness of it all and the degree of randomness with which suffering occurred. There are still many times when I find it incredibly painful to sit with patients and their families, with little I can offer to remove their suffering. One of the most challenging aspects of working within life-limiting services has been described as this dilemma facing clinicians: the move from providing cure/recovery to accepting that all that can be provided is symptom management (Desbiens & Fillion, 2007; Katz *et al.*, 2016; Wenzel *et al.*, 2011).

In this regard, I have found Yalom's (2008) work helpful, especially his recognition of how death anxiety can often stir significant discomfort in all who work in the area - staff, patients, and their families. He describes the importance of providing support but without falling into the potential risk of aligning with the patients' avoidance or denial of the reality of death. This is still something I constantly monitor and now train staff in, especially the nudge within us as helpers to provide reassurance during periods when the inevitability of suffering and dying is at the surface and cannot be avoided.

It was an important yet challenging professional and personal time for me. I had always striven to be emotionally in touch with my patients, but I was now concerned about becoming cut-off due to the painful nature of the presenting cases. It became a key aspect of my work to learn to sit within the therapeutic space, and not to respond too quickly when feeling an overwhelming urge to do so, or to find myself disassociating when the material was too painful, or close to home. Katz *et al.* (2016)

in their ground-breaking book '*When Therapists Weep*' have eloquently described this vital yet often overlooked need for therapists who work in palliative care to come to terms with their own histories of loss and suffering, as it is re-evoked in the work around them.

I recognised the vital importance of managing my own countertransference in order to help me to avoid forming barriers to emotionally connecting with those who were facing the end of their lives. I had to face my own painful memories and feelings that this work evoked, as much as I now realised a part of me continued to try and avoid facing this reality. It was not negotiable, as I was soon to see the inevitable damage caused to staff in repressing their own grief (Duarte & Pinto-Gouveia, 2017; Gallagher, 2010; Oh & Gastmans, 2015; Rafferty, 2000). I could not avoid facing ongoing loss, as many of my patients were at the end of life. I had a task ahead of continuously working on my past and current losses and the recognition that exposure to such insurmountable suffering could adversely affect my own well-being (Hill Jones, 2005; Katz *et al.*, 2016; Keidal, 2002; Rafferty, 2000).

1.10 Training opportunity with William Breitbart: Meaning Centred Therapy

The suffering evoked in palliative and end-of-life is often tangible. In Yalom's (2008) words it can bring with it a despondency and despair that can be 'contagious' for both patients and clinicians alike. Yalom describes the vital need for patients and staff to attempt to find some form of meaning in all this tragedy, and his accounts from the groups he ran on oncology wards give profound examples of discovering meaning, even at the very end of patients' lives. This description of the role of meaning in death and dying struck a chord with me, and I began to read more widely on the role of meaning as a therapeutic and human response to the inevitability of suffering. I was still in the midst of grief myself having lost my sister in the prime of her life. I found myself questioning the point of life in the face of such suffering and adversity. In retrospect, I can now see how much of my deeper self was searching for similar answers to the questions patients, colleagues and supervisees had so often asked me

since I started in clinical health psychology: *Can a purpose be found to all this needless suffering and pain?*

I came across the work of Dr William Breitbart, a psychiatrist based at Memorial Sloan-Kettering Cancer Centre Hospital in New York City. Breitbart pioneered the development of an innovative psychotherapeutic intervention to address issues such as hopelessness, loss of meaning, and despair in patients with advanced illness (Breitbart & Poppitto, 2014). This resulted in the development of an evidence-based individual and group centred psychological intervention, Meaning-Centred Psychotherapy (MCT). This has been rigorously tested and shown to be highly effective in helping patients to find renewed purpose and a reduction of anxiety and depression symptoms at the end of life. The theoretical underpinnings of this treatment model are based on the work of the Auschwitz concentration camp survivor Viktor Frankl, a psychiatrist who conceptualised logotherapy, or meaning-based psychotherapy (Wong, 2007).

After reading more of Dr Breitbart's pioneering work I contacted him in 2013 to introduce myself and the NELFT clinical health psychology service and made enquiries about the training requirements to introduce MCT into our service. Dr Breitbart notified me that his training centre had just received a research training grant from the National Cancer Institute to do a two-day intensive training course in MCT and asked if I would be interested in attending this training. In order to provide MCT in the UK it was imperative that I undertook this training myself. I was fortunate to have funding approved by NELFT for myself and a colleague to attend this training in 2018. The training has enabled our team to implement individual and group MCT therapy within our oncology service.

Whilst undertaking this training in New York City, I found myself considering how I could eventually make use of meaning-centred principles not only with patients but with staff working in this field. It was a rewarding training which infused me with new ideas and a sense of focus for my clinical work and supervision. Holland and Niemeyer (2005) have noted in this respect how health professionals may cope more

effectively with repeated exposure to trauma and death-related situations when they find ways to understand and consolidate their experiences into broader meaning structures. Similarly, Desbiens and Fillion (2007) looked at the coping strategies of palliative care nurses, and found that those nurses who were able to embed meaning-making strategies into the suffering they witnessed reported lower levels of emotional distress and higher quality of life than those who employed strategies such as disengagement and avoidance.

1.11 Setting up community clinical discussion groups for staff in palliative care and end-of-life settings

When I joined the psycho-oncology service at NELFT I was invited to become a member of the Expert Reference Group (ERG) for London Cancer Alliance (LCA)¹⁶. The group introduced me to the Level 2 model, a four-tier stepped model of evidence-based psychological care for cancer patients (National Institute of Clinical Excellence (NICE), 2004).¹⁷

In our local acute hospital setting the Level 2 model had already been established by my predecessor and it was now my role to ensure that the training and supervision of Cancer Nurse Specialists (CNS) continued. It has proven to be a valuable forum, and the analysis of the results of the feedback from Level 2 groups has so far confirmed that acute hospital CNS's find this forum to be helpful (London Cancer Alliance, 2019). It became apparent to me that, with enough operational and managerial support nurses could be provided with a vital forum to manage the complex emotional caseloads associated with oncology services.

¹⁶ Cancer Alliances bring together clinical and managerial leaders from different hospital trusts and other health and social care organisations, to transform the diagnosis, treatment, and care for cancer patients in their local area (London Cancer Alliance, 2014).

¹⁷ The Level 2 model describes levels of psychosocial care from Level 1 (all clinical and non-clinical staff) to Level 4 (mental health specialist). Cancer Nurse Specialists (CNS) and allied health professionals can be trained to provide Level 2 psychological interventions once they have completed a training day and attended once-monthly group supervision with a psychological therapist (London Cancer Alliance, 2014).

Soon after I began to provide Level 2 supervision to a group of acute hospital CNS's, I began to hear first-hand accounts of the many challenges of working with palliative and end-of-life cases. Quite early in my new role I was approached by a nurse who was working in the community with a mutual patient who had been recently readmitted to hospital. I became aware of the struggles that this community nurse faced in managing the complexity of the case and was concerned to hear that she had no available psychological supervision or support as she was employed by community, rather than acute, health services. I began to investigate the support available to nurses working in the community, and those supporting not only oncology, but other non-malignant palliative conditions such as heart failure and motor neurone disease. It became apparent that none of the palliative care community nurses I approached had any form of psychological supervision or support. This finding is in line with the wider literature which confirms that little is available in terms of psychological support for community nurses working within palliative and end-of-life settings in the UK¹⁸ (Kingsley, Ma, & Hussain, in press; Martin, Lizarondo, Kumar, & Snowdon, 2020; Medland, Howard-Ruben, & Whitaker, 2004; Palsson, Hallberg, Norberg & Isovaara, 1994; Rokach, 2005). Aycock and Boyle (2009) note this dilemma when they describe how community-based clinicians are expected to provide highly effective care to patients and families in emotionally-fraught settings, but often without receiving formal psychological supervision or training.

During this period I had rewarding meetings with the palliative care teams and their managers. Two of the key managers I approached had a background in palliative care nursing and had first-hand experiences of working in a stressful clinical environment. They showed an interest and eagerness to incorporate psychological support for their teams. I was introduced to the community palliative care multidisciplinary teams, which included medical doctors and allied health professionals (AHPs) such as dietitians, occupational therapists, speech and language

¹⁸ One key difference is found in hospices, where psychotherapeutic support is often more readily available for staff.

therapists, and social workers. The medical team had their clinical supervision in place. However, very few of the AHPs and none of the nurses had any clinical supervision, and many showed an enthusiastic interest to join a psychologically-led supervision group.

The challenges for palliative care teams to manage such levels of mental health complexity became apparent to me. With long waiting lists for generic psychology services, and no commissioned community-based clinical health psychology input for these patients and their families in North East London, the community teams found themselves offering psychological support on an almost daily basis. I was concerned about the risks to staff in carrying such heavy caseloads without adequate support and supervision. There was recognition by the palliative care teams that managerial supervision was different to that of clinical supervision. The clinicians I liaised with acknowledged that they did not feel they could express their vulnerability to the managers who were undertaking their staff performance and annual appraisals¹⁹. Managers similarly recognised that there was necessity for their staff to have access to clinical supervision provided by specialists in this area, due to the complexity of the material evoked in supervision (Allan, McLuckie, & Hoffercker, 2017; Blume-Marcovici, Stolberg, Khademi, & Giromini, 2015; Snowden, Leggat, & Taylor, 2017; Wilson, Davies, & Weatherhead, 2016).

I was invested in setting up some form of clinical supervision and support for these teams and was backed by palliative and end-of-life national guidelines which recommended staff support and reflective space for all clinicians working in these settings (Hunter, 2018; National Palliative and End-of-Life Care Partnership, 2015; West, 2019).

¹⁹ This sentiment would later be confirmed when I started running clinical discussion/supervision groups, where one of the most important findings was that participants appreciated the confidentiality of the groups and the freedom to speak openly without concerns about its impact on how they were perceived by management.

I was also backed by a national development for expanding supervision in the NHS workplace in a range of professional groups, including nurses and allied health professionals. As Health Education England (HEE) (2020) note, the supervision of healthcare practitioners through their training and beyond is the cornerstone of both professional and public safety. The Health Care Professions Council (HCPC) (2020) has similarly noted in an important report that workplace supervision, whether clinical or peer led, is integral to safe and effective healthcare systems, and that many professionals report difficulties in the context of traditional managerial supervision.

There is a large amount of theoretical and research literature on the topic of effective clinical and peer supervision in the workplace. (Allan, McLuckie, & Hoffeecker, 2017; Milne, 2009; Proctor, 2008; Rothwell, Kehoe, Farrook, & Illing, 2019; Wallbank, 2010; Wallbank, 2013). Clinical and peer supervision are seen to benefit the work-based clinician in many ways, such as by increasing self-awareness, confidence and knowledge, as well as helping to reduce the impact of emotional stress in the workplace (Bajad, Gaikwad, Spearpoint & Srivastava, 2019; Rothwell, Kehoe, Farrook, & Illing, 2019). An excellent summary commissioned for the HCPC by Newcastle University (Rothwell, Kehoe, Farrook, & Illing, 2019), for example, points to the effectiveness of a high quality supervisory relationship. In particular, the importance of an open and emotionally safe and trusting environment has been documented in many studies, where supervisees feel comfortable to reflect on their practice with their supervisor and/or peers (*ibid*). As McMahon (2020) has noted, supervising professional peers requires significant relational awareness and skill.

McMahon (2014, p.333) has noted, that with the growing evidence of the efficacy of the supervisory relationship, a ‘more detailed consideration’ is required regarding the supervisors engagement in the supervisory relationship.²⁰ She has presented ‘four guiding principles’ for the supervisory relationship, which include offering emotional presence and sensitivity; valuing both vulnerability and

²⁰ McMahon has noted that although supervisees are positive about the value of a good supervision relationship for their work, there is a dearth of clear research evidence to connect the supervisory relationship to client outcomes.

competence; offering knowledge and experience with humility and developing a relationship to support continued personal and professional growth (McMahon, 2014, p.333). Humility has been proposed by McMahon (2020, p.178) to be ‘a foundational quality underpinning good supervision practice’, and ‘...the central features of humility – a modest appreciation of our limits, a focus on the other, and an openness to learning –offer a valuable foundation for relationally sensitive supervision.’

Researchers to date have found that humility is associated with many positive qualities and outcomes (McMahon, 2020), and research into the specifics of humility in supervision has developed substantially (McMahon, 2020; Watkins, 2020; Watkins, Hook, Ramaeker & Ramos, 2016; Watkins, Hook, Mosher & Callahan, 2019; Worthington & Allison, 2018). McMahon (2020) illustrates five touchstones to foster supervisor humility, which can significantly impact on the quality of the supervisory work and relationships: our personal experiences, unconscious interpersonal dynamics, developmental dynamics, power imbalances, and our relationship to our own limits (ibid).

A further key area to good supervision practice that has been outlined recently is that of working from a multicultural model (Jones and Branco, 2020). Jones and Branco (2020) emphasise that a heightened multicultural understanding and informed multicultural action in supervision is vital for the effectiveness of supervision, and they have recently developed a model to describe the tenets of multicultural supervision: cultural humility, broaching in counselling, and multicultural orientation work as a whole for clinical supervisors.

Furthermore, there have been important work-based supervision models that have developed with good research outcomes. Milne (2009) has stressed the importance of such models incorporating an evidence-base and his evidence-based model for clinical supervision (EBCS) is now widely utilised and is particularly influential in the UK, where it has been incorporated within the IAPT (Improving Access to Psychological Therapies) initiative (Reiser, 2020).

Many allied health professions have also adopted Proctor's model of clinical supervision to guide them in their clinical supervision practice (Dawson, Phillips & Leggat, 2013). Proctor's model of clinical supervision is beneficial in that it describes how health professionals can be supported in different domains of practice: formative, restorative and normative (Proctor, 2008). The formative domain refers to the development of skills that are specific to the health professional's role; the restorative domain refers to supporting the professional through the emotional burden of their professional role; and the normative domain refers to the health professional's compliance with standards of care and organisational policy and procedures (Ibid).

Wallbank (2010; 2013) has also developed an effective model of restorative supervision and resilience training, which has been pioneered with maternity staff, and used in various other health settings with good outcomes. Wallbank (2013) notes that supervision in this context is not a method of managing the content of staff work, but one to specifically support clinicians with the emotional demands of the role, such as risk of burn-out, and compassion fatigue.²¹

With many important models of workplace supervision in mind, I decided to introduce the Level 2 model of group supervision to the community palliative care teams. As noted previously, Level 2 groups were already set up in our NELFT Clinical Health Psychology service providing group based supervision to acute hospital oncology sites, and have a good evidence base in acute settings (LCA, 2014). I had already been trained in this model, and had read of its efficacy with life-limiting conditions, such as cancer (LCA, 2014). I was aware of the need to ensure that the key factors described in wider supervision research were regularly considered and reviewed in the Level 2 model of group supervision. This included, amongst others, the role of the supervisory relationship, as well as the impact of factors such as humility, power imbalances and cultural sensitivity on the supervisory experience.

²¹ Wallbank's supervision training programme has now been delivered to many NHS trusts across the UK and has been recommended by the Department of Health service level agreement to strategic health authorities. Results from the programme show positive change in clinicians (Wallbank, 2013).

There was, however, little in the way of an evidence-base to guide my development of these supervision groups in such a specific area of community palliative care, as Level 2 staff groups were generally offered in acute hospital settings and little was known of the impact of these groups in community settings (Hussain, Kingsley, & Phil-Eboise, 2016). This was one of the key reasons that I developed these groups initially as a pilot study, to consider and assess their efficacy and suitability for community practitioners.

With the approval of the London Cancer Expert Reference Group, I expanded this Level 2 cancer model into community palliative care settings, which supported a wider range of patients with both malignant (cancer) and non-malignant (e.g. heart failure) end-of-life conditions. I also wanted to open the group to multidisciplinary team members rather than solely to clinical nurse specialists.

On reflection, I can see that it took persuasion on my part to get agreement from London Cancer Alliance and NELFT to expand these groups into community settings in the face of little available national evidence. I believe that my ability to achieve this is in part linked to my communication style and connection with others. I try to find ways of conveying my interests and ideas to others that are not prescriptive, but more about reaching and building shared beliefs and goals. It needs to feel that the project is shared and owned by all, rather than my individually motivated interest.

With the go ahead from the teams and my manager, I set up two pilot community Level 2 groups with Macmillan teams. I received a positive welcome from the clinicians who joined the Level 2 groups and managed to get three of my psychology colleagues to run groups alongside mine. It soon became apparent that the experiences we heard in supervision groups in acute hospital settings were mirrored in the community. To add to this, community clinicians were often left to manage exceedingly high caseloads of terminally-ill patients who, unlike acute patients, were predominantly based at home and often surrounded by their families. The families often presented with their own grief and trauma responses. There were also a number of cases brought to supervision which involved suicide risk, and risk management became a popular aspect of the training and supervision.

I have found running the Level 2 supervision groups in the community a rewarding and ground-breaking experience, and I will discuss this project in more detail in the next two chapters.

1.12 Summary

In this chapter, I have focused on a reflection of the personal and professional background to my development as a clinical psychologist and psychotherapist working within the NHS. It is to the particular public works which make up the basis of the doctoral study, to which I now turn.

Part Two: Public Works

‘One of the most extraordinary characteristics of humans as a species is our capacity to innovate in response to challenges. But the right conditions have to be in place for innovation to bubble up.’

(West, 2017, Web log)

I will now focus on the following three areas and innovative projects I have undertaken related to expanding the role of clinical health psychology in the NHS. This chapter will describe the content and rationale for each of the public works.

2.1 Public Works 1: The development of the Dental and Oral Trauma Psychology Service

The first of my public works to be discussed is my role in the development of the Dental and Oral Trauma Psychology (DOT-P) Service, which commenced as a special interest day in 2004 and culminated in a fully-funded NHS England service in 2019.²²

As the context statement requires me to consider the last five years of my public works I will focus on the development of the dental psychology project from the period of ‘renewed hope’ in 2017, through to the commencement of the fully-funded service in 2020. Prior to this discussion, however, I will outline key themes that I see as important to consider in the contextual development of the service up to 2017.

(i) The right conditions for innovative work to take place

West (2019) notes that the *right conditions need to be in place* for any innovative work project to take place. In reflecting on the unique factors in play in helping the dental psychology service to emerge and develop, I believe the

²² The timeline in Appendix 3a indicates key events that helped shape the service development

combination of managerial support, my own inner drive to succeed, and the psychological openness of the team helped sustain this long term goal.

I was fortunate to have had two psychology managers and a healthcare Trust which supported and nurtured my interest in undertaking clinical work in dental psychology services throughout a long period (in 2004 and again from 2013). This, together with my own determination and enthusiasm, enabled me to develop and expand the vision of a dental psychology service into a practical project. I was also fortunate to be introduced to a dental team who showed openness and willingness *to incorporate a psychological perspective* into their clinical practice. This is not something I had always found in my work within multidisciplinary teams, and it was a vital component to developing the dental psychological project. What struck me was that the maxillofacial surgeons who demonstrated remarkable abilities to alter and heal faces were willing to acknowledge that they often felt helpless in the face of patients' emotional distress. There was a team interest to improve the holistic care of their patients, and this was a key driving force that kept this project going.

The third factor was my own inner drive to succeed, a combination of what I consider to be enthusiasm and tenacity. I had discovered this inner drive at an early age, and it helped me to manage uncertainty and disappointments throughout my life. It was something that I fell back on when I was on the brink of giving up, and at times the dental psychology project did indeed feel fragile and unfathomable.

(ii) Developing and nurturing working relationships - a shared vision

Developing and nurturing solid working relationships within the maxillofacial/orthognathics team was another vital factor in the historical development of the dental psychology service. The timeline (**Appendix 3a**) shows how at times the psychology input was compromised and significant uncertainty prevailed. By maintaining a link with the orthognathics team over many years and developing a shared vision for a psychology service I hoped to keep the project alive. The continuity of these key professional relationships was helpful as when the opportunity to develop

a pilot psychology study presented itself in 2013, the key professional relationships had already been build and strengthened.

(iii) Ethical dimensions

It was through meeting with the *Changing Faces* charity when I commenced my special interest day in 2004 that I was introduced to an important ethical dimension to my work. The *Changing Faces* model not only provides specialist psychosocial interventions for people with facial disfigurements, but it also challenges societal interpretations of ‘normality’ and responses to disability and body difference. I first encountered the concept of the disabled as a socially oppressed minority group when I undertook a research project on the Disabled Students Union for my sociology degree as an undergraduate student. Now, having met with *Changing Faces* I was again introduced to a broader debate about disfigurement and the risks of prejudice and oppression of a specific group of people - the physically disabled (Watermeyer, 2009).

Within the UK health system, care for people with disfigurements is generally constructed around biomedical procedures designed to normalise appearance. This falls in line with the predominant focus of modern medicine on ‘correcting’ structural or functional difference or defects within the body (Gabriel, 2015; Skogstad, 1997; Watermeyer, 2009).

Gabriel (2015) has noted that implicit in this approach is the assumption that a person’s quality of life will improve if their looks or their body are altered. Watermeyer (2009) has noted that this could be viewed as an invisible form of social oppression by society, including the clinicians who are set to ‘normalise’ disabled bodies.

I recognised when I started my clinical day that I needed to keep in mind these wider societal concerns and maintain a reflective stance on the predominant aim of the maxillofacial service. Its main function was to provide a surgical service in which defects to the face could be altered. From the outset I would hear terms such as ‘dis-

figured’ and ‘*ab-normal*’, which indicated, linguistically, that there was something ‘wrong’ with the body appearance and that the difficulty lay within the patient rather than society’s interpretation of normality. I began to question and confront this viewpoint of disfigurement, and it did bring with it a period of uncertainty for me. I wanted to ensure that I was not complying with a broader societal view that sanctioned oppression, and I began to question for whom this service was running: society, our patients, or both?

McCaffrey, Raffin-Bouchal and Moules (2012) note that in taking such a reflexive stance, the researcher/ clinician is careful not to take their prejudices for conclusions but to vigorously question and challenge both their individual and professional practice. It was through my own personal experience of living with a craniofacial condition, as well as reading the psychological research available (for example Bradbury, 2012; 2013; van den Elzen *et al.*, 2012; Kovalenko *et al.*, 2012; Moss & Rumsey, 2002; Rumsey, 2002; Singh & Moss, 2015) that I examined the broader views on the topic. I also listened to the experiences of patients in the clinic, especially those who had undertaken surgery, and many of whom felt liberated by their transformation. I felt comfortable enough to work ethically in the area, with the recognition that patients electively chose the surgery and that for some (but not all) surgery could offer a sense of relief and potential for psychological improvement (Cunningham, Gilthorpe, & Hunt, 2000; Stirling *et al.*, 2007).

(iv) Renewed hope: 2017 business case and commissioners’ meeting

As I have outlined in the timeline there was a period of uncertainty in which I personally felt disillusioned about the possibility of a funded dental psychology service evolving. I remember that this came to a head in 2017 when we heard that Barts Health NHS Trust had approached their own psychology service and I believed that the bid to continue the service had been lost. A period of disillusionment set in, and my manager and I met regularly to discuss our mutual feelings of disappointment and sadness about the potential end to this exciting project. My initial reaction was to shut down the pilot study; I felt upset that our hard work was being by-passed and it felt too painful to

continue with the pilot study. I was able to reflect on these feelings however, in supervision with my manager.

Having an emotional space to name and explore my feelings and urges was vital to this period, it provided me with a necessary and safe space in which to consider my responses before acting on them. This was also important for me, as I similarly had to help manage the feelings of the psychologist, and the wider orthognathics team, who had invested so much of their time into the project.

I have found the work of Casement (1985), expanded on by Hawkins and Shohet (2000), to be invaluable in this regard. They draw a parallel of supervision with Winnicott's²³ concept of the 'good enough mother'. This is termed 'the nursing triad'. Just as mothers provide an important containing function for their babies, so they also need to be held and contained by someone else (for example by their partner/spouse), in order to enable this good-enough mothering to occur. Similarly, the supervisory relationship can provide this containment for the therapist/supervisee who needs to manage the challenges of their emotionally-provoking work. Rafferty expands on this concept of the nursing/therapeutic triad, and notes:

'The supervisor's role is not just to reassure the worker, but to allow the emotional disturbance to be felt within the safer setting of the supervisory relationship, where it can be survived, reflected upon and learned from' (Rafferty, 2000, p.160).

The containment of my supervisory relationship assisted me to 'survive' this turbulent period, and not impulsively react to this set-back. This, together with my own feelings of loyalty to the orthognathics team and their patients enabled me to step back and to make a decision to let go with the hope that a new psychology team could continue the input, and that the project could therefore survive. I agreed to continue to provide the pilot service for another six months to enable the orthognathic team a period of 'handover' until there was more clarity of psychology provision from another source.

²³ Donald Winnicott was a paediatrician and psychoanalyst who made a significant contribution to the British Object Relations school of thought.

However, the orthognathics team, unknown to us, continued to fight for NELFT psychology input. The sense of loyalty we felt towards the orthognathics consultants was similarly felt towards us. In a surprising and exciting turn around, within two months we received important news that NHS England wanted meet with us to consider a business case for a NELFT/Barts Health joined orthognathic psychology service. Ms Christine Casey, a consultant orthodontist wrote me an email during this time:

‘This looks like the best chance we have had in years and I really want to make this finally happen for us both.’

(C. Casey, personal communication, July 22nd, 2017).

I felt a sense of renewed enthusiasm and determination. I started this process by working collaboratively with colleagues to develop a business case that would best meet the needs of the proposed make-up of the commissioned orthognathic service (**PW 1**). I took a lead on this project and used the business case as an opportunity to describe my vision and hopes for a psychology service. During this period, I chaired a pre-presentation meeting with the Trust lead for NELFT CHPS, the general manager and clinical director for Barts Health, and several consultants to collate our ideas and consolidate our shared vision. I also liaised with the finance team to cost the service prior to the commissioners meeting.

It was during this period, that I was also invited to speak at the alumni meeting of ‘the Old Londoners’ (Queen Mary University, London) on psychological support for patients undergoing facial surgery and trauma (**PW 2**). This was a good opportunity for me to provide a forum to expand on the role of psychology in dental hospitals, and to make valuable connections, as the audience at this lecture was a mixture of students, professionals, and academics.

The meeting with NHS England took place at the end of September 2017. It was a vital opportunity to provide (for the first time) an overview of the orthognathic psychology vision to the commissioners since I started my clinical interest day in 2004 (**PW 3**). In Leadbeater’s (1997, p.51) terms, we now had exposure to ‘a network of

contacts and supporters', who had the financial capital available to help us to develop the service and make it a reality. In this regard, it was a golden opportunity to meet with powerful investors.

I recognised that my role in this meeting was to take an entrepreneurial as much as a clinical role (du Plock & Barber, 2015). The importance of demonstrating the viability and success of the service was a key area of discussion in the meeting. The NHS in many ways follows a business model (Squires, 2014) and in this respect an assessment of the viability of the business venture would need to be considered by NHS England. Funding was restricted at this time as new measures had recently been brought into place by NHS England to enable the NHS to get back onto a sustainable financial footing (NHS England, 2016). I bore in mind that, although savings and value for money were clearly embedded in the NHS model and a key component when considering the funding of the psychology service, the NHS was still meant to be a public service (Squires, 2014).

I therefore needed to demonstrate that funding this new psychology service was not only financially viable²⁴, but would also meet the broader and as important NHS commitment to commission patient-focused NHS services (NHS England, 2016). In the meeting, I discussed that a key population group, i.e. orthognathics patients, were currently not being provided with an essential health service, i.e. psychology. I felt that by the end of the presentation and discussion we had, as a collaborative group of clinicians, been able to communicate these key points to the commissioners. The commissioners seemed to realise that psychology was a vital health requirement and they also showed an interest in the possibility of further expanding dental psychology beyond the area of orthognathics. It seemed as if we again had in our midst the right conditions available for innovation to take place (West, 2017; 2019).

(v) Approval granted for a fixed term contract

²⁴ We were able to demonstrate in the business plan how a significant proportion of cancelled appointments and orthognathic surgeries were due to mental health distress and concerns, and that this directly impacted on financial loss for the NHS.

It took just over a month after the presentation to the commissioners for us to receive the exciting news that NHS England had agreed to fund the Orthognathic Psychology Service across the whole of Barts Health. This was a substantial breakthrough, and the vision of a funded psychology service became a reality. The only proviso was that the psychology service could not be permanently funded until we could show its efficacy through a period of time.

I reached an agreement with NHS England to provide these outcomes by means of a mixed methods approach, in line with my more pragmatic philosophical world-view outlined in Part One. I was able to demonstrate that using the mixed methods approach could provide more comprehensive feedback on the efficacy of the service. The quantitative measures, such as surveys and audits, could provide the statistical data often required for continued service provision in positivist medical settings, while qualitative methods such as open-ended questionnaires could be used to enrich this statistical data by analysis of themes that emerged through subjective feedback. NHS England was able to recognise that this more holistic approach was in line with the NHS commitment to listening to ‘the Peoples Voice’, a wide-ranging approach to capturing patient, carer, and staff feedback (NHS England, 2017).

With this agreed, it was now time for me to head the development of this newly funded service.

In the next period I chaired meetings between NELFT and Barts Health to set up a job plan for the new psychology team. We needed to create a vision of how the psychology service would look and meet our performance requirements. As an area of speciality, we needed clinicians with experience in detecting mental health difficulties as well as offering staff support and training. I developed the job descriptions and advertisements for the new service with senior clinical psychologists in mind (**PW 4a; 4b; 4c; 4d**). The financial costings of the service level agreement (SLA) were simultaneously drawn up by the finance teams and we now entered the recruitment phase.

Recruitment successfully took place in March 2018, and with the three months' notice period we employed two clinical psychologists on Band 8A, one clinical psychologist on Band 7 and a job share for two Band 4 Assistant Psychologists.

The first few months of the new service were an exciting, although stressful, period for me. I set up weekly meetings with the new psychology team and led in the development of the service structure. During this period, we developed patient leaflets and referral criteria, and agreed on the outcome measures that would be used in the psychology service (**PW 5a; 5b; 5c; 5d**).²⁵ The team seemed to respond with enthusiasm to the development of the service, and although it was early days it seemed that they worked well together.

The key concern at this stage was that there was a long delay in Barts Health issuing honorary contracts to the psychologists. As NELFT was employing the team through an SLA (Service Level Agreement) with Barts Health, there was a hiatus in providing clinical work until the honorary forms were issued. There was also a difficulty in providing office space to the clinicians although this had been agreed when the service was set up.

The new team therefore quickly became unsettled and a regular function of my role during this period was to try and provide reassurance and containment for team members. I did this by instigating a weekly meeting in which we could identify and brainstorm concerns and challenges. As a result of listening to staff feedback, I contacted NHS England and explained about the practical delay to the clinical work. I asked for the 12-month clock to be brought forward to when the clinical work could commence. NHS England quickly responded and agreed to this extension, which took some of the pressure off us during this unsettling time. It also helped us as a psychology team to recognise that the commissioners were working together with us, were willing to be flexible, and consider unexpected changes that could happen, and which were out of our control.

²⁵ As I had already made contact with the University of West England we were able to use the Derriford Appearance-Related Scale (DARS-24), an evidence-based outcome measure of appearance-related distress, as one of the routine measure in our assessment packs.

Once the honorary contracts were issued, I recognised that we needed to start to collate data for NHS England. The whole future of the service hinged on this and I was uncertain, albeit hopeful, as to whether our results would demonstrate efficacy. I worked closely with the two lead psychologists by providing them with weekly line management, supporting them on a regular basis to get their clinics established and to work with the realities of a growing and 'live' team.

I also spent time researching other psychology services at the forefront of holistic care. As I worked in Clinical Health Psychology, I spent a substantial period of time with colleagues at the hospice. It soon became apparent from the hospice model that the key to a successful service was close multidisciplinary partnership and the strengthening of a holistic vision of health (Hospice UK, 2015). I spent time examining and exploring processes that would need to take place to strengthen such a holistic vision of patient well-being, especially in a dental service which predominantly worked with physical health. A key angle I worked on was to incorporate consultation, training, and reflective practice as significant components of the new psychology role. This was a combination of relationship building with the wider team and providing psychoeducation on the merits of integrated, holistic care. This took some time, but we found our dental colleagues to be open and interested as many already intrinsically followed a holistic model of health.

It became clear, after a shorter period than we had envisaged, that patients and staff alike were finding the new psychology service helpful. We set up our first quarterly feedback session with NHS England commissioners in December 2020. This presentation gave the commissioners the opportunity to meet the new team, and to see how far the service had come since the initial request for funding just over a year prior to this **(PW 6)**.

The presentation was a success and led to the extension of the fixed-term contract for a further year. It was also at this meeting that I introduced a vision for the further expansion of the dental psychology service. The commissioners said that they would be willing to meet with me to discuss this proposal further, and this was a big step forward for the service.

Although this was a positive time in our service development, I began to get a sense from the psychology team that they were finding the uncertainty of the ongoing funding a challenge. At several meetings with the psychologists I was informed that they were going to start looking for permanent jobs, and not too long after this I received the first of three resignations. It was clear to me that the most important next step was to work towards a substantively funded service. Without a stable workforce, the potential for the success of the psychology service was in jeopardy. I discussed this openly with NHS England commissioners in a subsequent meeting, and it was agreed that the issue of permanent funding would again be discussed at the next quarterly meeting.

At the same time, I was approached by several consultants in the Barts Health dental hospital, who were eager to expand psychological input into their own broader dental services. This included the oral trauma service, which at this time had no psychological input, in direct contradiction to national recommendations for trauma care in the UK. I invited the consultants and oral trauma surgeons to a meeting in which I requested each service lead to provide a wish list, and how they envisaged psychology could support their service. The meeting was an important opportunity for me to gauge the extent of support for psychological work in the dental hospital and to begin to set out the areas in which psychology was most needed. I agreed at this meeting to begin to work on business cases to present to the commissioners. This took two months of intensive work in which I undertook literature reviews and requested a summary of activity on psychological presentations in the different dental clinics (Kingsley & Royan, 2019).

The key themes that I managed to ascertain from this review were:

The Oral and Maxillofacial Service (OMFS)

- The Oral and Maxillofacial Service (OMFS), Royal London Dental Hospital, is a regional NHS centre. The OMFS plays a key role in the care of patients with multiple injuries to the neck, face, mouth, and head regions. As a result, the oral and maxillofacial surgeons treat approximately

2,000 complex trauma cases every year, which is more than any other centre in the UK (Barts Health NHS Trust, 2020).

- Facial trauma patients present to the OMFS clinic with high psychological morbidity that includes PTSD, depression, appearance distress, anxiety, and post-operative adjustment difficulties. (Choudhury-Peters & Dain, 2016).

- Facial trauma patients have no direct access to a clinical psychology service as part of their specialist pathway of care. This is in contradiction to national standards of care, including the NHS England framework for service delivery for major trauma (NHS England, 2013).

- The knock-on effect to other health services is significant. There are high numbers of referrals to already overstretched primary and secondary mental health psychological services that are often unable to accept these patients due to their specialist psychological presentations.

Oral Medicine

- The Royal London Dental Hospital is one of the largest outpatient dental departments in the UK. There is a particular focus on patients who need secondary and tertiary care and there are thirteen dental specialties (Barts Health NHS Trust, 2020).

- The paediatric dentistry department sees the most patients of any of the four dental hospitals in London. The range of care ranges from the extraction of teeth under general anesthesia (the most likely reason a child is admitted to hospital anywhere in the UK) to children with special needs who cannot be managed anywhere in the community (Barts Health NHS Trust, 2020).

- In adult and paediatric patients with psychological distress related to receiving dental treatment a significant risk of the deterioration in dental/oral health has been widely reported (Kingsley & Saminathan, 2019).
- A brief review of clinical records undertaken from the Sedation Clinic at the Royal London Hospital found that the majority of referrals for sedation were due to psychological factors, especially dental phobia and dental anxiety (Kingsley & Royan, 2019).
- A significant number of re-referrals were due to chronic oral/dental pain without a physical basis for the pain.
- Dental anxiety and fear-related behaviours are one of the most challenging aspects of paediatric dentistry. A significant number of paediatric patients have appearance-related distress, due to oral conditions, which significantly impacts on their psychological well-being.
- Royal London Hospital paediatric dental consultants reported that Child and Adolescent Mental Health Services (CAMHS)²⁶ no longer provided a referral route for their patients. This lack of psychological support was having a direct impact on patient well-being as well as inability to proceed with essential oral health treatment due to the level of comorbid mental health distress.

With this information in mind, I approached NHS England and set up a further presentation to demonstrate the vision for the expansion of the psychology service in the dental hospital (**PW 7**). During the presentation I provided different options for funding, from a part-time service through to a ‘gold standard’ full-time service. I also discussed how we would risk the success of the service if we did not provide the

²⁶ CAMHS stands for Child and Adolescent Mental Health Services. CAMHS are the NHS services that assesses and treat young people with emotional, behavioural, or mental health difficulties.

security of permanent jobs for the psychology team. It was a difficult but important discussion with the commissioners in that I was concerned about the viability of the project without a solid and secure workforce. The commissioners agreed that if they did fund the service, it would be done on a permanent basis. They were pleased by the patient feedback and results of the Orthognathics Service so far and could see the importance of holding on to valuable staff.

I was asked to liaise with finance and provide costings. I worked closely with our Trust lead to consider the staff structure during the period following the presentation. The business cases and service structure outline were sent to NHS England ²⁷ and we were informed that we would get an answer within a few months of the presentation (Kingsley & Royan, 2019).

(vi) DPS expansion approved as a permanent service

It was approximately two months after the presentation to the NHS England commissioners that we received exciting news:

‘NHS England and NHS Improvement (London Region) approves of the proposed expansion of the dental psychology service. In addition to the current service for orthognathics we agree to the provision of services for trauma patients and dental (phobic and pain) patients. This will allow Bart’s (sic) to provide a comparable service to other trauma units and trusts across London.’ (NHS England, personal communication, October 1st, 2019).

This culminated in a move from a fixed-term to permanent and fully-funded NHS England service in which all four of the dental psychology services we recommended were commissioned in 2019: Orthognathics, Oral Trauma,

²⁷ As the business cases are confidential material, I have not been able to include these in the evidence of public works.

General Dentistry (Oral Medicine) and Paediatric Dentistry. This included the provision of psychological assessments and therapy for adult and paediatric dental patients and their families; mental health screenings for new patients referred to oral medicine and dental clinics; as well as monthly group and individual clinical supervision workshops and training for dental staff. It had also been approved for us to set up a staff-based psychological support service for dental staff, especially those who were in the front line of working with oral trauma on a regular basis.

The service was agreed to commence in April 2020, and at present I am developing the structure and implementing the new service guidelines (key areas in which the Dental Psychology team and I have begun to expand the psychological service can be found in **PW 8, 9, 10, 11, 12, 13, 14**).

2.2 Public Works 2:

The promotion of the psychological well-being of staff

The second of the public works, which I will now describe, is linked to my role of developing psychological services in physical health settings. This is to consider the holistic well-being of NHS staff, as staff form an integral part of the NHS as a wider system/ organisation.

One of the key perspectives of a systems approach is to view the whole (such as the NHS) as made up of different parts (such as patients and staff) that are interdependent and affect and interact with each other (NHS England, 2018). Health and social care organisations (such as the NHS) are complex systems organised around a purpose: the provision of treatment for health and recovery (Fillingham & Weir, 2014). In this respect the emotional health and well-being of all its parts, including its staff, is vital to consider and manage (West, 2017; 2019; West, Eckert, Collins, & Chowla, 2017).

Since the onset of my work as a clinical psychologist in the NHS, staff support and well-being has been a key aspect of my interest and role. Prior to my starting in clinical health psychology I developed staff support, training, and consultation in Psychiatric Intensive Care (PICU). I also wrote about staff support when invited to contribute a chapter on psychological approaches in the first multidisciplinary textbook on Psychiatric Intensive Care published by Cambridge University Press (**PW 15**). This is now in press awaiting its third edition of publication (**PW 16**).

Since my move to Clinical Health Psychology I have continued and expanded on the area of staff support and well-being. I will focus this chapter on staff support in palliative care settings as the promotion of staff well-being in the Dental School has only just commenced at the time of writing up the context statement.

(i) Staff support in palliative care and end-of-life settings

When I commenced my clinical health psychology role, I was struck by the gaps in clinical health psychological service provision for patients and their families in vast areas of North East London. Psychology referrals were sent to generic psychology departments and to primary care, but patients with complex physical health conditions had no psychological cover. I was keen to develop specialist clinical health psychological services for patients and their families, but lack of funding was a significant barrier. This was especially the case for palliative care and end-of-life services. I discussed these concerns with the psychologist whom I managed in the clinical health psychology service and we agreed to write a journal article on this area of concern, with a focus on cancer services. We particularly chose a journal that focused its audience on NHS management, with an aim to expand awareness of these gaps in service (**PW 17**).

It became apparent that due to these gaps in clinical health psychology provision the emotional care of patients and their families often fell on the shoulders of the doctors, nurses and allied health professionals based in the palliative care teams (Hunter, 2018; Hussein, Kingsley, & Phil-Eboise, 2016). In order to gain evidence of

the psychological presentations of patients in palliative care teams I met with a manager of one of our Macmillan community palliative care services. It was agreed that I could undertake an audit to assess some of the key psychological issues found in the case notes of patients **PW 18**). The results of this audit confirmed high levels of mental health distress in the patient sample. A staggering 97% of patients reported low mood, followed by 78% of patients experiencing clinical levels of anxiety and panic. Emotional despair and hopelessness were found in 40-46% of the sample. As there was no psychologist in this service, the clinical nurse specialists in the community-based team found themselves faced with high levels of patient distress and no referral route into psychology. Many felt obliged to offer nursing support on an emotional level, but they felt that this was beyond their scope of practice and skill base.

The results of this audit were collated and presented to NELFT managers to demonstrate the need for Clinical Health Psychology Services at NELFT to provide support to the palliative care community teams (Kingsley, Crowe, & Royan, 2015). The justification was that palliative care and end-of-life staff are particularly at high risk of work-related emotional distress, such as burnout, compassion fatigue and eventual withdrawal from the field (Abendroth & Flannery, 2006; Aycock & Boyle, 2009; Brotheridge & Grandey, 2002; Halter, Boiko, Pelone, Beighton, & Harris, 2017; Hospice UK, 2015; Keidel, 2002; Toh, Ang, & Devi, 2012; Vachon, 1995,1998; Wakefield, 2000).

As noted in Part One, I began to make enquiries as to whether psychological services in our Trust provided any specialist support /supervision for community staff working with palliative and end-of-life cases. I was concerned to find that there were no current supervision groups or psychologically-led reflective groups for community palliative care staff. It was with these concerns in mind that I approached London Cancer ERG to obtain permission to pilot supervision groups, based on the Level 2 model, in the community. With permission in place and as a result of the audit and presentation to NELFT, it was agreed that I develop community Level 2 groups as a key role of the clinical health psychology service. I piloted Level 2 clinical discussion groups in each of the four North East London boroughs of NELFT. I ran three of these

groups with a colleague supporting the running and development of a fourth Level 2 community group in Waltham Forest.

The groups have been running over the past six years, and they have become a regular aspect of the palliative care team's activities (feedback on the efficacy of these groups will be further expanded in Part Three).

In 2019, I was approached by the Director of Nursing for NELFT who had heard about the success of the community Level 2 supervision groups and was keen to further expand access for community staff to the groups. As a result, I agreed to undertake a survey of palliative care community staff at NELFT to evaluate their experiences of psychological supervision. I wrote up the results of this survey with a colleague in a journal article, which is currently in press (**PW 19**). These results will be discussed in more detail in Part Three under the impact of my public works.

2.3 Public Works 3:

The promotion of suicide risk assessment, management, and training in palliative and end-of-life health settings

The third area of my public works is related to my contribution to the area of training and support for healthcare clinicians, particularly those in palliative and end-of-life settings, and in suicide risk assessment and management.

The need to develop staff skill and confidence in detecting and managing suicide risk is a Public Health England national agenda, and my public works are closely tied and relevant to these key national recommendations (NHS England, 2019, 2020).

(i) Historical public works and their later relevance to palliative/ end-of-life settings

I was promoted to Clinical Risk Lead for Redbridge Psychology Service in 2010 and began to attend NELFT working groups on risk management. In these groups it became evident that NHS staff often felt anxious and uncertain about managing suicide risk in both inpatient and community mental health services. I worked closely with the Trust's Risk Assurance group to explore ways to increase staff confidence in detecting and managing suicide risk, such as through training and supervision. It was also during this time that I first became aware of the lack of specialist support and supervision for NHS staff with complex mental health and risk presentations in physical health settings.

(ii) The development of the Clinical Risk Advisory Group (CRAG)

It soon became apparent that our Trust could benefit from a clinical risk group to specifically overview sudden unexpected deaths and suicide in the Trust. I proposed this, and in 2010 this was approved by NELFT and I was asked to chair the group. I agreed to this and the group was formed and termed the Clinical Risk Advisory Group (CRAG). The CRAG was made up of a multidisciplinary group of clinicians and was the first to be chaired by a clinical psychologist. The phases of the development of the

CRAG are outlined in **Appendix 3b**. The key purpose of the group was to overview suicides reported to the Trust, and to capture clinical themes and trends that emerged through an analysis of the clinical notes of deceased patients (Kingsley, 2010).

I completed an audit of the CRAG in 2012 (**PW 20**) and presented the results to NELFT Trust wide forums including the Trust board of directors and non-executive directors over a period of two years (**PW 21; PW 22**). As a result, NELFT developed a clear plan on how to provide much needed suicide training and support for staff within mental health and physical health services. I was involved in providing this training to clinicians throughout the Trust.

(iii) **NHS Patient Safety Agency (NPSA) representation**

I chaired the CRAG successfully for three years and during this period important developments occurred in my professional career. I began to give more extensive presentations to the NHS on the risks of suicide, and I was recommended by NELFT and invited to become a member of the NHS National Patient Safety Agency (NPSA) working group for developing suicide prevention toolkits²⁸ (**PW 23**). This was a rewarding experience, in which our working group was tasked with supporting mental health services to start using toolkits to assess and manage their patients' suicide risks in acute and community mental health services.

In the NPSA working group, I represented psychology nationally and ensured that psychological and psychotherapeutic factors were considered in the toolkits. For example, I brought group awareness to the increased risk of suicide related to the ending of important interpersonal factors such as relationship breakdowns (including therapeutic relationships in NHS settings). As part of this role I led in developing *Zoning Prompts* (**PW 24**), which were to be used in zoning meetings²⁹ to help

²⁸ The National Patient Safety Agency (NPSA) was commissioned by the Department of Health to develop a series of Suicide Prevention Toolkits for the NHS that included A&E departments, GP surgeries, Ambulance Trusts and Community Mental Health Teams.

²⁹ 'Zoning' is system used by community mental health teams to ensure that patients receive appropriate levels of support. It consists of displaying a team's caseload of patients on a white board with different traffic light-coloured zones (red, amber, and green) in which patients are moved within according to risk and the level of support they require.

clinicians to consider if any of their patients fell into high risk groups for suicide according to national characteristics. For example, national evidence points to characteristics such as gender, age, history of suicide attempts, and chronic pain amongst others, which make patients more vulnerable to suicide risk (Kingsley & Wright, 2012). I presented these 'zoning prompts' to various teams and they were published and distributed across NELFT. These prompts enabled clinicians to have a format on hand to alert them to high risk patients, and at times when risk needed to be more closely monitored. During this period of delivering training on suicide risk prompts I was also invited by NELFT to lead in the development of the Trust's clinical risk policy. Although this included risks beyond suicide, a large proportion of the document focused on how to support NHS staff to assess and manage suicide risk from practical to clinical dimensions (**PW 25**).

(iv) Digital Risk involvement

Due to my links with NPSA and the CRAG, the Homicide Inquiries team at NHS England became aware of my interest in suicide risk management. I was invited to contribute to a workshop at the Tavistock Centre focused on issues of the use of digital media by mental health service users (NHSE, personal communication, November 3, 2011). The seminar was arranged as a result of a number of incidents involving vulnerable patients who were interacting online while under the care of the NHS (*ibid*) (**PW 26**). At the seminar I discussed the risks associated with online activity with special reference to completed suicides in our Trust in which internet (digital) access played a critical role. This included examples of patients joining pro-suicide forums or searching for suicide methods online prior to their death.

During this period, I also began to expand on my understanding of the complex inner lives and struggles of vulnerable people who went online. I introduced a theoretical perspective on the area of Digital Risk, by conceptualising my understanding of the hidden lives of patients and their ambivalent relationships to their therapist and the internet. I wrote about this theory in more detail in my blog (**PW 27**); and later in a published paper (**PW 28**). I also presented on this theoretical development at an international conference on suicide (**PW 29**).

I was invited to be part of a working group set up by Dr Richard Graham from the Tavistock and Portman NHS Trust in assessing digital/ online risks of suicide. This working group included the NHS, Metropolitan Police and third sector services. I continued to belong to this working group when I moved jobs and became the care pathway lead for Clinical Health Psychology. This enabled me to continue my interest in working with suicide risk management, but now in particular to focus on suicide risk in physical health settings such as palliative care and end-of-life.

With the summary of my public works now completed, I will focus on discussing their impact in three key areas of the NHS.

Part Three: Impact of Public Works

3.1 Introduction

The aim of this chapter is to introduce the reader to the relevance and impact of my public works in three key areas of the NHS. To think about the impact I have made in my organisation and profession, it has been necessary to step back and review the contributions that I have made to the public domain with a reflexive stance. This has been a rewarding, albeit challenging, process. Rewarding in that it has helped me to consider a more panoramic view of my life journey and how this is interwoven with my professional life. Challenging, in that I have needed to reflect on the very personal steps and processes that I have made on this professional journey. I have not always found this an easy or comfortable process and, similar to facing myself in psychotherapy, it has required honesty, courage, and a willingness to accept when things have not always worked. I have found myself querying throughout this process - have I made a difference? How accurate am I in seeing my journey; what may I be avoiding or denying?

The last twenty-one years of my career have been served in the NHS, and the basis of the measurement of the impact of my achievements is therefore intrinsically linked to my public works in this public health system. When thinking of impact, I think of *change*, and especially how the changes I have contributed continue to *transform practice*, even after their initial introduction. My view of change is linked to the NHS Change Model, i.e. a framework for any project or programme in the NHS that is seeking to achieve ‘*transformational, sustainable change*’ (NHS England, 2018, p.3). As an entrepreneur and leader in my area of practice I am dedicated to supporting change which not only transforms but also *improves* services, as without such movement, traditional models remain unchallenged and risk stagnation (ibid).

Psychological therapists have a key role in leading change but being able to make such change on a broader systemic level, such as in the NHS, can bring challenges. I have needed to listen to what has not worked so far, what patients and staff note as necessary, and find innovative ways of achieving sustainable change when presented with limited resources.

Du Plock and Barber (2008) discuss the entrepreneurialism inherent to the success of a completed Doctorate in Public Works projects. This is of a particular type which they came to conceptualise as *professional entrepreneurialism*. I have generally associated being an entrepreneur with the business world, and at first found it difficult to contextualise myself in this framework. I had considered the idea of a Bachelor of Commerce degree as a teenager, but my socialist leanings were strong, and I wanted to work with people without profit as a motivator. I can see in retrospect that my role as a psychologist in the NHS has required me to incorporate entrepreneurial components and business models in my work. For Leadbeater (1997), social entrepreneurs make use of business methods and models to find new solutions to a wide range of social issues and unmet needs, including healthcare and public sector work. It therefore moves the concept of entrepreneurship beyond profit motivation.

I will make use of Leadbeater's (1997) concepts of effective entrepreneurship to demonstrate how I have made such an impact on my organisation and profession. Effective entrepreneurship includes:

Entrepreneurial: for example, I have made use of underutilised resources (such as meeting with NHSE for funding) to satisfy unmet needs for psychology (such as developing psychology in dental services).

Innovative: I have helped create new services and products, and new ways of dealing with problems, often by bringing together approaches that have traditionally been kept separate (such as bringing together the psychology supervision groups for palliative care teams).

Transformatory: I have helped create sustainable transformation of institutions such as the NHS and professional areas of psychology. I will show how my public works have gone through a cycle of development (du Plock & Barber, 2015) in which I was successfully able to navigate through different and challenging stages to achieve set goals and my overall vision for psychology in the NHS.

I have formulated three key areas in which I believe that my public works have an impact on my organisation (the NHS) and my profession (psychology):

Expanding psychology into areas of unmet need: dental and oral trauma services.

Supporting the well-being of NHS staff and transforming practice for community palliative care professionals.

Developing psychological factors in suicide risk assessment and management, such as in Digital Risk and palliative and end-of-life settings.

3.2 Expansion of psychology into areas of unmet need: physical health settings

“Psychology...joining...our dental services has brought us one step closer to our goal of holistic excellent world class care for our patients and the trust as a whole”.

Dr Zahra Syed, Consultant in Oral Medicine, Barts Health NHS Trust.
(Appendix 4):

The first key discussion of my public works is to consider my role in the expansion of psychology and psychotherapy into the dental and oral trauma NHS services. The relevance of these public works is that they are closely tied to the national agenda for increased parity of esteem between mental health and physical health in the NHS (Department of Health and Social Care, 2011; NHS England, 2019).

From the onset of my training I have been struck by the diverse views of what constitutes health, particularly mental health. I have often found that a medical and diagnostic model of health has predominated, in which classification systems such as

the DSM-5 and ICD³⁰ are used to categorise mental health into signs and symptoms. An important component of my role has been to try and increase the recognition of emotional distress as distinct from mental illness. For example, when I worked in acute psychiatry, I wrote on the psychological responses to involuntary admission on a psychiatric intensive care unit (Kingsley, 2008).

In this respect, I discussed how the emotional responses to involuntary admission and confinement could be misinterpreted as symptoms of a mental illness such as agitation or withdrawal (ibid). Similarly, when I moved into clinical health psychology I was drawn to the psychological theories of adjustment, in which emotional distress in the face of living with a physical illness were considered as vital components of presentations such as in low mood or anxiety (Brennan, 2004). I made it a priority in my role as Care Pathway Lead to promote the development of psychological models in physical health settings, particularly those with traditionally limited or non-existent psychological input.

In terms of the current chapter, I will focus on the development of the dental and oral trauma psychology service (DOT-P) as a key example of service expansion for psychology within an area of unmet need in a physical health setting.

To contextualise the relevance and impact of my public works in developing the DOT Psychology Service the importance of the broader NHS philosophy to physical and mental health integration should be considered. Mental health continues to move up the policy agenda across government (The Kings Fund, 2016; NHS England, 2019). The breakthrough was a paper from the Department of Health and Social Care, entitled *No Health without Mental Health* (2011), as this provided a basis for mental health services to obtain the same level of recognition as physical health services in government funding. By the time I commenced my role in CHPS, NHS England had outlined a commitment for mental health to be firmly included within local government responsibilities for improving public health.

³⁰ The Diagnostic and Statistical Manual of Mental Disorders, Fifth edition (DSM-5) is a psychiatric classification system published by the American Psychiatric Association (APA). The ICD-10 is an international diagnostic classification standard for reporting diseases and health conditions.

There was a recognition that NHS staff needed to improve their understanding of mental health in physical health settings, and that the physical health needs of people with mental health problems needed to be more closely monitored. This was further supported by the independent Mental Health Taskforce *Five Year Forward View* (2016, 2020) which set out the current state of mental health service provision in England and made recommendations in all service areas.

Since the NHS Five Year Forward View in 2016 several initiatives have developed to promote collaboration between different parts of the NHS and the commissioners who provide the funding, to work more closely together to plan and develop health services. This opened up the gate for additional NHS England investment into mental health provision, and I included this philosophy of NHS England commissioning in the business cases that I developed to request funding for the dental psychology services (Robertson & Ewbank, 2020).

(i) The impact of the expanded DOT-P (Dental and Oral Trauma) Psychology Service

At the time of writing this context statement, the development of the NHS England commissioned DOT-P Service had only just started as funding was provided from the beginning of the new financial year in April 2020.³¹ In addition, the starting date for the service was adversely affected by the onset of the COVID-19³² pandemic. The dental hospital temporarily closed in April 2020, and staff were redeployed to other hospital sites. This was a sudden and unexpected change to the plans for setting up the psychology service. As the impact of the expanded dental psychology service is difficult to evidence in detail at this time, I will give a brief outline of the newly expanding dental and oral trauma service followed by primarily focusing on the impact of the already developed Orthognathics Psychology Service.

³¹ Please see the current DOT-P website for more detail on the current service outline <https://www.nelft.nhs.uk/services-clinical-health-psychology>

³² Coronavirus disease 2019 (COVID-19) is an infectious disease caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

My role in spearheading and developing a newly funded dental psychology and oral trauma service within North East London and regionally has helped transform what is available for patients, staff, and communities in this vital area of oral medicine. I facilitated the development of a relationship with a network of contacts within Barts Health and NELFT NHS Trusts, and later with NHS England commissioners, which gave me the ‘social capital’ and support I needed to spearhead the project (du Plock & Barber, 2008). I made use of a business model (through business plans and key performance indicators) to ensure that permanent funding was eventually achieved to develop the Dental and Oral Trauma Psychology (DOT-P) service (Kingsley & Royan, 2019).

The impact of the development of this new psychology service has been far-reaching:

- ***For the hospital and surrounding community***

The Royal London Dental Hospital (RLH) is one of the largest outpatient dental departments in the UK. Psychology will now be provided as a key component of regular multidisciplinary treatment across adult and paediatric dentistry. This is a significant development, in that until now all patients attending the RLH dental hospital have needed to be referred to specialist dental hospitals, such as the Eastman Hospital, for psychological assessments and treatment. As a result of this new psychology service patients and staff will be able to develop in-house psychological care plans through which their holistic care needs can be met at one base.

A consultant in Oral Medicine at the RLH, Dr. Zahra Syed, has noted in her testimonial about the new psychology service (**Appendix 4**):

‘...psychological care either could not be accessed in community by our cohort of patients on the NHS, they had to wait over a year to receive this or was delivered by psychologists with minimal experience in our patients diseases potentially affecting their outcomes. As such the need was great and I was looking to solve this problem

quickly. I was blessed to find that Marc Kingsley was developing such a service with our orthognathic team...and I approached him...’.

I have also taken a key role in developing psychological screening packs which have been recently implemented as a standard component of holistic treatment in the dental hospital (PW 5c; 8; 9; 12). This is primarily to help support the wider national objective for parity of esteem between physical and mental health treatment in NHS settings by ensuring that mental health is considered, and screened for, in the regular assessment of dental patients. I believe that this is a breakthrough in clinical practice as until now mental health screening in the Barts Health dental hospital has been ad hoc, leading to a variation in fully recognizing the mental health presentations of patients. I also hoped that by introducing routine psychological screening as standard practice this could help reduce the stigma for many patients of being referred for a mental health assessment in physical health settings.

- ***Oral Trauma Service***

During the development of the business case for the dental hospital I argued for specific funding for the Barts Health Oral Maxillofacial Service (OMFS). This service housed one of the biggest trauma centres in London and the UK, but did not have access to an in-house oral trauma psychology service until we secured funding. Patients relied on external referral routes for psychological treatment. This resulted in referrals to GPs, with long waiting lists for external funding to specialist psychological services.

I was keen to ensure patients had access to psychologists employed with specialist and advanced training in evidence-based psychological trauma models, and that specialist trauma-informed supervision was available for clinicians working in this area in lines with best practice models (Collins, 2003; Courtois, 2018; Knight, 2018). I was also aware that staff who worked in the OMFS were often exposed to traumatic caseloads, and a key component of my vision for this service was to provide a specific psychological staff well-being service. This could offer debriefing, counselling, and

reflective practice for this team, as the risk of vicarious trauma for staff exposed to traumatic incidents on such a regular basis has been clearly evidenced (Canfield, 2005; Lérias & Byrne, 2003; Pearlman & Mac Ian, 1995; Sabin-Farrell & Turpin, 2003; Sexton, 1999; Sinclair & Hamill, 2007).

Professor Simon Holmes, a leading maxillofacial surgeon in the oral trauma service, has written a testimonial regarding the impact of the development of the new psychology service in the OMFS (**Appendix 5**):

‘Currently we are, as we have been for years, desperate to formally engage with an embedded psychologist. There are already a number of patients who are waiting to see the new incumbent - and without this knowledge of this appointment - we would be really struggling. With respect to the work that you (Marc Kingsley) have done in raising the profile and in successfully marshalling the process resulting in the posts appointed - I can only wonder at how you managed to do this, and our patients will benefit greatly, myself and my successors will be forever grateful.’

- ***Paediatric Dental Service:***

The paediatric department at the Royal London Dental Hospital sees more patients than any of the four dental hospitals in London (Barts Health NHS Trust 2019). During the period in which I was mapping the service expansion for the dental hospital I met with the paediatric consultant orthodontists, who reported that there were no longer referral routes available to CAMHS. This lack of psychological support had a direct impact on patient well-being as well as an inability to proceed with essential oral health treatment. In my discussions with NHS England, I emphasised the importance for paediatric dentistry to obtain their own funding stream for psychology due to the complexity of this specialist area. I also argued for the development of a consultant clinical psychology role to be established for paediatric dentistry, to ensure that there was a parallel service to the adult dentistry psychology service. This was approved, and I then led in developing a job description and recruitment process for this specialist post (**PW 30**).

I have been involved in developing both the paediatric dentistry referral form (PW 43) and referral pathway (PW 44). This has included ensuring that we use evidence-based outcome measures to assess dental anxiety, low mood, and appearance-related distress in children. We have also ensured that packs are child-friendly in that a certain percentage of screening forms will go to younger children (PW 8). As part of this process, I recommended that our paediatric psychology team contact Great Ormond Street Hospital (GOSH), to obtain guidance on the best practice for psychologically assessing and treating paediatric patients and their families.

- ***Placement Opportunities for D Psych Clinical Psychology trainees:***

I have made it a key component of my vision in developing the orthognathics and dental psychology service to provide an opportunity for students to undertake placements. I have begun to do this with clinical psychology doctoral trainees and hope to expand this to other professional training groups, such as psychotherapy trainees. I have had recent discussions with Clinical Health Psychology Placement List coordinators for the North Thames Region and received positive feedback

‘The Dental Psychology and Oral Trauma Service sounds like a very exciting development. It is also excellent to hear that this will potentially open up 4 new placement opportunities for our North Thames trainees.’

(Michelle Wilson, personal email correspondence, 12th March 2020):

The impact of this is significant for the profession of clinical psychology in that it is a unique opportunity for North Thames clinical psychology trainees to obtain placements in highly specialist areas of physical health (such as oral trauma, and paediatric dentistry). This has not been easily available to clinical psychology trainees until now and will open up the potential for expanding the role of clinical psychologists in a highly relevant and expanding area of clinical health psychology practice (PW 31).

I will now turn to discussing in more detail the impact of the first phase of the development of a dental psychology service, the Orthognathics Psychology Service, which obtained NHSE funding in 2018.

(ii) Phase One: Orthognathics Psychology Service (OPS) development

Until the agreement for NHSE to fund the orthognathics psychology service, the provision of psychology in this area of oral medicine was minimal in north and east London and specialist referrals had to be made to hospitals outside the area.

As noted in Part Two, in comparison to general population controls craniofacial patients with orthodontic and orthognathic concerns show greater appearance-related distress, according to valid and reliable psychometric scales (Cunningham *et al.*, 2000; Singh & Moss, 2015; van den Elzen *et al.*, 2012). There is, furthermore, a vital need to support orthognathic patients with decision-making about their elective surgery to transform their faces, and psychology is a key component of this process (Kingsley *et al.*, 2016). This includes guidance from the Royal College of Surgeons Working Group (2013), which has emphasised the importance of a psychological approach to the multidisciplinary treatment of maxillofacial and oral surgery patients, and those undergoing elective surgery.

Again, in Part Two, I outlined that the psychology input we could provide to orthognathics prior to the funded service was sketchy and location specific (the Whipps Cross Hospital pilot site). An important transformation happened when approved funding was secured, and the impact of the newly formed Orthognathics Psychology Service has been far-reaching. I have subdivided this into the impact to three areas: service, patients, and staff.

Impact on the Orthognathics Psychology Service (OPS):

“Extremely helpful and valuable part of the service that we could not do without. It means we are really able to provide a gold standard level of care to our patients.” Consultant Orthodontist. Staff Survey, 2020 **(PW 32)**.

“This service has been needed for years, its madness it’s a new service really”. Patient feedback, Family and Friends, 2020 **(PW 33)**.

- The NHS objective for parity of esteem between mental and physical health has been delivered at Barts Health OPS is now recognised as an integral component of standard orthognathic assessment and treatment in the Barts Dental Hospital **(PW 6)**.

- The first demonstrable analysis of mental health specific data of orthognathic patients in the Barts dental hospital was published in 2019 (PW 33). This was vital evidence I presented to support the bid for permanent funding for the OPS to NHS England **(PW 34)**.

- The results of a six month analysis of the psychological screening of patients confirmed the hypotheses set in the business case of the need for an Orthognathics Psychology Service: a significant proportion (20.4%) of all orthognathic patients presented with psychological distress and mental health difficulties requiring a referral to psychology **(PW 33)**.

Impact on patients:

- *“Very useful to speak to non-medical team member and express my concerns in a less intimidating setting”*

- *“I think the psychology service offered has been extremely beneficial to me in regards to scoping out my potential treatment and managing key expectations. It has been a vital part of my overall treatment”*

(Family and Friends qualitative feedback result, 2020, **PW 33**).

- All new Barts Health patient referrals in to the Orthognathics department, on both hospital sites, are offered a psychological screening as a standard component of their multidisciplinary oral medicine assessment (**PW 5c; 5d**).

- A better understanding of the underlying psychological presentations of the orthognathic patients has been captured by using standardised outcome measures, such as the Derriford Appearance Related Scale (**PW 5c; 5d**). For example, **60%** of all new screening patients (n=233) had clinically elevated scores for appearance-related distress (**PW 34**).

- All Barts Health orthognathic patients can be referred directly for in-house clinical psychology assessments and treatment rather than out of area (**PW 5b**)

- The length of waiting time between accepted referral and first appointment offered is low. OPS Patients are generally seen within five weeks, with the majority seen within two-three weeks of referral time (**PW 34**).

- Patient feedback on the OPS has been very positive with 98% of patients in a recent survey (May 2019-January 2020) finding it easy to get care, treatment or support from the orthognathics psychology service; and **80%** of the sample of patients either extremely likely or highly likely to recommend the OPS to their family and friends³³ (**PW 33**).

Impact on staff

³³ The most important measure of quality is what people who use mental health services think. The Friends and Family Test asks patients and staff how likely they are to recommend a health or care provider's services to their friends and family if they needed similar care or treatment.

*‘As a result of the service I have been able to treat complex cases that just would not have been possible without the detailed (psychological) assessments and treatments provided by Marc and his colleagues’ (Nayeem Ali, Consultant Oral Surgeon). (Testimonial, **Appendix 6**).*

*‘Marc has been an excellent support through this journey and we are making plans to write up our experiences in development of the service for publication in an Orthodontic journal so as to inform our colleagues who are looking to develop similar services.’ (Christine Casey, Consultant Orthodontist). (Testimonial, **Appendix 7**).*

*“I feel we are now properly assessing the patients in all aspects and I welcome the input from the team.” (Consultant Orthodontist, Staff Survey 2020). (**PW 32**).*

*- “All the (orthognathics psychology) team are extremely caring and responsive to us as staff” (Orthodontist, Staff Survey 2020). (**PW 32**).*

An analysis of the testimonials received from the Clinical Director of Barts Health Dental Hospital (**Appendix 8**); consultants in the Orthognathics Service (**Appendices 4, 5, 6 and 7**); the NELFT Trust Lead for Clinical Health Psychology (**Appendix 9**); and the results of a recent staff survey (**PW 32**) capture some key themes of the impact of the psychology service for staff:

- 100% of the staff who answered the survey agreed that it was a significant and positive development to incorporate psychology into the care of the wider Orthognathics Service.
- 100% of staff found that psychology involvement in the Orthognathics Service had helped them to deal more effectively with patients. As a consultant oral surgeon recently noted in a testimonial: ‘I would go as far as saying that I would not continue to perform such surgery without them (psychology)’ (**See Appendix 6**).

- Staff noted in qualitative feedback that the incorporation of psychology into the Orthognathics Service has particularly strengthened the comprehensive and holistic care of all patients' needs.
- All staff who responded noted that the role of a psychologist in an Orthognathics Service is clearer since the psychology service commenced.
- High satisfaction with the responsiveness of the psychology service to staff requests and needs (50% very satisfied and 50% satisfied).
- High satisfaction with psychology's ability to work as a multidisciplinary team member with other professionals in the Orthognathics Service (100%).

Although feedback on the psychology provision has been primarily positive, I am aware of the need to recognise my limitations and recognise that the service could have benefitted from more patient and carer involvement in developing the psychology pathways. Patient/carers feedback helps to shape a service from a grassroots level, and I would have liked this input from the outset. I have discussed this now with the DOT-P psychology team, and we have agreed to send out expressions of interest to patients and carers to form part of a review group in six months. This will be to ascertain how the service is running, how user-friendly outcome measures are, and what could work differently.

I have aimed in this section to provide a synopsis of the ways in which my public works have impacted in expanding psychology into areas of unmet need in the NHS, such as in dentistry. I will now turn to the second area in which I will demonstrate the impact of my public works, that is, in supporting the well-being of NHS staff.

3.3 Supporting the well-being of NHS staff and transforming practice for community palliative care professionals

‘The introduction of level 2 supervision to my practice has been one of the most beneficial things I have received in my 40yr nursing career. As someone who thinks they have seen it all, it is not until you can take the time to reflect and discuss with a senior professional, how beneficial this experience is... I am so pleased at this stage of my career I have had the opportunity to be part of these sessions with Marc and my team.’ (Testimonial from Viv Hancock, Macmillan Clinical Nurse Specialist, Redbridge Community Palliative Care Clinic, **Appendix 10**).

‘I find my sessions with you... (Marc Kingsley) ... invaluable. I feel that they have had a positive impact on my life and professional career.... I now feel confident to deal with what once I would have shied away from. This I feel has resulted in positive outcomes for me as a nurse and for my patient’s through holistic patient centred care.’ (Testimonial from Sharon Kite, Macmillan Cancer Nurse Specialist, Havering Community Palliative Care Clinic, **Appendix 11**).

My public works are highly relevant in that they are closely tied to the national agenda for supporting the well-being of NHS staff. There is now a wealth of research which shows that good staff health, well-being and engagement are vital to the continued functioning of the NHS (NHS England, 2019; West, 2017, 2019; West *et al.*, 2017). There is also growing evidence that staff who are treated with compassion and who can find a safe place at work to share their work experiences have improved emotional wellbeing and reduced levels of staff sickness (Bailey, 2019; Ross & Bennett, 2018). In turn, this then fosters more empathy and compassion towards colleagues and patients alike (*ibid*).

A key component of my public works has been to promote and develop staff well-being and to work towards promoting a compassionate work environment. This has included providing staff support to clinicians working on the forefront of oral

trauma services who are at risk of vicarious trauma and running monthly clinical discussion groups for community palliative care teams. Historically these staff groups had no supervision to unpack the emotional consequences of working with daily exposure to death, dying and tragedy. I will now focus on providing examples of the impact of my public works on the promotion of staff well-being through the development of psychology-led supervision groups in community palliative care and end-of-life settings. Due to COVID-19 there have been delays in obtaining evidence of the efficacy of staff support in the dental hospital (**PW 35; PW 36**).

(i) The promotion of staff support for palliative care community staff

As I have outlined in Parts One and Two, throughout my time meeting with NELFT community palliative care teams I have become aware of the large gaps in service provision created by the lack of government funding in community clinical health psychology services in North East London. A significant proportion of daily care, including emotional and psychological input, seemed to fall on specific groups such as community palliative care and district nurses without adequate mental health focused supervision and training (Adams & Maben, 2013). I co-authored a journal article with two colleagues at the end of 2016 in which I outline my concerns related to the adverse consequences of this lack of psychological support in cancer care in the community (**PW 17**). The impact of this article was to bring this topic into the public arena, as it was published in *The British Journal of Healthcare Management* which reaches a wide range of NHS groups and professionals including hospital managers and commissioners.

Within the first three years of commencing my role as the strategic lead for CHPS I made it a priority to introduce psychological supervision for clinicians working in community palliative care sites and piloted this as a project across three London boroughs. I decided to follow a known and trialled method of delivery, termed *Level 2 groups*, which was already set up in acute hospital oncology sites. With the approval of the London Cancer Expert Reference Group I expanded this Level 2 cancer model into community palliative care settings, which supported a wider range of

patients with both malignant (cancer) and non-malignant (e.g. heart failure) end-of-life conditions. I also wanted to open the group to multidisciplinary team members rather than solely to clinical nurse specialists.

There was little in the way of an evidence-base to guide my development of these supervision groups, as psychological staff groups were generally offered in acute hospital settings. Little was known about the impact of these groups in community settings, especially for district and community oncology nurses (Hussain *et al.*, 2016). It was important for me as a clinician and researcher to measure the efficacy of the groups.

In 2019, I was approached by the Director of Nursing for NELFT who had heard about these community Level 2 groups and was keen to consider expanding these for nurses who currently had no specialist supervision for their palliative/end-of-life cases (D Searle, personal communication, November 28, 2018). As a result, I agreed to undertake a survey of palliative care community staff at NELFT, to evaluate whether they had access to piloted Level 2 supervision groups (see **Appendix 12** and **13** for more detail).³⁴

Questionnaires were sent through to staff groups via Survey Monkey. Confidentiality was guaranteed as responses were kept anonymous with no identifiable demographics (Kingsley *et al.*, in press). I was aware that a large number of clinicians in the Level 2 attenders group knew me well, and I wanted to give them as much freedom as possible to express their feedback.

The target population for the present study included registered nurses (RNs), allied health professionals, and social workers who met the following inclusion criteria: (1) they were employed by NELFT community teams during the study (for at least one month); (2) they had no access to Level 2 groups in acute hospital settings; and (3) they interacted directly with palliative care and end-of-life patients and their families in the community on a regular basis (*ibid*).

³⁴ The survey was sent to current attenders of the piloted Level 2 groups, of which I ran three, as well as to community staff without current access to the groups.

All participants received written information on the aims of the research and gave their informed consent for the findings of the audit to be shared by responding to the Survey Monkey link. Participation was voluntary and there were no adverse consequences to declining or withdrawing from participation (ibid). This was important so that no respondents felt coerced by virtue of being NELFT employees. Ethics were discussed with the NELFT Research and Development department, and as ethics approval was not required an agreement was reached for the survey to be registered as an audit (NELFT Audit Department, personal communication, July 10th, 2020).

I obtained the support of an assistant psychologist, and we used a mixed methods approach to analyse the results.

Participants in both the attender and non-attender groups were given questionnaires which enabled a quantitative methodology to be employed. Given all variables were categorical, a chi-square test³⁵ was used to compare proportional differences in these questions between attenders and non-attenders (ibid). All analyses were carried out in Stata, version 14.³⁶ We also then provided a comments section, where participants could expand on their answers, as well as give their own feedback. This provided a qualitative methodology to be employed, where we would undertake a thematic analysis of the responses.

In total, eleven (n=11) participants completed the questionnaire for attenders; all had previously attended or were currently attending a Level 2 community supervision group. Twenty-seven (n=27) participants completed the questionnaire for non-attenders, none of whom had ever attended any form of Level 2 or group supervision.

³⁵ Chi-Square test is a statistical method to determine if two categorical variables have a significant correlation between them (Tutorialspoint, 2020).

³⁶ Stata is a general-purpose statistical software package created by StataCorp.

The analysis of the results helped me to obtain a measurement of the efficacy of the four Level 2 supervision pilot groups:

- 82% of the attenders report that the Level 2 group had improved their capability to manage their own emotional wellbeing inside and outside of work.
- Over 90% of the attenders found that the group had boosted their confidence in working with patients who suffer from emotional distress.
- Over 90% of the attenders said that they would recommend the group to colleagues who also work in palliative care/ end-of-life settings

(For detailed results, please see **Appendices 12 and 13**).

There were some common themes that emerged as to the benefits of Level 2 supervision groups (Kingsley *et al.*, in press):

1) Level 2 group facilitators *provided a safe and confidential environment*, which enabled the responders to talk freely and to discuss their difficulties and concerns with their patients or related to work/organisational concerns.

2) Level 2 groups *provided a sense of containment*, especially for complex and distressing material that could otherwise feel overwhelming to the participants. The responses identified the important role that the facilitator of the groups created in providing this containment. The value of containment in supervision, especially in relation to nurses, has been extensively evidenced and documented (Kühne, Maas, Wiesenthal, & Weck, 2019; Menzies-Lyth, 1988; Palsson *et al.* 1994; Rafferty, 2000; Winship, 1995a, 1995b).

3) Level 2 groups provided a *supportive peer environment*. Group attenders reported that they were able to learn from other members' experiences, and that the emotional support and suggestions they received from the others helped plan their patient care. This result supports that of wider literature which identifies the positive

outcome of peer support, especially that for nurses (Adams *et al.*, 2017; Brunero & Stein-Parbury, 2008; Brunetto *et al.*, 2013; Cohen, Brown-Saltzman & Shirk, 2001; Medland *et al.*, 2004; Rothwell, Kehoe, Farrook & Illing, 2019).

4) Group attenders experienced a sense of *shared relatedness*, and this seemed to become prevalent in group discussions. They were able to recognise similar rewards and challenges evoked by the palliative/end-of-life cases. This seemed especially important in discussions related to complex cases in which mental health concerns were identified.

5) Group attenders reported a *reduction in feelings of isolation* by belonging to a regular, consistent group. Respondents noted that this was especially helpful in that they found working in palliative care challenging and it was difficult to share the stressors of the role with family and friends.

6) Level 2 group discussions provided a therapeutic space in which attenders *felt truly listened to*: their feelings and thoughts were validated by the facilitator and group members. This finding falls in line with the broader literature, in which the interpersonal connection between group members is documented as an important and positive factor in supervision (Allan *et al.*, 2017; Beddoe & Howard, 2012; Brunetto *et al.*, 2013).

7) Level 2 groups *improved and built participants' confidence* especially in working with mental health presentations compared to when they first started in the group.

As a senior clinical nurse specialist noted in her testimonial about supervision:

'I have a role of trust and because of my (home) visits I build up a rapport with many of my patients and family members. Often, they open up about life experiences that have had a negative impact on their life. This can be an emotionally heavy burden for me, have I said the right thing to allay their anxiety? Do they feel supported? Your sessions (Marc Kingsley) have given me direction and allowed me to grow and develop my Level 2 conversations...' (Appendix 11).

Feedback from both the recent questionnaire and the testimonials obtained from clinicians has demonstrated a transformation of practice in NELFT staff able to access community palliative care Level 2 supervision. In particular, there appears to be a significant development in a more psychologically-minded approach to clinical practice. Psychological mindedness is defined as an individual's ability to recognise and reflect on their own range of psychological /emotional states, and the emotional experiences of others (Nyklicek & Denollet, 2009). I have been witness to clinicians in the community Level 2 groups growing in confidence when working with the inner lives of their patients and acknowledging their own emotional responses and experiences. Wahass (2005) confirms that the development of psychological-mindedness in staff not only increases self-reflection and improves well-being, but it also helps staff to consider a more *holistic* view of their patients and their recovery. As a clinical nurse specialist recently noted in a testimonial about her supervision (see **Appendix 14**):

'Having Level 2 supervision as a Clinical Nurse Specialist has been vital in enabling me to continue to support my patients...Level 2 supervision has definitely enhanced my practice allowing me to provide a more holistic approach to palliative care, whilst feeling valued and well supported.'

The survey also helped me to obtain verification of concerns I have raised regarding the lack of formal supervision structures for community palliative care teams. In the non-attender responses, none of the clinicians reported any access to supervision specific to the emotional presentations of their patients. The risks associated with carrying complex cases, especially those presenting with high risks without formal supervision structures is well documented (Coxon, 2012; Rothwell *et al.*, 2019; Snowdon *et al.*, 2017). Furthermore, almost 86% of the non-attenders disclosed that their own emotional well-being at work was adversely affected by the nature of their caseload, and that a key reason why they would join a Level 2 supervision group was to gain support in managing work-related stress and their own emotional health (Kingsley *et al.*, in press) (**Appendix 12**). This finding is in line with the broader literature on the risks of compassion fatigue, burn-out, and high turn-over rates in community staff, especially those working in palliative care settings

(Abendroth & Flannery, 2006; Aycock & Boyle, 2009; Duarte & Pinto-Gouveia, 2017; Keidel, 2002; Smith, 1992, 2008; Vachon, 1995).

A mixed methods approach helped me to demonstrate a comprehensive understanding of the impact of the Level 2 supervision groups. This was achieved by incorporating both quantitative data, such as data analysis of differences between groups; and qualitative data, such as thematic analysis of patient feedback. I have recently co-authored a journal article which outlines the results of this survey (**PW 37**) and given a lecture to the London Cancer Alliance Expert Reference Group on the findings of the survey (**PW 45**). The aim of this lecture was to disseminate the findings of the survey to the lead psychologists working in oncology services in several London hospital trusts. It also provided an opportunity for me to share my vision of the expansion of the Level 2 model outside acute hospital trusts, and beyond cancer specific nurses to multidisciplinary teams in wider community settings.

There have been some important developments within NELFT as a result of the publication of the audit results. I was invited by NELFT's Director of Nursing to provide feedback on the Level 2 community audit to the end-of-life working group and NELFT management structure. As a result, the Trust has agreed to prioritise psychological support for palliative care and end-of-life community clinicians for 2020-2021. This has resulted in funding to expand community Level 2 groups into a further two Essex sites and bring psychology-led supervision for community palliative care and end-of-life clinicians beyond the London borders (D. Searle, personal communication, August 25, 2020).

Using Leadbeater's approach to social entrepreneurship, my public works in developing community Level 2 supervision groups have fulfilled the following qualities:

Entrepreneurial: I made use of underutilised resources (Level 2 oncology group material not yet utilised in a community settings) to satisfy unmet needs (for multidisciplinary staff support in community palliative care and end-of-life settings).

Innovative: I developed an adapted training and supervision model in community settings to support non-psychological staff working with the emotional lives and difficulties of their patients. In this respect, I brought together approaches that have traditionally been kept separate, such as the emotional and physical experiences of palliative and end-of-life patients and the supervision opportunities for acute cancer nurse specialists versus community multidisciplinary team clinicians.

Transformatory: I helped create sustainable transformation of multidisciplinary working in community palliative and end-of-life care settings in North East London. Community Level 2 supervision groups are now embedded in three London boroughs, and have recently been awarded further funding by NELFT to expand into Essex palliative care and end-of-life community sites. It has transformed the clinical practice of the group of clinicians who joined the pilot study in 2015. All the clinicians who initially joined continue to attend monthly groups regularly and report a substantial change in their approach to their patients' presentations, as well finding strategies to manage their own emotional well-being.

I have aimed to provide a synopsis of the ways in which my public works have impacted on enhancing staff support in the NHS. I will now turn to the third area in which I will demonstrate the impact of my public works, that is in developing consultation and training in suicide risk assessment particularly in the area of Digital Risk.

3.4 Developing psychological factors into suicide risk assessment and management in palliative care settings

'A wonderful heartfelt talk...so interesting & thought provoking about a very difficult, complex & deep topic'.

Feedback from presentation to hospice clinicians on suicide risk, 2017
(Appendix 15)

For patients with physical health conditions, the risk of suicide is significantly higher than the general population especially those with chronic and painful conditions (NICE, 2019). Similarly, the risk of suicide in the palliative care and end-of-life patient group remains a particularly underreported yet significant concern in health care (Calati, Di Mattei & Courtet; Choy, 2017; Kingsley, 2019; Moss, 2014). The relevance of incorporating suicide risk consideration into medical settings such as palliative care has therefore been a vital component of my role in clinical health psychology.

With the development of my role in palliative care, I was asked to contribute to training and support for clinicians and teams in the area of suicide risk assessment and management. As discussed in Parts One and Two, this was an area where many clinicians asked for specialist psychological support as limited or no clinical supervision was available. Many clinicians expressed their anxieties related to holding (often sole) clinical responsibility for patients with complex mental health presentations. Whilst mental health is covered in the training programme for palliative care nurses and allied health professionals this is often at a foundation level, and clinicians may describe a lack confidence in their risk management skills (Coxon, 2012; Kingsley & Wright, 2012).

I had worked extensively with suicide risk management in my previous position at NELFT, and I was able to fall back on my previous experience to assist in the development of more robust suicide risk management processes in palliative and end-of-life settings. Whilst chairing the CRAG (2010-2013), I had been struck by several cases of suicides in patients who were experiencing painful and life-limiting physical health conditions. One such case was of a patient who was given a terminal diagnosis, and without sharing her distress with her family spent several weeks online to research methods to take her life. In this time, she managed to order medication from an online pharmacy, after finding the exact dosages required for death in an easily

accessible Wikipedia article. Although the patient was well known to her oncologist and district nurses she had never been asked about her mental health and had never revealed suicidal intent.

I had a similar experience in my own caseload soon after I started working in the oncology service, when I was asked to do an assessment on a young lady who had been showing signs of low mood. She was highly intelligent, and was devastated by the fast, progressive nature of her condition. Her admission on to the ward was linked to unusual blood results which were life-threatening. When I asked the patient about her internet use, she acknowledged researching online for methods as to which drug interactions could hasten her death. Until I asked this question directly, no one in her medical team had any awareness of her own contribution to her worsening health or her deeply hidden suicidal ideation.

It was examples such as these, and the lack of psychological in palliative care and end-of-life settings, that contributed to my interest in developing much needed clinical risk staff training and consultation. Initially I did this in my clinical role on hospital wards when I met with teams to look at the holistic care of their patients. I also introduced clinical risk training in my regular monthly supervision groups with clinical nurse specialists and allied health professionals. After I was invited to help organise and contribute to mental health training events at our local hospice (St Francis Hospice) I began to reach a broader audience. The hospice training events became popular, and I received positive feedback (**see Appendices 15, 16**). As the Director of Training at the hospice noted in her feedback to me:

‘Marc...Thank you so much for helping to organise such a successful study day. The general feedback was we need more mental health study days and certainly for many it was the first they have attended and found it really useful’ (personal email correspondence from Santhini Avorgbedor, 2017).

My work at St Francis Hospice reached a wider group of palliative care clinicians and students, and I contributed to lectures and study days. St Francis Hospice also worked closely with the end-of-life team at NELFT and through this forum I was invited to participate in a range of different training events, such as at that at the Royal College

of Nursing (**PW 38**), and two London Borough end-of-life conferences (**PW 39 and 40**).

The impact has been that the topic of suicide in palliative and end-of-life settings has become a key component of training days in various NHS and hospice settings in North East London. NELFT has published links to my work in a blog (**PW 41**) as well as in a video review of the Havering end-of-life conference (**PW 42**). Clinicians have reported that they have been able to extend their assessment and management skills, and that their view of risk has extended from a physical specific focus, such as risks of medication interactions, to an awareness of psychological risk factors such as hopelessness and demoralisation (see **Appendices 15, 16 and 17**). I have recently joined the newly formed NELFT Suicide Prevention Strategy working group, and hope to continue to support the Trust in the area of suicide risk assessment and management.

(i) RiO Electronic system working group:

A further key area in which my work in suicide risk management has had an important impact on the NHS has been in risk recording, such as on RiO. RiO is a web-based electronic care record system, which is designed for health and social care organisations to store and retrieve information about their clients (Whitfield, 2008). Healthcare professionals across several London and UK mental health trusts now routinely use this (ibid).

In 2015, I was invited to take part in a working group set up by NELFT to assist with developing risk assessments for RiO. The work of this group fed into a national contract that managed electronic risk recording on RiO across London and the south east of England. I was the representative for Clinical Health Psychology. I primarily contributed to providing a psychological perspective on risk, and this had an impact on how risk has been assessed, recorded, and managed nationally in mental health and general clinical settings. Patricia Aveling, the clinical lead for mental health outcomes at NELFT, notes in her testimonial that

‘... as well as a broad range of knowledge and information on risk factors and good practice in risk assessment, monitoring and recording, some of Marc’s specific contributions included incorporating high risk factors such as hopelessness and ensuring questions relating to digital risks were included...’(Appendix 18).

I contributed to ensuring that a holistic approach was taken by NHS staff to the electronic recording of risk. In particular I emphasised the important need for clinicians to routinely assess and consider psychological risk factors, such as hopelessness and impulsivity, in patient presentations (Kingsley, 2008; Kingsley & Wright, 2012). The impact of my contribution to this working group has been significant, in that NHS trusts using RiO now routinely incorporate psychological risk factors into clinical risk assessments and management in all health settings. It is to my contribution in the area of Digital Risk that I now turn.

(ii) Digital Risk

The growing propensity for people to use online and digital means to research suicide methods and to find pro-suicide groups continues to increase dramatically (Kingsley, Stockmann, & Wright, 2017). As mentioned in Part Two, it was an important development to join the Digital Risk working group at the Tavistock Clinic, and it was during this period that I began to participate more in disseminating my own contribution to the area of digital risk assessment (**PW: 24; 25; 26; 27; 28; 29**). As noted in a testimonial from Dr Richard Graham, who led the working party on Digital Risk at the Tavistock Clinic in London:

‘Marc Kingsley has undertaken pioneering research and clinical service development to identify better and support those who may be at risk of self-harm and suicide due to online influences...This development has prevented a number of suicide pacts, which may have otherwise passed undetected...Marc has presented the outputs of his work at many national and international conferences, including to the Child & Adolescent Faculty of the Royal College of Psychiatrists, influencing the practice of clinicians beyond his own mental health trust.’ (Appendix 19).

One such international conference where I presented my work, and had the opportunity to share my practice, was with my colleague Dr Tom Stockmann at the 15th European Symposium on Suicide and Suicidal Behaviour, which was held in Tallinn, Estonia, in August 2014 (**PW 29**). This conference gave me the first opportunity to share my own theoretical contributions of suicide risk with an international audience, as well as to help clinicians and academics to consider the hidden online influences on the therapeutic relationship.

This has since been written about and published in a peer reviewed article (**PW 28**), highlighted by the editor of the journal in her introduction to the series (Yakeley, 2017). Digital Risk now forms part of suicide training we provide at NELFT, as well as being presented at national conferences, with positive feedback (**See Appendix 20**). I have included this theoretical consideration into my updated chapter of psychological approaches to the acute patient in the PICU handbook, which is to be published in 2020 (Cambridge University Press, personal communication, October 9, 2019).

In this section, I have attempted to delineate that one of the most significant risks affecting patients who present with chronic and enduring physical health difficulties is the risk of suicide - from the overt manner with a wish to die through to more indirect means of giving up on life and any hope of recovery. Through my public works I have attempted to increase the awareness of clinicians working in the NHS of the often underreported and insidious risks of suicide in physical health settings.

It has been a rewarding experience to see that an important impact of my public works has been to witness a transformation of my local NHS Trust to be more mindful of the reality of suicide in physical health settings, such as in palliative and end-of-life settings. Suicide risk assessments are now a standard assessment undertaken by staff at NELFT (from district nurses to doctors); high risk factors such as hopelessness and depression are now considered in treatment plans, alongside blood pressure monitoring. The work is still in its early days, but my hope is that this more integrated and holistic approach to patient health and well-being will continue to flourish, as staff

become more comfortable and familiar with training and working with their patients emotional lives and struggles - not only in my local Trust, but in the wider NHS setting.

Conclusion

My journey leading up to, and through, the Doctorate in Public Works process has been a deeply personal and meaningful period of self-reflection. In this regard, it has illuminated my own unresolved struggles and the personal motivation which has driven my public works. From the start of developing this context statement I have been mindful of how private and revealing this journey has been. It has not been as writing up any other previous research project or publication. I have needed to bring myself into the project, not in an intellectualised and abstract way but in a very real and intimate way. In this regard, it has been important for the reader to reach me to reach my public works.

During the writing of the context statement there were some moments of revelation, where I had '*a-ha*' experiences, similar to those that I have uncovered in my own personal therapy and supervision. For example, the image of my seventeen-year-old self, sitting in a dental hospital and trying to process the disappointment of a prosthetic ear that did not fit properly became a prominent image that emerged during my reflection of my public works. As noted by Moustakas (1990), it brought something from deep within myself to the fore and guided me to understand how personal struggles with my own craniofacial condition have impacted on my determination to develop psychological services in physical health settings.

As an entrepreneur and leader in my area of practice I am dedicated to supporting change which transforms and improves services, as without such movement traditional models remain unchallenged and risk stagnation. Psychological therapists have a key role in leading change but being able to make such change on a broader systemic level in the NHS is not always easy. I have needed to listen to what has not worked so far; what patients and staff note is necessary, and find innovative ways of achieving sustainable change with limited resources.

Finlay (2013) describes how reflexivity in research creates a tentative approach, where findings are always open to further description and interpretation. This is important to my approach to my public works as I believe that my work journey, as my broader life journey, is constantly evolving and transforming. It is not complete, and I am interested in discovering how my public works up to this point may influence and be influenced by my future experiences.

Thank you for your time in reading my personal journey.

Addendum

”.. “The support ...the psychology team... have offered...has revolutionised the care we provide for our patients...I have seen patient outcomes improve significantly as we are now able to offer this valuable resource. The support the team has offered to their dental colleagues during the Covid-19 pandemic, through working groups and individualised sessions has meant staff have felt supported and well looked after throughout”

Joe McQuillan, Clinical Director for Dentistry, Oral Maxillofacial Surgery & Ophthalmology, Barts Health NHS Trust. September 2020 (**Appendix 23**)

Since completing this context statement there have been significant changes to my work role as a clinician and manager, due to the unexpected consequences of the COVID-19 pandemic. The aim of this addendum is to provide an update on how the pandemic has impacted on one of the key areas that I have discussed in my public works - the DOT Psychology Service - and my responses to the challenges it has created. The COVID-19 pandemic has brought to the fore some of the key drivers of working as an entrepreneurial leader, as outlined by Leadbeater (1997) and du Plock and Barber (2008). These include flexibility, working with unexpected changes and providing containment for individuals and teams.

There is a growing amount of recently-published literature on the consequences of the COVID-19 pandemic for NHS services, including the provision of psychological services (NHS Check, 2020; Public Health England, 2020; British Psychological Society, 2020). However, at the time of the first wave of the virus in March 2020 there was little to guide NHS managers, department heads or clinicians on how to prepare and manage the psychological impact of the pandemic. It was a sudden and abrupt challenge that I faced, as the DOT- Psychology Service was set to open at the beginning of the new financial year in April 2020.

My initial challenge was that NHS England had to focus funding on the pandemic, which left the funding for the new DOT-Psychology service in question.

There was a move within other NHS services for staff to be re-deployed to essential and high-risk areas, and the majority of the dental psychology service was deemed to be non-essential. As a result, the new contract for the DOT-Psychology service was queried by the finance departments of the NHS Trusts.

It was a stressful period, as I was uncertain as to whether a new psychology team would be able to commence their posts - especially difficult for those psychologists who had left other posts to join the new DOT-Psychology service. I decided that the best course of action was to obtain a response from NHS England in writing, and to then manage the consequences of this response. Together with the Clinical Director for Dental Services at Barts Health, I contacted NHS England and was surprised to receive a very quick response via email. This was a clear and reassuring message that the funding for the DOT-Psychology service had been safeguarded and that the service could commence as agreed. The relief we felt was tangible, but further challenges were to follow as we headed into the thrust of the pandemic.

As mentioned earlier, there was an urgent move in the NHS from non-essential to essential NHS cover. This was to support the significant influx of very unwell patients coming through to the NHS and flooding inpatient services. Staff were moved to completely new areas, and this applied to the dental hospital. The majority of dental services were suspended, including the Orthognathics Service and Paediatric Dental Service. Consultant orthodontists, dentists and surgeons were all re-deployed to areas outside of dentistry, such as maternity services, A&E, ICU and COVID-19 testing areas. Only a handful remained in dentistry, and this was for urgent dental care. There was also reduced cover for the oral trauma service. This meant that there were limited dental teams available to provide referrals to psychology, and outpatient clinics and procedures were suspended for patients. Similarly, NELFT requested that psychologists be re-deployed to areas that were deemed essential, and this left me uncertain as to where the new DOT-Psychology team would be stationed.

I worked closely with Lindsay Royan, the Professional Lead for Clinical Health and Specialist Services at NELFT. We met regularly and planned a response to the

requests for our clinical health psychology teams to re-deploy to essential services. We managed to secure agreement from NELFT for our psychologists to continue providing a clinical service, albeit at a reduced amount. This was a positive development for our psychology service, as we wanted to ensure that patients had some level of continuity at a time when their key clinicians were no longer available, and treatment suspended. I also encouraged our psychologists to develop patient-focused audits to monitor the impact of COVID-19 on the suspension of their dental treatment. This audit is currently underway, tracking the experiences of patients waiting for orthognathic surgery suspended due to the pandemic (Clinical Effectiveness Unit, Personal Communication, 2nd July 2020).

We also wanted to be there to support dental hospital staff, as there was a clear indication that staff were finding the COVID-19 pandemic stressful (NHS Providers, 2020). The move to support staff well-being through the pandemic tied in closely with my vision of both the DOT-Psychology service as highlighted to NHS England in 2019, and my broader public works - i.e. to promote the psychological well-being of NHS staff. It was also closely linked to a recent publication by NHS England on the NHS People Plan 2020-21, in which from September 2020 every member of the NHS would have a health and well-being conversation and develop a personalised plan (NHS Providers, 2020).

Although our clinical contact with patients reduced during this period, we had an important opportunity to utilise the highly qualified and talented psychology team at DOT-Psychology to support the emotional health and wellbeing of the Dental Hospital staff, whether administrators or surgeons. As a service, the DOT-Psychology psychologists provided support on both individual and team levels. This included both one-to-one support, in terms of short-term work to help support staff to manage their psychological responses to the pandemic, and signposting staff to mental health services if they required more intensive mental health involvement. An online mindfulness group was set up for staff (to join via video conferencing) to support their own well-being and stress management during the period of redeployment. I also spearheaded the development of a 'return to work' psychology group, for dental staff

to explore and manage the potential for health anxiety and stress responses related to their return to ‘business as usual’ in the dental hospital in August 2020.

We have received positive feedback from the dental hospital about our role in managing the significant changes that occurred through the pandemic period to date. Dr Zahra Syed, Consultant in Oral Medicine notes (**Appendix 22**):

‘The dental psychology service have provided both staff and our oral medicine patients the support they needed to be able to continue working and improve their conditions with the added stresses of the COVID -19 Pandemic. Their adaptability, care and professional attitude has allowed us to support our patients as best possible under difficult circumstances and improved the quality of care for our patients significantly...’

Similarly, Professor Simon Holmes, Lead Surgeon in the OMFS notes (**Appendix 21**):

‘The embedding of the... psychology... team within the outpatient setting allows prompt assessment and targeted support - and the work should simply be described as transformational. This group will simply make so many patient’s lives better and break the vicious cycle of descent into psychological distress and re-injury. The support that the teams give us as clinicians is also incredible - we should not forget that the harrowing stories and witness the torment that our patients undergo also leaves its fingerprints on our souls - I am personally grateful for this support.’

This is an ongoing project, as we remain uncertain as to how the pandemic may impact on the dental hospital moving forward.

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Appendix

Volume 1: Appendices

Appendix 1: Definition of Terms and Acronyms

BARTS HEALTH NHS TRUST/ ROYAL LONDON DENTAL HOSPITAL

BARTS HEALTH NHS TRUST is an NHS Trust made up of five hospitals who have been working together since 2012. This includes the Royal London Dental Hospital, a leading specialist a leading specialist and research centre offering a full range of services for patients with injuries, diseases or abnormalities affecting the face, jaws, mouth, head and neck. Patients come from across London, Essex and the rest of the country.

BURN-OUT

Burnout is a term sometimes used interchangeably with vicarious trauma, but this condition does not necessarily involve a traumatic element. People can experience burnout when they have a toxic work environment or when they feel themselves to be doing tedious or otherwise trying work without getting enough time for rest or appropriate self-care.

CAMHS

CAMHS stands for Child and Adolescent Mental Health Services. CAMHS is the NHS service that assesses and treats young people with emotional, behavioural or mental health difficulties

CCG

Clinical Commissioning Groups (CCGs) commission most of the hospital and community NHS services in the local areas for which they are responsible.

CLINICAL HEALTH PSYCHOLOGY

Clinical Health Psychology is a specialism within Clinical Psychology, focusing on the planning and delivery of interventions to affect positive change and improve coping in relation to physical health problems or illness

COMMISIONING

Commissioning involves deciding what services are needed for diverse local populations, and ensuring that they are provided.

COVID-19

Coronavirus disease 2019 (COVID-19) is an infectious disease caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

DSM-5

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) is the 2013 update to the Diagnostic and Statistical Manual of Mental Disorders, the taxonomic and diagnostic tool published by the American Psychiatric Association (APA).

ECT

Electroconvulsive therapy (ECT) is a psychiatric treatment in which seizures are electrically induced in patients to provide relief from mental disorders.

ICD-10

The ICD-10 is an international diagnostic classification standard for reporting diseases and health conditions.

MICROTIA and ATRESIA

Microtia is a congenital deformity in which the cartilage of the outer ear is underdeveloped or absent and atresia is the absence or closure of the external auditory ear canal

NELFT

NELFT NHS TRUST provides an extensive range of integrated community and mental health services for people living in the London boroughs of Barking & Dagenham, Barnet, Havering, Redbridge and Waltham Forest and community health services for people living in the south west Essex areas of Basildon, Brentwood and Thurrock.

NATIONAL HEALTH SERVICE (NHS)

The National Health Service (NHS) is the publicly funded national healthcare system in the United Kingdom, which was founded in 1948. The organization, funded primarily by taxation, provides free or low-cost healthcare to all legal residents of the U.K

NHS ENGLAND

NHS England leads the National Health Service (NHS) in England. It has seven regional teams that support the commissioning of healthcare services for different parts of the country.

ORTHOGNATHICS

Orthognathic surgery is a specialist branch of oral and maxillofacial surgery and is usually part of orthodontic treatment. It involves the modification of the jaws in order to change their alignment and position to improve both the function and appearance of the mouth and sometimes airway.

SERVICE LEVEL AGREEMENT (SLA)

A service-level agreement (SLA) is a contractual commitment between a service provider and another organisation, such as an NHS Trust or a commissioning group. Particular aspects of the service – quality, availability, responsibilities – are agreed between the parties in the form of Key Performance Indicators (KPI).

VICARIOUS-TRAUMA

Vicarious trauma, also known as secondary trauma, can be described as indirect exposure to a traumatic event through first-hand account or narrative of that event. People in the helping professions—counselors and therapists, rescue workers, police officers, doctors, and lawyers—may be at risk of vicarious traumatization.

ACRONYMS

BHR (Barking, Havering and Redbridge)

EOL (End of Life)

CHPS (Clinical Health Psychology Service)

CNS (Cancer Nurse Specialist)

CDG (Clinical Discussion Group)

DHPS (Department of Health and Social Care)

DPS (Dental Psychology Service)

DOT-P (Dental and Oral Trauma Psychology Service)

LCA (London Cancer Alliance)

MDT (Multidisciplinary Team)

NAPICU (National Association of Psychiatric Care Units)

N.E London (North East London)

NHS England (NHSE)

NPSA (National Patient Safety Agency)

OMFS (Oral Maxillofacial Surgery)

PICU (Psychiatric Intensive Care Unit)

PTSD (Post-traumatic Stress Disorder)

PW (Public Works)

QMUL (Queen Mary University, London)

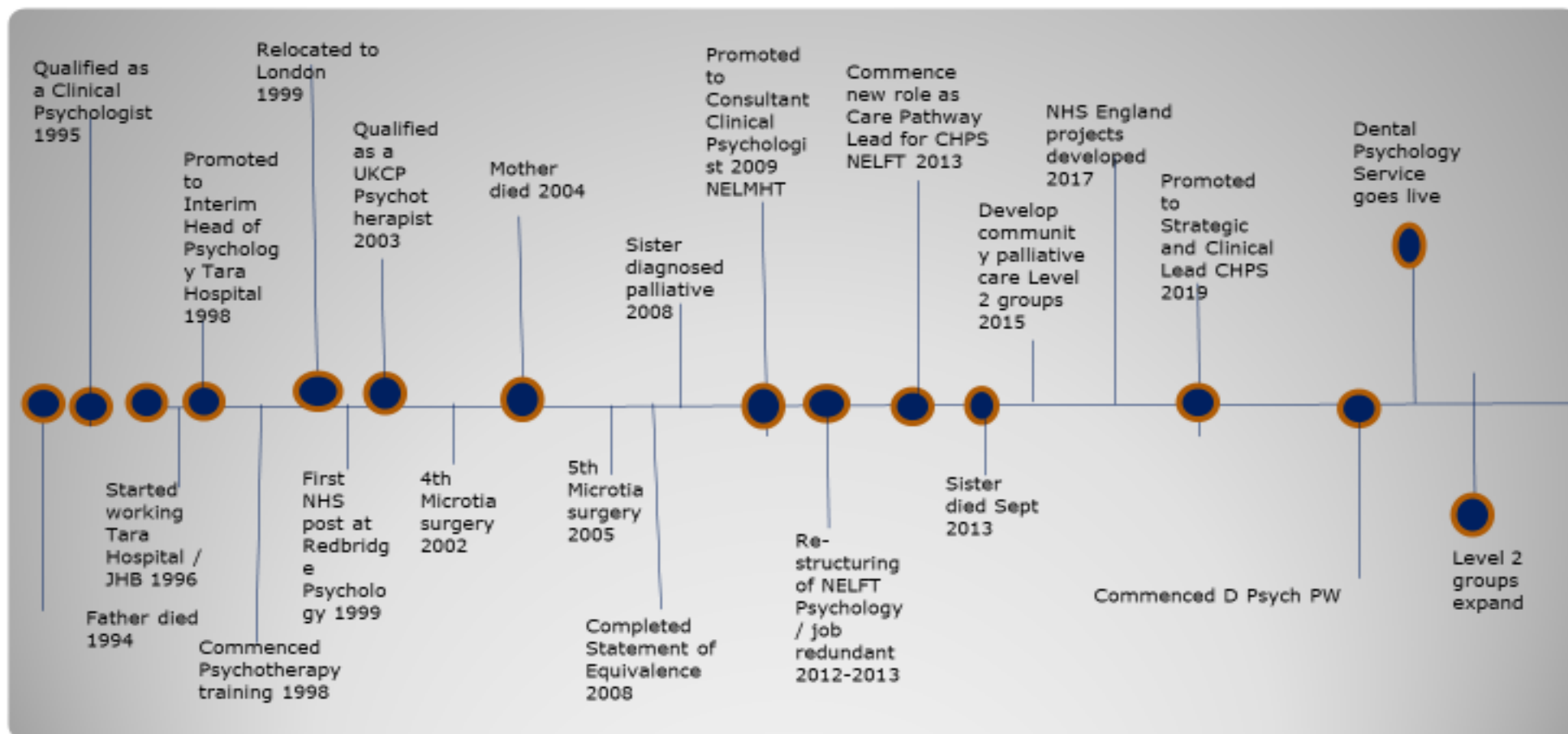
RLH (Royal London Hospital)

SLA (Service Level Agreement)

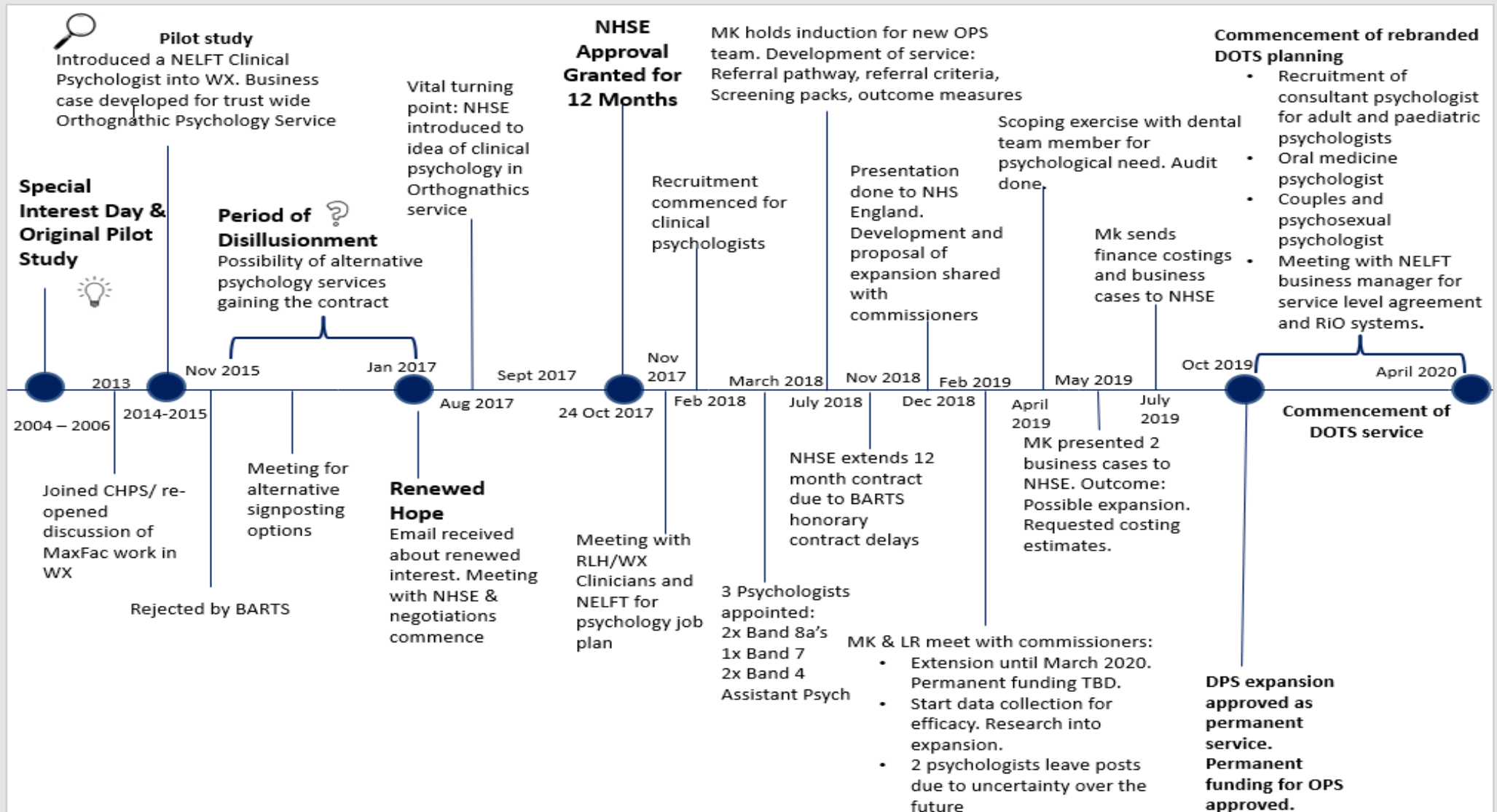
UK (United Kingdom of Great Britain and Northern Ireland)

Appendix 2: Timeline

TIMELINE 1994-2020



Appendix 3a: Timeline of dental psychology timeline



Appendix 3b: CRAG Review 2010



CLINICAL RISK ADVISORY GROUP REVIEW:

Core members:

Marc Kingsley (Consultant Clinical Psychologist/ Chair)

Viv Hayes (SUI manager/nurse)

Harjit Bansal (Ethnicity /Cultural)

Marilyn Wilson (IMPART specialist)

Lorna Mess (PICU)

Roy Li (OT rep)

Laura Capellino (older adults)

Heather Bollock (CPN/ CMHT)

Dr Prabha Moorti: Consultant-RHTT

Susan Smyth (Practice Improvement/nurse)

Nick Gould (Practice Improvement practitioner/nurse)

John Stanbury (AOT/WF)

Pat Ryan (AOT HAVERING)

Modupe Popoola (Team Leader: D.R.I.V.E : B&D)

Dave Hartie (CMHT Havering/ Drive)

Tim drew (advisory)

We require an A&E representative.

Proposed members for 2011

Amanda Jones (Perinatal Service)

Adolescent rep (Brookside)

Initial Phases of the CRAG development:

<i>PHASE ONE: (Dec 09-April 2010)</i>
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After initial discussions with members of the Risk Assurance Group, in December 2009, Marc Kingsley agreed to assist in the development of a Clinical Risk Advisory Group for NELFT. This group was to be closely linked to the Risk Assurance group; its primary aim being to utilise the expertise of MDT clinicians to overview major incidents reported to the Trust, and to report these findings to the Risk Assurance Group. The hope of the formation of such a group would be to capture clinical themes and trends that may emerge, and by virtue of this, to hopefully help reduce risk and increase best practice.

After careful discussions with the Risk Assurance Group, Alex Horne and Tim Drew, a provisional list of group members was devised. With this in mind, invitations to considered members were sent out, and an enthusiastic response was received. With the help of the Risk Assurance Group members, a tendency towards higher level clinicians was noticed, and a request to try and balance out the membership to include clinicians 'on the shop floor', was encouraged. This included broadening the invitation to practice nurses, support workers and other clinicians dealing with risk on a daily clinical basis.

The initial phases of the CRAG meetings from January-April 2010 were directed towards:

1. Finding a specific area of reported risk for clinicians to focus on, and
2. To develop a clinically suitable tool to capture relevant information.

1. Risk focus:

As a consequence of this decision, Viv Hayes kindly presented the ***Sudden Unexpected Death Report (SUD's) 2008-2009***, an annual report produced by the G&A department providing statistical data on the number of deaths subject to a Coroner's inquest, excluding deaths from natural causes and homicides. The group agreed that the trend indicating a year on year increase in the number of service users subject to a coroner's inquest, who could possibly seen as having ***ended their own life*** was worth further analysis.

Due to the restricted time available to clinicians in the CRAG group, a clear focus was hence discussed, and an agreement was reached by the CRAG to focus on those Sudden Unexpected Deaths that had occurred ***in the community***, as this was the area of **higher incident rating**. This feedback was brought back to the Risk Assurance Group, who agreed to the CRAG focusing on this specific piece of work.

2. The development of a clinical risk template/checklist:

Discussion within the CRAG focussed on identifying a **standardised tool** for use in any project work undertaken. It was agreed that a **template/checklist** would be pulled together, which would hopefully capture known important demographic and clinical features linked to suicide, drawn primarily from the NPSA suicide audit tool, relevant literature, as well as ideas and feedback from members of the CRAG group.

The first draft of this was presented to the CRAG in April 2010. Feedback received at that CRAG meeting was that the initial checklist was felt by members to be too time-consuming and arduous to use when looking through files.

Viv Hayes and Sue Smyth hence kindly volunteered to assist in producing a checklist which would be more user-friendly and easier to navigate. A major development and insight from Viv and Sue was to ensure that the checklist categories (eg demographics and clinically relevant information) could be easily accessed through a format linked to RiO, and especially to the findings of information in care plans, core assessments and risk assessments. (see Appendix 1).

3. A discussion of cases to be reviewed:

The CRAG had agreed to focus on Sudden Unexpected Deaths in the Community 2008-2009:

- It was agreed that the next step would be to **prioritise the cases to be reviewed** at the next CRAG meeting in May with members voting according to their own personal interest/criteria (no set criteria to be agreed or imposed)
- It was agreed that the **cases would be reviewed in CRAG time**, members working together in a suitable room, with computers available for access to RiO.
- Viv Hayes agreed to produce a **thumbnail sketch of 20 cases** of SUD's to inform this process, but it was agreed that due to the complexity of some cases, not all 20 may be able to be reviewed this year.

PHASE TWO: May 2009-July 2009

1. Cases Prioritised:

During the May 2010 CRAG meeting, Viv Hayes identified and discussed the twenty cases of sudden unexpected deaths of NELFT Service users which had occurred in the in the Community 2008-2009.

CRAG members were then requested to give priority to the twenty Sudden Unexpected deaths discussed, using a nominal voting form provided. (See Appendix II)

Those with the highest priority were then selected for the study. (See Appendix III)

It was at the end of this May meeting, and through discussions with fellow CRAG members, it became apparent and was recognised that a vital element of the group process would be on having a period of de-briefing as a group after each following meeting, as the group was now becoming much more clinically oriented, with the emphasis on reviewing difficult and emotionally challenging cases.

2. Discussions on the proposal of registering the CRAG as an audit:

In discussions with Tim Drew, Viv Hayes, and Marc Kingsley, the proposal of registering the CRAG as an audit was introduced. This proposal was keenly accepted by CRAG members, and Dawn Nortman, Audit Facilitator, was hence approached.

An Audit proposal form was developed by Viv Hayes, and further meetings, including those with Sue Smyth, from Practice Improvement, ensured that the audit proposal was ready to be submitted to the Audit Department.

The title of audit project is:

CRAG – Trends and Themes arising from Sudden Unexpected Deaths in the Community 2008-2009: a clinical perspective.

The process of developing the checklist to formic to capture data entry was developed with the help of Dawn Norton. (See Appendix 1V)

Audit proposal:

A brief summary of the audit proposal can be found in Appendix IV and includes the aims and objectives of the Audit, which clearly link the Audit findings to recommendations for improving practice, and reducing the number of SUD's in the community. As noted in the Audit Proposal (p.3), the findings of the audit are to be disseminated through local and Trust-wide Integrated Governance & Practice Improvement forums, to share lessons learnt and inform recommendations (on a number of levels from clinical to training). Hence, in discussions with Maureen Dodds and colleagues, the vital link with risk training will be an essential aspect of the function of the CRAG group, and the audit findings.

Proposed Timescale of the Audit:

Data collection: **Start Date:** **March 2010** **End Date (approx):** **October 2010**

Input and analysis: **Start Date:** **October 2010** **End Date (approx):** **December 2010**

Final Report: **Start Date:** **February 2011** **End Date (approx):**

April 2011

The final report will include Recommendations and Action plans.

PHASE THREE: July 2009-October 2009

Monday 28th June 2010 saw the commencement of the first meeting in which CRAG members began the practical review of the cases shortlisted. Important feedback from this initial practical review process identified some helpful themes:

1. Group members found the ability to work in pairs more helpful, as it added the dimension of addressing and discussing information emerging from the notes.
2. The necessity of time for group members to offer feedback, and debriefing element at the end of the group was felt to be an important aspect of the monthly meetings.

3. Lack of information on many of the cases being reviewed became apparent, in that information could be sparse, and at times no other reports/case notes were available other than what was originally available for internal inquiry. Some deaths that fell into the chosen category of the priority list had had no further information at all and could hence not be included.

CONCERNS RE MEMBERSHIP:

August/September posed a difficult period for the CRAG in that attendance was less frequent and some group members were finding it difficult to attend due to a number of different meetings clashing with times.

As a result of this, the few members that did attend used the time available to discuss the current dilemma experienced by the CRAG, and an agreement was reached by the group members that due to the short period left in which to get through the cases allocated for this year, a necessity to allocate two further extraordinary dates was required. It was also found that due to the difficulty in finding the necessary information and notes, it would be best to focus on completing more thoroughly the cases identified than solely on a number basis.

The Chair sent out an email to view concerns regarding the lack of consistent presence at the CRAG meetings.

The essence of the email reiterated the importance of consistent presence at the group, and the Chair's concerns that without the extra dates suggested in place, and the commitment of members to **regularly** attend meetings, the CRAG group will not be able to fulfil its objectives and functions by the year end.

On a more positive note, from September 2009, onwards, attendance dramatically improved, and a core, smaller group of members have been dedicated to going through the cases being analysed.

The good news is that the CRAG is meeting its audit deadlines and is ready for the 'input and analysis' phase which is set to commence from October-December 2010.

Some comments from CORE members on trends and themes thus far: a flavour of possible emergent themes: this information will need require further analysis.

1. Some of the cases seemed to be a combination of both paper notes and RIO entries, with more integral and significant information being found in the paper notes rather than on the RIO system.

We would wonder if this trend would now be ameliorated now that RIO has been running for a period of maturation?

Some concerns regarding the quality of risk assessments and the dearth of significant historical information available on RIO and in cross service transition were reported.

2. What struck a number of clinicians was that some of the reported SUD's occurred at a period where the service users had reported a period of progress in their mental health, and appeared to be collaboratively engaging in their treatment plan and/or with identified support.
3. Chronic pain, as well significant adverse changes to physical health and consequent functioning seemed to be a theme emerging in a number of cases, and may point to the necessity of a more integrated risk management process with medical as well as psychiatric health systems. The development of a possible 'red flag' system in physical health settings to alert for potential risk factors (eg hopelessness or despair after hearing 'bad news') could be a vital process in practice development.
4. Important themes related to ethnicity and sexuality appeared in some of the male service users, with a trend of men in this group to openly discuss and accept their sexuality within their family and broader cultural system.
5. A closer examination of some of the very complex and long-standing cases showed a repeated expression by the service users of feelings of hopelessness and demoralisation linked to the enduring and chronic nature of their mental health condition.

(Marc Kingsley, Roy Li Oct 2010)

WAYS FORWARD.

The focus of the rest of the year for the CRAG will be on the **thematic analysis of trends and themes that emerge from cases reviewed**, Lessons learned and the implementation of guidelines and training with the essential aim in the reduction of SUD's in the community.

The National Patient Safety Agency have been interested to hear about the CRAG, and have invited Marc Kingsley to be a member of a steering group in working towards the development of a **community checklist for suicide prevention** (in lines with the similar inpatient checklist). This proposal will be discussed with the RAG in October 2010.

A close link between lessons learned, themes emerging from the CRAG analysis and the future **training of staff** in the process of risk management is envisaged.

Marc Kingsley, C.Psychol

Chair

Clinical Risk Advisory Group

Appendix 4: Testimonial from Dr Zahra Syed

From: SYED, Zahra
Sent: 24 February 2020 10:54
To: Kingsley Marc
Subject: Re: Hi from Marc

Dear Marc

As requested below:

I am an oral medicine consultant at the royal london hospital. I started my post 2.5 years ago and found that our group of patients in majority had painful chronic disease which which altered appearance, limited speech and nutrition hugely impacting their psycho-social health and therefore their quality of life and ability to cope with the burden of disease. This was leading to poorer responses to clinical care and prolonging treatment within this tertiary hospital setting and causing an impact on review clinical waiting lists, impacting clinician patient relationship and putting awaiting list burden on the advice which was impacting staff morale and levels of stress. As well as this we were seeing that patients psychosocial profile was increasing the number of new diseases occurring within our population impacting on a high volume of new referrals burdening this waiting times also. More than this we were trying to help with this aspect of their care in the appointments prolonging them increasing waiting times in clinics which was our major source of complaint from patients. This was necessary despite minimal training in such matters to cope with this added emotional burden on staff as psychological care either could not be accessed in community by our cohort of patients on the nhs, they had to wait over a year to receive this or was delivered by psychologists with minimal experience in our patients diseases potentially effecting their outcomes.

As such the need was great and I was looking to solve this problem quickly. I was blessed to find that Marc Kingsley was developing such a service with our orthographic team to deal with such things as body dysmorphia etc. Dr Christine Casey was kind enough to put me in touch with him and his team. He was completely approachable and engaged and understood our need well given his previous experience with the our orthognathic team. He was able to build a business case Which allowed nhs England to fund and build a dental hospital service for which we have fully recruited for. So far this has given staff a psychological advantage that we will be able to move forward in the care of some of our most struggling patients giving us hope to improve the service as a whole. I look forward to this and the research that could come out of this.

Without his involvement it would not be happening. Thank you Marc.

Dr Zahra Syed
Consultant in oral medicine

Appendix 5: Testimonial from Dr Simon Holmes

From: HOLMES, Profsimon (BARTS HEALTH NHS TRUST)
Sent: 14 March 2020 11:49
To: Kingsley Marc
Cc: MCQUILLAN, Joe (BARTS HEALTH NHS TRUST)
Subject: Re: Update

Hi Marc,

Many apologies - I am literally sprinting to keep up.

Currently we are , as we have been for years , desperate to formally engage with an embedded psychologist.

There are already a number of patients who are waiting to see the new incumbent - and without this knowledge of this appointment - we would be really struggling.

With respect to the work that you have done in raising the profile and in successfully marshalling the process resulting in the posts appointed - I can only wonder at how you managed to do this, and our patients will benefit greatly, myself and my successors will be forever grateful.

With respect to precise timetabling - this should be done in concert with Joe McQuillan - my CD - copied in - who is also embedded within the trauma team - and he too has seen the benefits of an embedded psychologist and in addition what it is like to not have one.

April sounds good

Appendix 6: Testimonial from Mr Nayeem Ali

From: ALI, Nayeem (BARTS HEALTH NHS TRUST)
Sent: 09 March 2020 12:23
To: Kingsley Marc
Subject: Service citation

I was appointed Consultant Oral and Maxillofacial Surgeon to Whipps Cross and The Royal London Hospitals in 2002. One of my remits was to develop an Orthognathic (corrective Jaw surgery) service at Whipps Cross to support patients undergoing treatment in the Orthodontic department.

As a registrar I was interested in the psycho-social aspects of jaw and face deformity and felt that this was important to consider in the overall management of such patients. Indeed, I believed that understanding patients concerns and experiences, as well as identifying underlying conditions of anxiety and depression that may affect management and outcome is essential, especially in this vulnerable adolescent/young adult group.

It was serendipity then that Marc Kingsley walked into my department one afternoon. Marc explained his role as a clinical psychologist and also his interest in how this can be applied to the face and patients undergoing facial surgery. We found we were immediately on the same page. After arranging an honorary contract Marc started coming to my clinics to better understand the journey and experience's of orthognathic patients. Psychological support services for this patient group was scarce enough, but our model brought all parties together in an MDT format which I believe was unique, certainly at that time.

As the service developed we refined aspects according to our experience and workload and introduced PHD students and research aspects. The service was punctuated at times due to the demands of Marc's home trust which was providing the service for free and the financial problems of our own trust which was unable to fulfil a commitment to fund the service once setup.

What we did find was that I as a surgeon learned a lot of important information about my patients and patients were supported in understanding their feelings about their appearance an social embarrassment and also their fears of having surgery and change to such an important part of their body.

As time went on Marc introduced new colleagues such as Nicola Taylor who were equally outstanding and it was clear from our patients that this aspect of the service was very important in their management. As a result of the service I have been able to treat complex cases that just would not have been possible without the detailed assessments and treatments provided by Marc and his colleagues. Outcome measures have demonstrated this, and following Marc's never ending positiveness in pushing for funding and the diligence of my orthodontic colleague Christine Casey, we did secure long term funding for the service which is now part and parcel of the overall care we offer. Indeed, I would go as far as saying that I would not continue to perform such surgery without them.

Nayeem Ali
Consultant Oral and Maxillofacial Surgeon

Appendix 7: Testimonial from Dr Christina Casey

From: CASEY, Christine (BARTS HEALTH NHS TRUST)
Sent: 04 March 2020 15:07
To: Kingsley Marc
Cc: ALI, Nayeem (BARTS HEALTH NHS TRUST); p.k.sharma; CASEY, Christine (BARTS HEALTH NHS TRUST)
Subject: Re: Orthognathics service

Dear Marc

Please find my statement below (I have cc'd Nayeem and Pratik in as a reminder of dates etc).

Statement by Christine Casey

"I initially met Marc at Whipps Cross Hospital in February 2014 when we had a new clinical psychologist start working in the department called Nicola Taylor. Marc and Nicola both worked for NELFT and Nicola would be working at Whipps for a few days a week (funded by NELFT) to help to demonstrate need for a clinical psychology service within Barts Health. Nicola would be working under Marc's direct supervision and prior to Nicola starting at Whipps Marc had also worked at Whipps Cross alongside the Orthognathic service with our OMFS surgeon Nayeem Ali in 2003/2004 predating when I started working for the trust in 2011.

Marc had been extremely keen to support our service and build a case for the establishment of clinical psychology services at Whipps and we worked closely together to write a business case for the service as well as eventually to make a pitch for a service to NHSE in September 2017. We went to NHSE to pitch or the service along with Lindsay Royan on 28th September 2017 and were successful in securing 130K for a service funded by NHSE on initially on a trial basis for a year. We then were able to recruit three clinical psychologists supported by two assistants to run the service for the next 12 months. This proved immensely successful and ultimately lead to the agreement for NHSE to make the funding available on a permanent basis following numerous monitoring meetings over that twelve month period.

Marc and I have been involved in the advertising and recruitment of all these staff members as well as the careful development of the service from the ground up with service operating procedures and development of paperwork for assessments and referral forms. Nayeem Ali and Pratik Sharma have both worked closely with Marc to establish this service and quality assure its development alongside me.

We currently have two clinical psychologists working one at RLH and one at WX supported by one assistant. We are now concentrating on building the service to include patient information clinics for patients about to start orthognathic clinics as well as patient case discussion forum meetings for staff education in complex case management and staff mindfulness work to improve the quality of working life of staff. Charlotte recently presented a lecture on clinical psychology with Marcs support as part of the annual orthognathic course run by Pratik Sharma at RLH.

Marcs assistance and support has been instrumental in securing funding for further services by NHSE (500K) providing psychology services for trauma, paediatrics, special care and oral medicine. There are also plans to develop the cleft service within Barts Health which works in partnership with GOSH.

Marc has been an excellent support through this journey and we are making plans to write up our experiences in development of the service for publication in a Orthodontic journal so as to inform our colleagues who are looking to develop similar services."

Bw
Christine

Appendix 8: Testimonial from Dr P. Taylor, Clinical Director of Barts Dental hospital

From: PD Taylor
Sent: 24 February 2020 12:26
To: Kingsley Marc
Subject: Letter

DENTAL PSYCHOLOGY PROJECT AT BARTS HEALTH NHS TRUST FROM THE CLINICAL DIRECTORS PERSPECTIVE.

Although Dentistry has obvious historical connotations with patients fearing accessing dental care from several aspects including pain and fear of losing teeth with consequential aesthetic alterations to the face.

Very little work has been done around the psychological impact of dentistry as a whole and undergraduate curriculae have little input from the Psychology or Psychiatry professions. Only KCL can boast a full time Professor in Dental Psychology and the majority of work in recent times has emanated from that department with others often providing amateur attempts to link patient profiling to diagnostic nomenclature without real knowledge.

Barts health had linked with NELFT in the past (2004 -13) on a project where severe facial disfigurement through jaw size discrepancy caused significant psychological issues but there was no finance for this and as such the service was not secure. In addition this work was centred at Whipps Cross hospital had not been shared across the networked departments in the Dental / OMFS service so, although valuable, had little impact centrally.

My personal view as Clinical Director has always been that the sharing of good practice is essential and silo working should be avoided. To this end I had fought hard to ensure the proposal for a commissioned orthognathic service with NELFT should be across site. This was finally agreed and the service began and has since run successfully. As the commissioning team in London trusted this approach and could see the KPIs were being achieved they were persuaded that a more comprehensive service was needed and funded us to the tune of £590,000 pounds per annum as a continuing specific service funding.

Along with Marc Kingsley as the Consultant Psychology Lead for the project we together formed a close alliance in building the new team which will begin work in April of 2020. Personally I have learned a lot from this process and understood how the Psychology service runs in an ever changing NHS and more importantly the specialised areas which can affect Dentistry and OMFS. With this work we are able to provide patient support to Facial and Dental Trauma, Paediatric Dentistry, Special Care Dentistry, Oral Medicine, Orthodontics and support the Dentist themselves who deliver this service.

Marc has delivered at every level in the setting up of this service and with his guidance, together we have managed the expectations of the dental clinicians and provided a broad based but relevant team of psychologists who all have specialist knowledge in the specific areas in which they are to work. I personally have found working with Marc an amiable and educationally exhilarating experience, learning myself the complexities of how Psychology is funded, managed and delivered

in today's NHS where budgets often intrude on excellence in clinical care. I have been inspired by the way Marc has led his team which fits exactly in the expectations I have of my Dental colleagues and together we are working on the next stage of the project which will be to engage QMUL in progressing the research elements of the work.

P.D.Taylor

Appendix 9: Testimonial from NELFT Trust Lead

I am delighted to be able to write this testimonial for Marc. Through his diligent combination of research study, academic interest and clinical skills he identified the need for a strong psychological element to be part of the treatment pathway for a wide range of dental and other oral problems. He recognised that because we live in an image-obsessed culture, any facial impairment can have fundamental psychological impact on the individual. This will not only affect their self-esteem and relationships, but can also impact on educational and occupational opportunities making a profound difference to their life

chances. He was able to communicate his findings and ideas clearly to the dental department of Barts Health Trust so effectively that NHS England agreed to fund what will be the largest and most diverse dental psychology service in London. In addition to employing qualified and assistant psychologists with broad backgrounds in clinical health psychology he has also recognised the need to recruit specialists in relationship therapy, neuropsychology, trauma, paediatrics and adult, to name a few, such is the wide impact of facial trauma. He has worked hard to produce the necessary evidence-base for every aspect of the service and has worked with the University of West England's Department for the most relevant and latest research in the field.

Marc has inspired others. Many psychologists wanted to join the new service. His genuine enthusiasm and passion for the subject is evident. He strives for the highest levels in everything he does, and accepts nothing less from himself. He is innovative and conscientious, always wanting to improve and develop services. Working with the evidence-base is the cornerstone of his work but he also wants, or encourages his colleagues, to contribute to it as well. He has the upmost integrity and I feel very lucky to be counted as one of his colleagues.



Lindsay Royan

Consultant Clinical Psychologist

Appendix 10: Testimonial from Vivien Hancock

From: Hancock Vivien (RAT) Macmillan Nurse
Sent: 14 April 2020 17:35
To: Kingsley Marc
Subject: RE: Level 2 summary

Hi marc

Level 2 supervision groups for non attenders

Thanks for your e mail and hope you are ok.

Effect of level 2 Supervision

The introduction of level 2 supervision to my practice has been one of the most beneficial things I have received in my 40yr nursing career.

As someone who thinks they have seen it all, it is not until you can take the time to reflect and discuss with a senior professional, how beneficial this experience is. The human brain is a complex thing, and having time to discuss the psychology behind a type of behaviour or reaction is so interesting. It brings a different dynamic to the situation and a different way of thinking how to handle something. In these sessions we also discuss the complexities and theory behind behaviours, and learning about assessment tools that can aid our practice.

Without doubt these sessions have been enormously beneficial to me personally and to our group. Palliative care sees the best and the worst in people, their highs and lows. The dynamics within families and cultures, and the work we have been doing in the sessions allows us the space and time to explore these issues. We have also been able to off load in a secure, safe environment, Marc is always caring in his approach.

I am so pleased at this stage of my career I have had the opportunity to be part of these sessions with Marc and my team.

Kind regards

Vivien

Appendix 11: Testimonial from Sharon Kite

From: Kite Sharon (RAT) Community Services

Sent: 22 April 2020 10:34

To: Kingsley Marc

Subject: PHd

Dear Marc,

Level 2 supervision groups for non attenders

Level 2 psychological support

I find my sessions with you invaluable. I feel that they have had a positive impact on my life and professional career. I enjoy dissecting a person's behaviour to get an insight into their actions and thought process. This has allowed me to get a better understanding of the psychological factors that influence their behaviour and in turn this guides my conversations.

I have a role of trust and because of my 121 visits I build up a rapport with many of my patients and family members. Often they open up about life experiences that have had a negative impact on their life. This can be an emotionally heavy burden for me, have I said the right thing to allay their anxiety? Do they feel supported? Your sessions have given me direction and allowed me to grow and develop my level 2 conversations. I now feel confident to deal with what once I would have shied away from. This I feel has resulted in positive outcomes for me as a nurse and for my patient's through holistic patient centred care.



Sharon Kite

Macmillan Nurse

Appendix 12: Level 2 Supervision Groups for non attendees

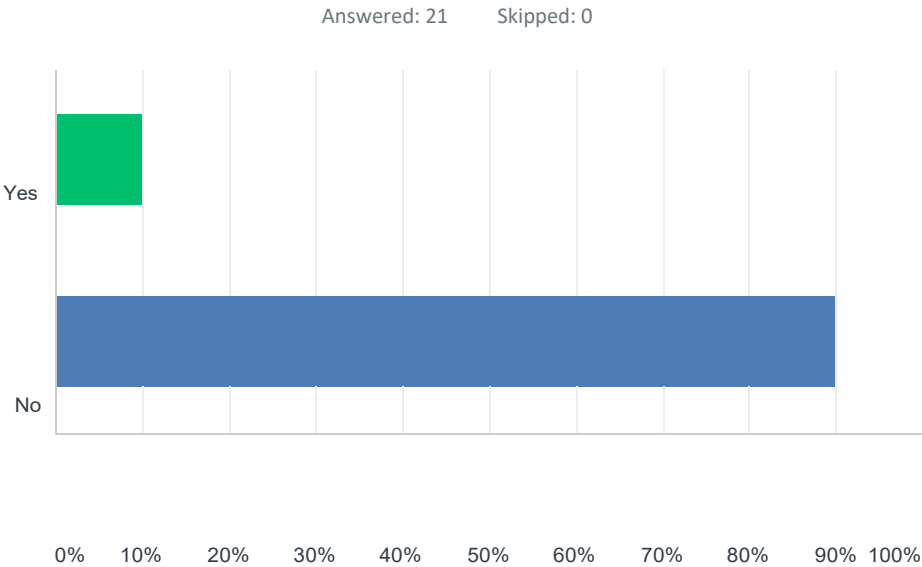
Q1 Please enter your participant ID here:

Level 2 supervision groups for non attenders

Answered: 19 Skipped: 2

Level 2 supervision groups for non attenders

Q2 Part 1. Level 2 supervision group attendance.Have you completed Level 2 Training?

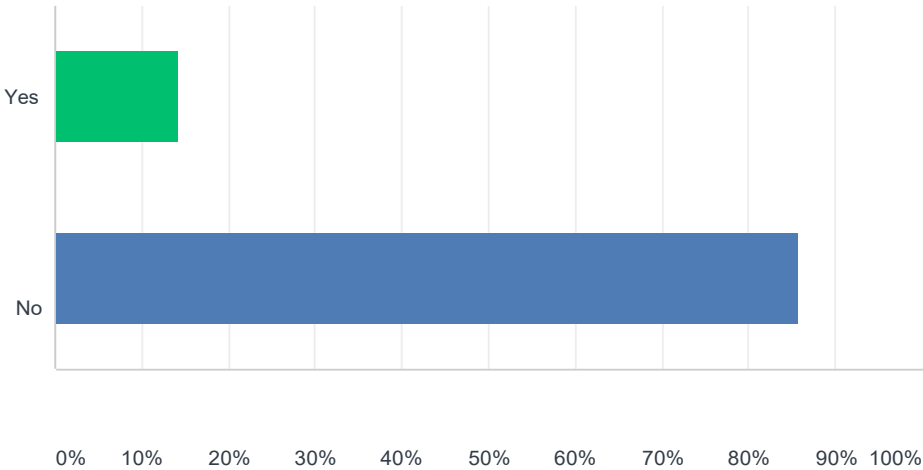


ANSWER CHOICES	RESPONSES	
Yes	9.52%	2
No	90.48%	19
TOTAL		21

Level 2 supervision groups for non attenders

Q3 Are you aware of Level 2 supervision group?

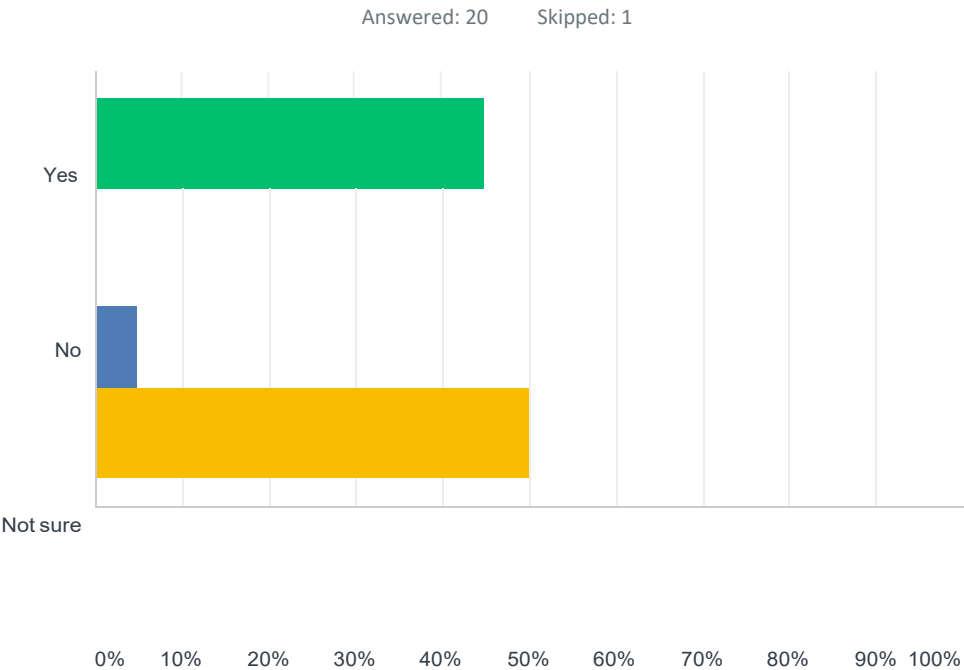
Answered: 21 Skipped: 0



ANSWER CHOICES		RESPONSES	
Yes		14.29%	3
No		85.71%	18
TOTAL			21

Level 2 supervision groups for non attenders

Q4 The description of Level 2 supervision group has been provided above. So, if you are invited to Level 2 supervision group in the future,will you attend it after completing Level 2 training?

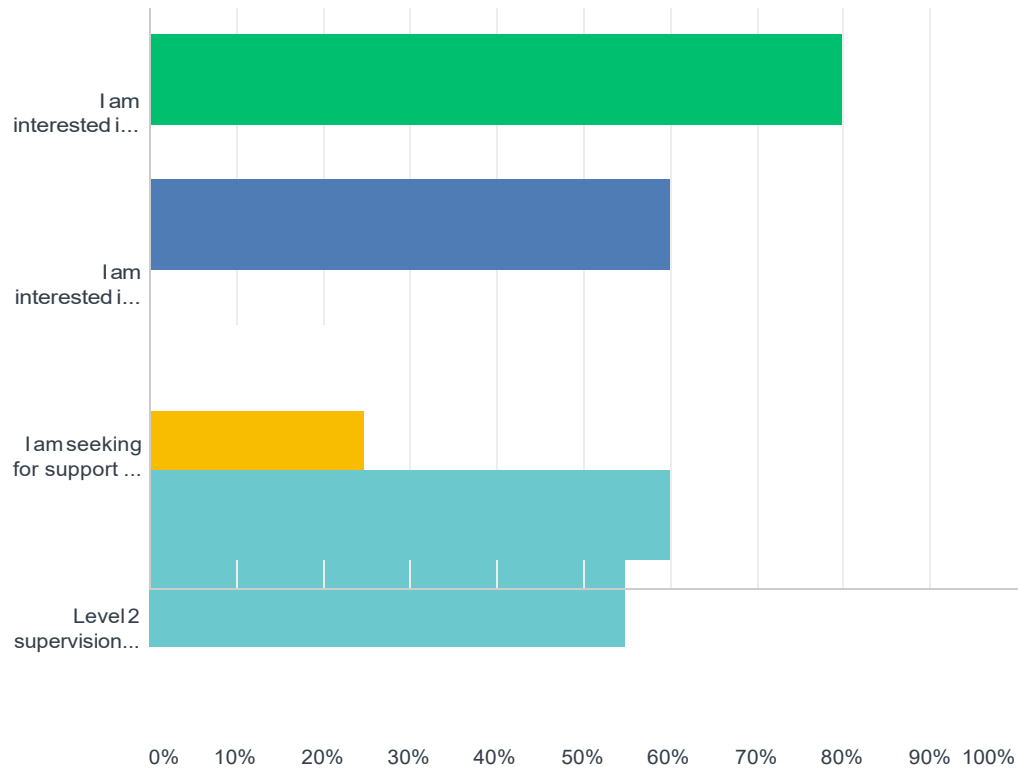


ANSWER CHOICES		RESPONSES	
Yes		45.00%	9
No		5.00%	1
Not sure		50.00%	10
TOTAL			20

Level 2 supervision groups for non attenders

Q5 After reading the description of Level 2 supervision group, canyou explain why you want to attend if you are invited? (multiple choices, please pick all answers apply to you)

Answered: 20 Skipped: 1

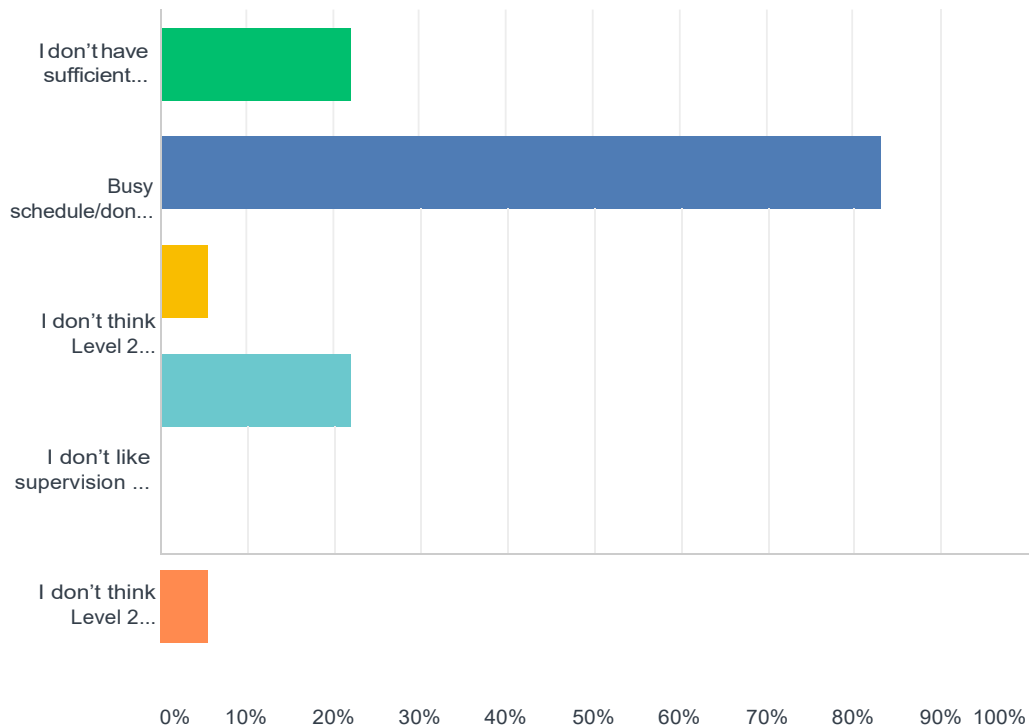


ANSWER CHOICES	RESPONSES	
I am interested in improving my capability in working with patients who suffer from emotional distress	80.00%	16
I am interested in increasing my capability in managing my own emotional wellbeing, inside and outside work	60.00%	12
I am seeking for support in general, regardless of the benefits of Level 2 supervision group listed above	25.00%	5
Level 2 supervision group sounds interesting and/or helpful	55.00%	11
Total Respondents: 20		

Level 2 supervision groups for non attenders

Q6 Please pick the reasons listed below explaining why you are unlikely to attend Level 2 supervision group (multiple choices, please pick all answers apply to you)

Answered: 18 Skipped: 3

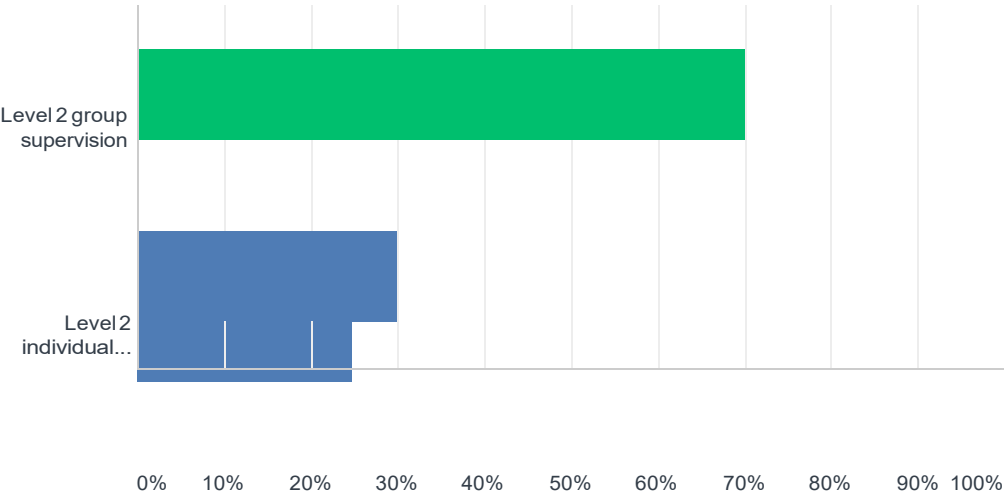


ANSWER CHOICES	RESPONSES	
I don't have sufficient information regarding Level 2 supervision group	22.22%	4
Busy schedule/don't have time/high work caseload	83.33%	15
I don't think Level 2 supervision group is suitable for me	5.56%	1
I don't like supervision in a group/don't feel like talking around other people	22.22%	4
I don't think Level 2 supervision group will be beneficial	5.56%	1
Total Respondents: 18		

Level 2 supervision groups for non attenders

Q7 Which one do you prefer, Level 2 group supervision or Level2 individual supervision?

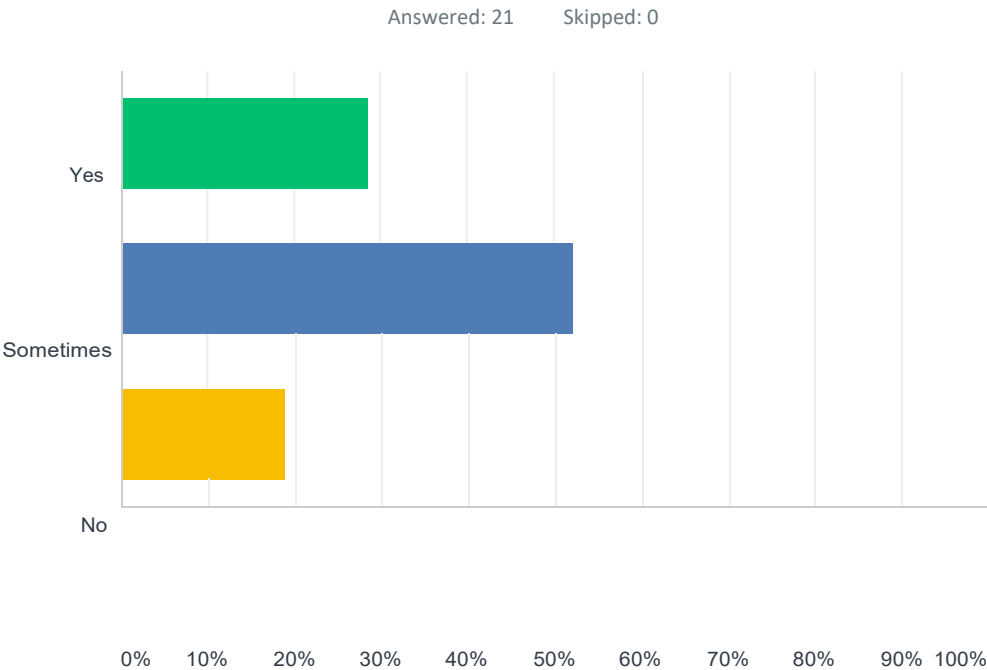
Answered: 20 Skipped: 1



ANSWER CHOICES		RESPONSES	
Level 2 group supervision Level		70.00%	14
2 individual supervision		25.00%	5
TOTAL			20

Level 2 supervision groups for non attenders

Q8 Part 2. Your work life and support.Do you think that your own emotional well-being at work can be affected by the palliative/EoL nature of your caseload?

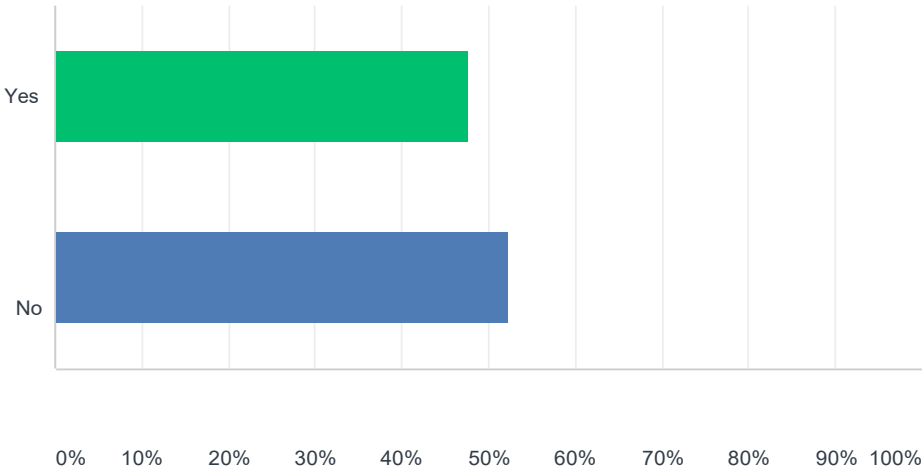


ANSWER CHOICES	RESPONSES	
Yes	28.57%	6
Sometimes	52.38%	11
No	19.05%	4
TOTAL		21

Level 2 supervision groups for non attenders

Q9 Do you have any other additional support to assist you to detectand manage the psychological/emotional needs of your patients and their families, as well as helping you to find strategies for self-care in your role?

Answered: 21 Skipped: 0

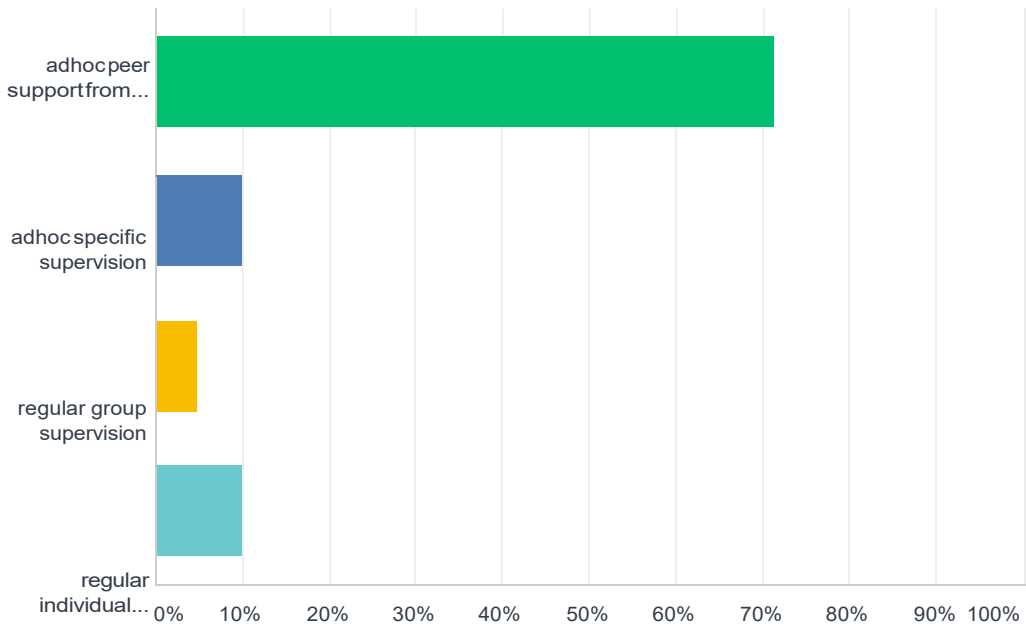


ANSWER CHOICES	RESPONSES	
Yes	47.62%	10
No		
	52.38%	11
TOTAL		21

Level 2 supervision groups for non attenders

Q10 What support do you currently get?

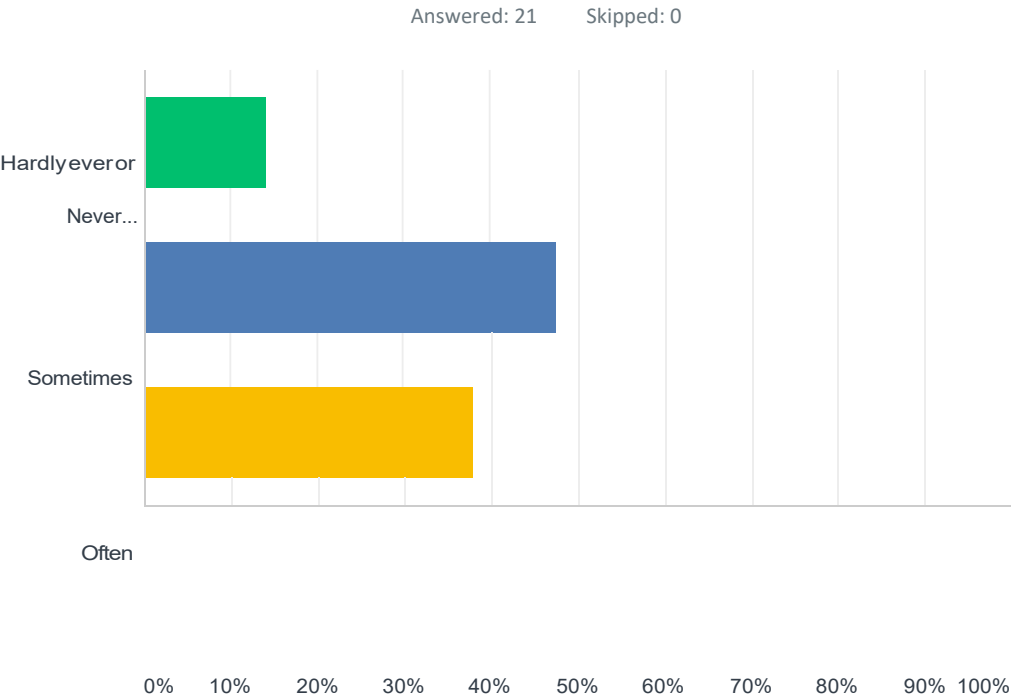
Answered: 21 Skipped: 0



ANSWER CHOICES	RESPONSES	
ad hoc peer support from team/individuals	71.43%	15
ad hoc specific supervision	9.52%	2
regular group supervision	4.76%	1
regular individual clinical supervision (not managerial)	9.52%	2
Total Respondents: 21		

Level 2 supervision groups for non attenders

Q11 How often are you able to find the types of support mentionedabove when you need them?

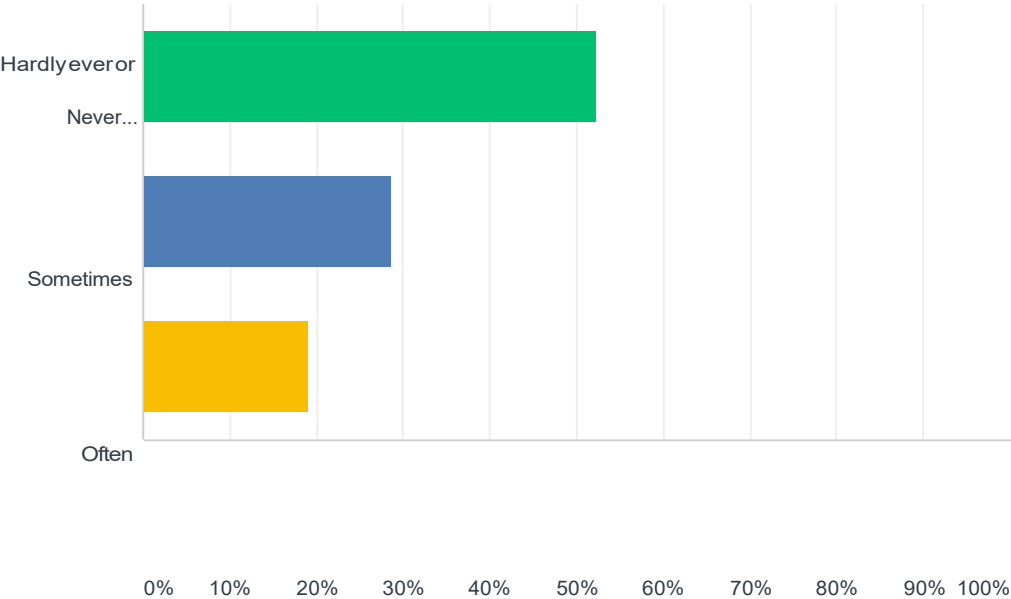


ANSWER CHOICES		RESPONSES	
Hardly ever or Never		14.29%	3
Sometimes		47.62%	10
Often		38.10%	8
TOTAL			21

Level 2 supervision groups for non attenders

Q12 How often do you feel that you lack companionship?

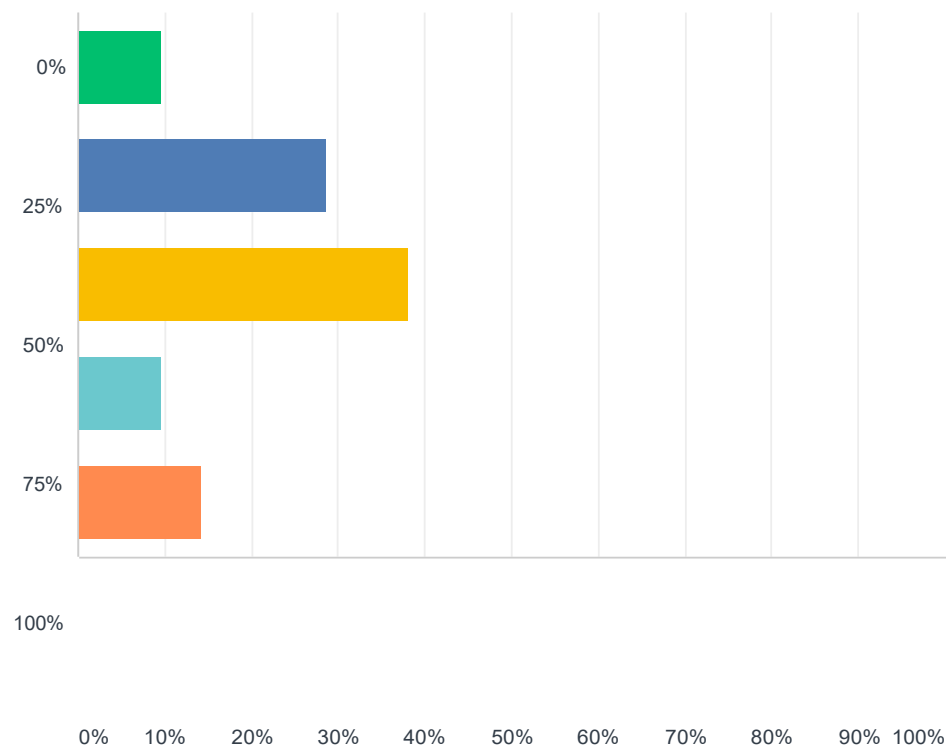
Answered: 21 Skipped: 0



ANSWER CHOICES		RESPONSES	
Hardly ever or Never		52.38%	11
Sometimes		28.57%	6
Often		19.05%	4
TOTAL			21

Q13 How many of your patients present with emotional distressand psychological difficulties?

Answered: 21 Skipped: 0

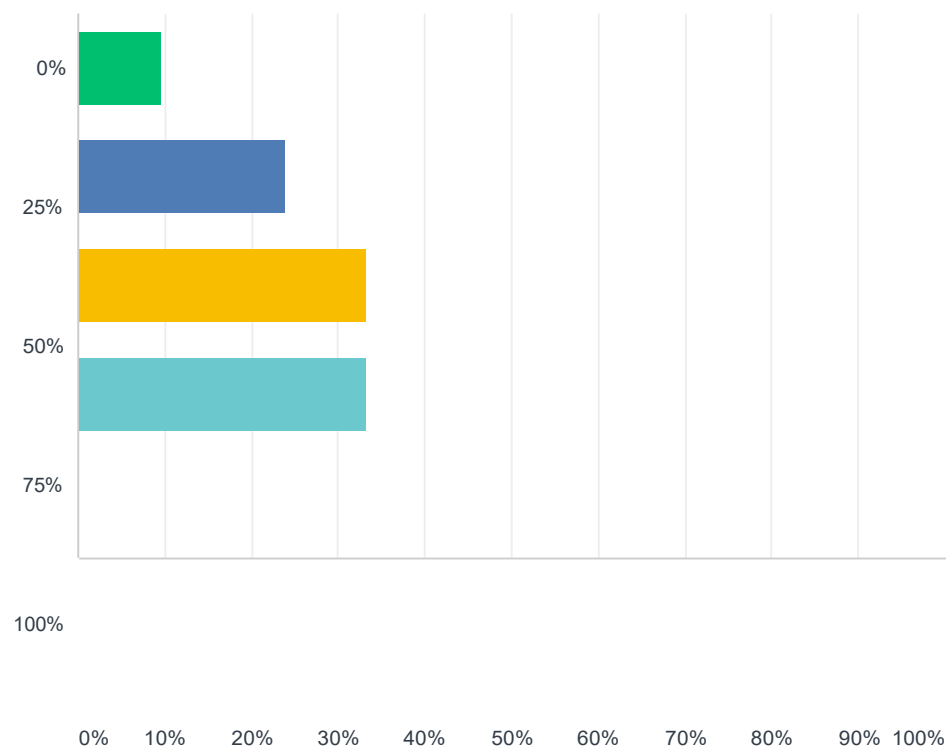


ANSWER CHOICES	RESPONSES	
0%	9.52%	2
25%	28.57%	6
50%	38.10%	8
75%	9.52%	2
100%	14.29%	3
TOTAL		21

Level 2 supervision groups for non attenders

Q14 How many of your patients present with couples or familyrelated difficulties in the context of their health condition?

Answered: 21 Skipped: 0

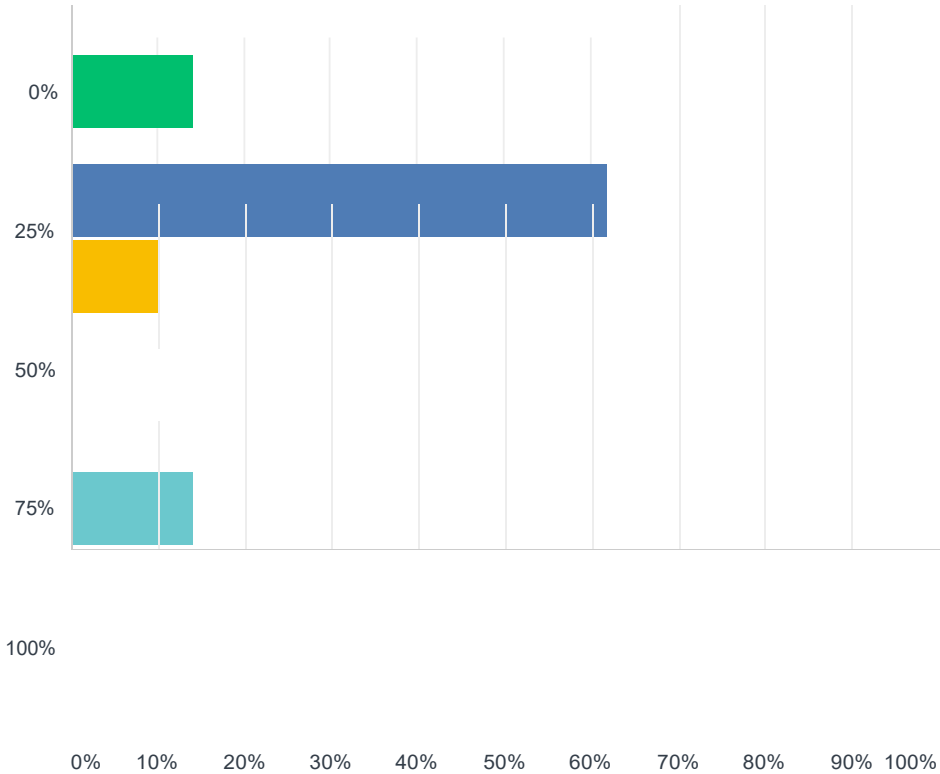


ANSWER CHOICES	RESPONSES	
0%	9.52%	2
25%	23.81%	5
50%	33.33%	7
75%	33.33%	7
100%	0.00%	0
TOTAL		21

Level 2 supervision groups for attenders

Q15 How many of your cases have a child/adolescent component, e.g.as a close relative?

Answered: 21 Skipped: 0



Appendix 13: Level 2 Supervision Group for attenders

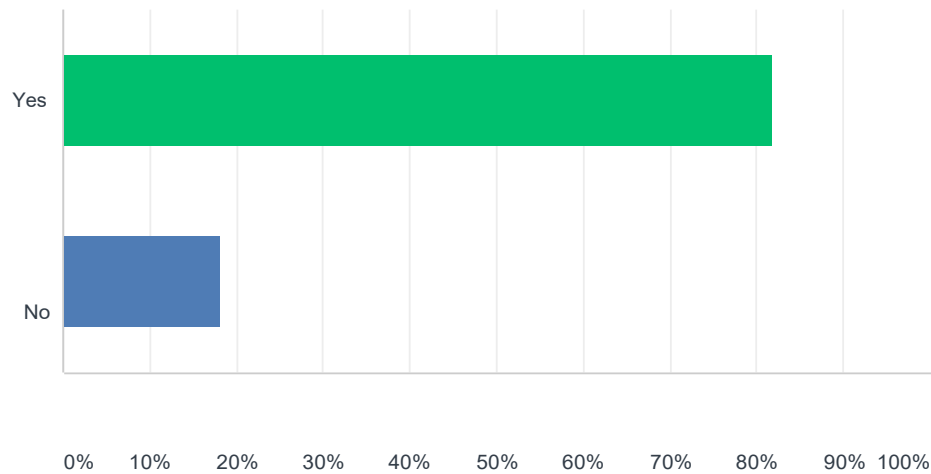
Q1 Please enter your participant ID here:

Answered: 8 Skipped: 3

Level 2 supervision groups for attenders

Q2 Part 1: Level 2 supervision group attendance and experiences. Have you completed Level 2 Training?

Answered: 11 Skipped: 0

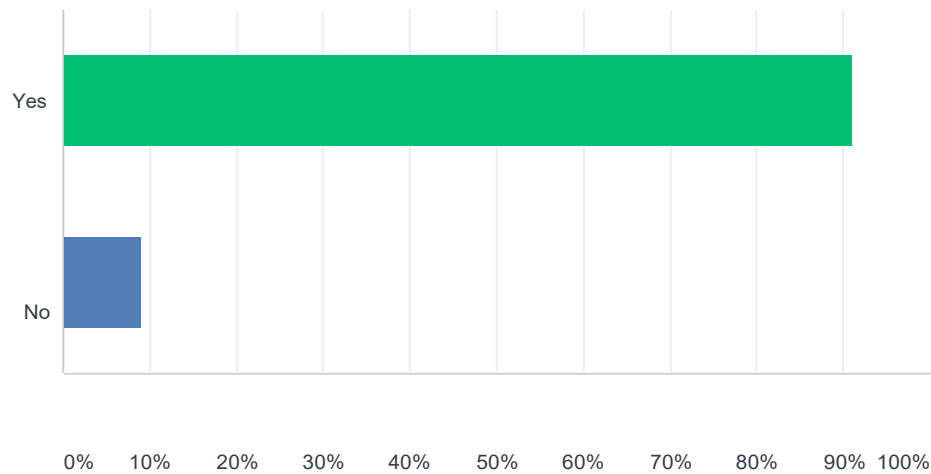


ANSWER CHOICES	RESPONSES	
Yes	81.82%	9
No	18.18%	2
TOTAL		11

Level 2 supervision groups for attenders

Q3 Do you attend Level 2 monthly clinical discussion groups?

Answered: 11 Skipped: 0

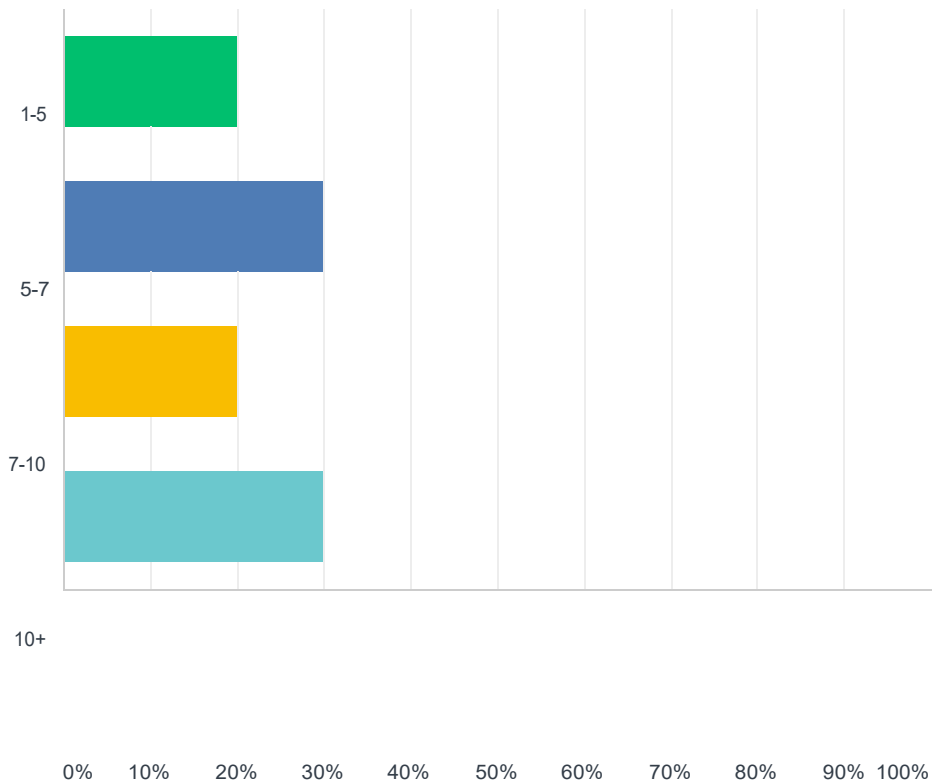


ANSWER CHOICES	RESPONSES	
Yes	90.91%	10
No	9.09%	1
TOTAL		11

Level 2 supervision groups for attenders

Q4 How many Level 2 supervision group sessions have you attended?

Answered: 10 Skipped: 1

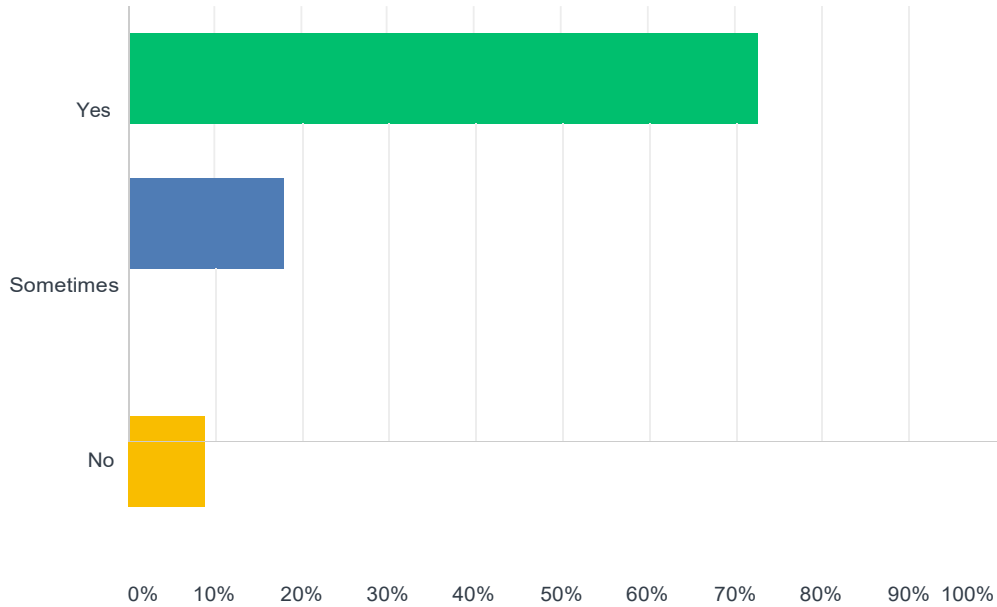


ANSWER CHOICES	RESPONSES	
1-5	20.00%	2
5-7	30.00%	3
7-10	20.00%	2
10+	30.00%	3
TOTAL		10

Level 2 supervision groups for attenders

Q5 Has Level 2 supervision group improved your confidence in working with patients who suffer from emotional distress?

Answered: 11 Skipped: 0

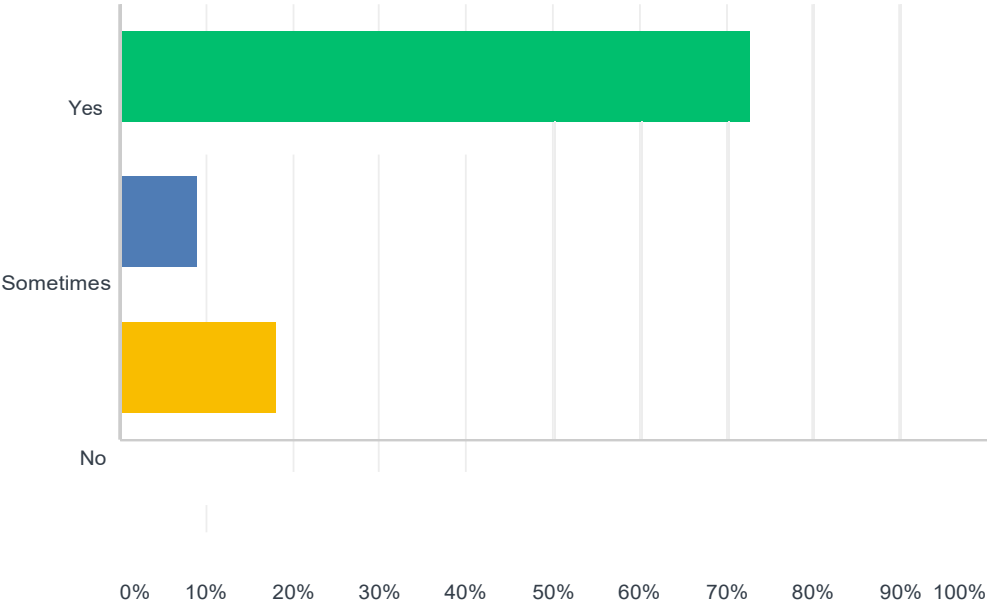


ANSWER CHOICES	RESPONSES	
Yes	72.73%	8
Sometimes	18.18%	2
No	9.09%	1
TOTAL		11

Level 2 supervision groups for attenders

Q6 Has Level 2 supervision group improved your capability in managing your own emotional wellbeing, inside and outside work? (E.g. manage your work stress, depressive mood)

Answered: 11 Skipped: 0

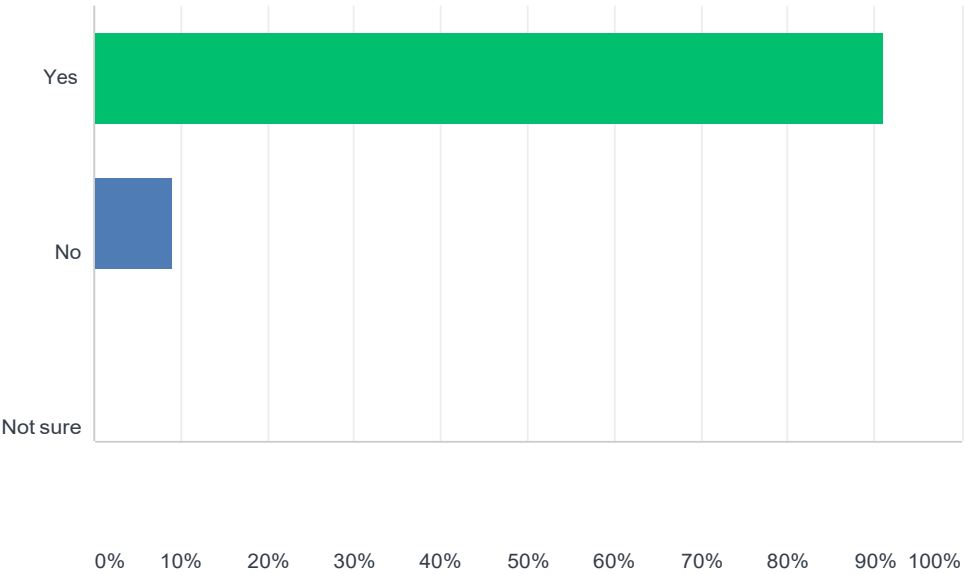


ANSWER CHOICES		RESPONSES	
Yes		72.73%	8
Sometimes		9.09%	1
No		18.18%	2
TOTAL			11

Level 2 supervision groups for attenders

Q7 Part 2. Your opinion on Level 2 supervision groupWould you recommend Level 2 supervision group to colleagues working inpalliative care/end-of-life (EoL) settings?

Answered: 11 Skipped: 0

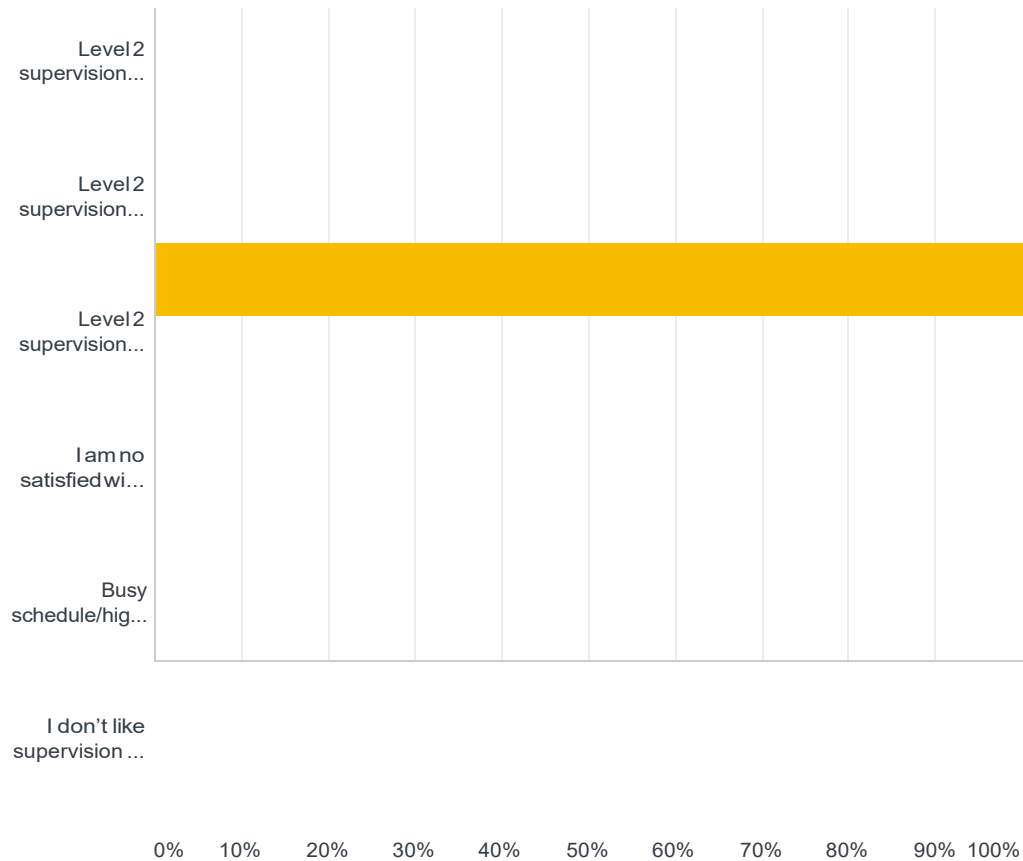


ANSWER CHOICES		RESPONSES	
Yes		90.91%	10
No		9.09%	1
Not sure		0.00%	0
TOTAL			11

Level 2 supervision groups for attenders

Q8 Please pick any reasons listed below explaining why you won't recommend Level 2 supervision group or reasons why you don't like the group (multiple choices, please pick all answers apply to you)

Answered: 1 Skipped: 10

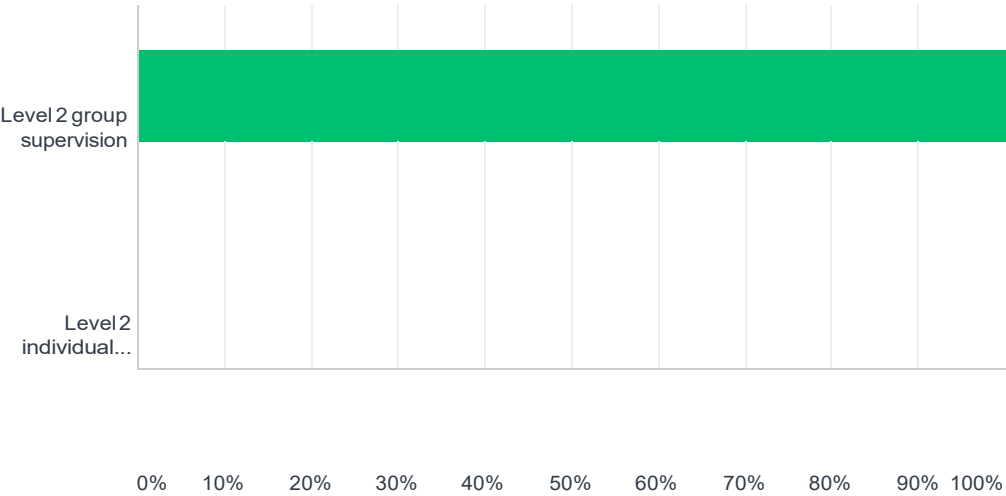


ANSWER CHOICES	RESPONSES	
Level 2 supervision group has not improved my capability in working with patients who suffer from emotional distress	0.00%	0
Level 2 supervision group has not helped my capability in managing my emotional wellbeing, inside and outside work	0.00%	0
Level 2 supervision group in general is not suitable for me	100.00%	1
I am not satisfied with the specific Level 2 supervision group I attended	0.00%	0
Busy schedule/high work caseload/don't have time	0.00%	0
I don't like supervision in a group/don't feel like talking around other people	0.00%	0
Total Respondents: 1		

Level 2 supervision groups for attenders

Q9 Which one do you prefer, Level 2 group supervision or Level2 individual supervision?

Answered: 10 Skipped: 1

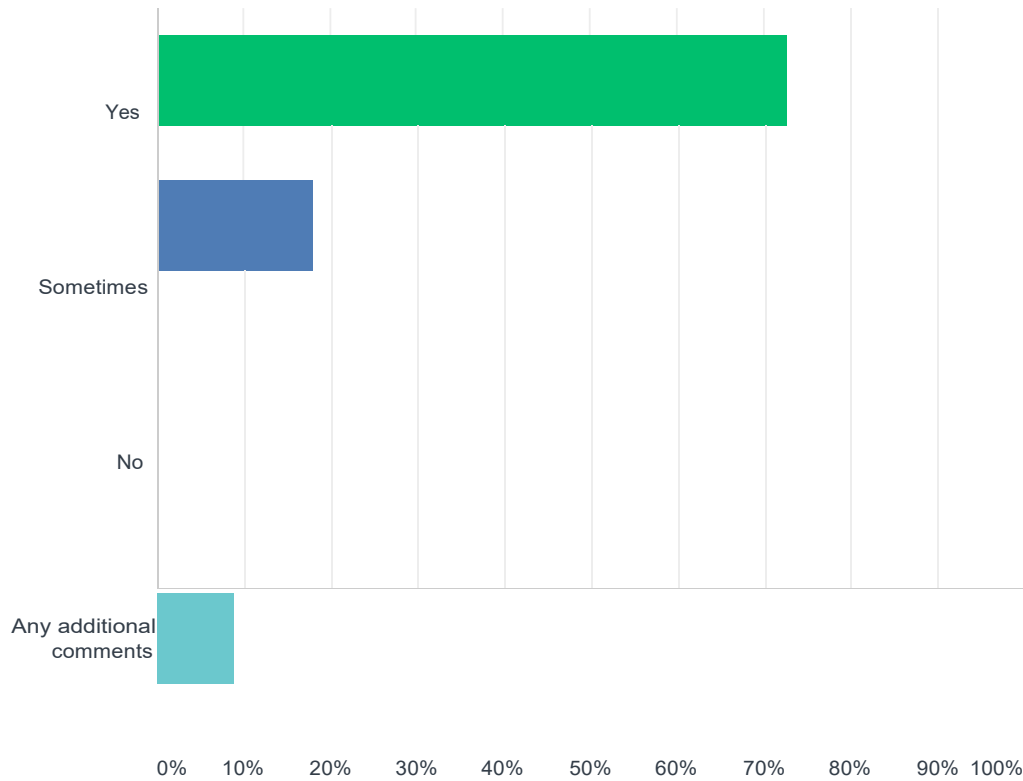


ANSWER CHOICES		RESPONSES	
Level 2 group supervision Level		100.00%	10
2 individual supervision		0.00%	0
TOTAL			10

Level 2 supervision groups for attenders

Q10 Part 3. Your work life and support. Do you think that your own emotional well-being at work can be affected by the palliative/EoL nature of your caseload?

Answered: 11 Skipped: 0

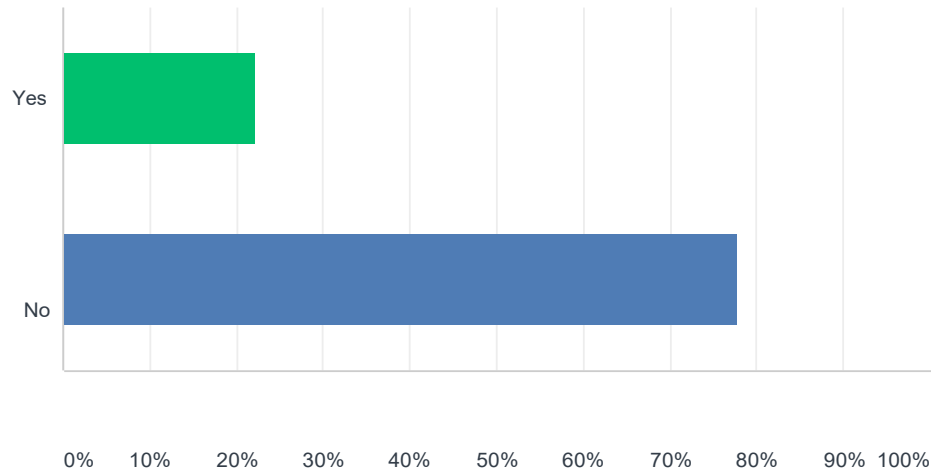


ANSWER CHOICES	RESPONSES	
Yes	72.73%	8
Sometimes	18.18%	2
No	0.00%	0
Any additional comments	9.09%	1
TOTAL		11

Level 2 supervision groups for attenders

Q11 If you do not have level 2 supervision, do you have any other additional support to assist you to detect and manage the psychological/emotional needs of your patients and their families, aswell as helping you to find strategies for self-care in your role?

Answered: 9 Skipped: 2

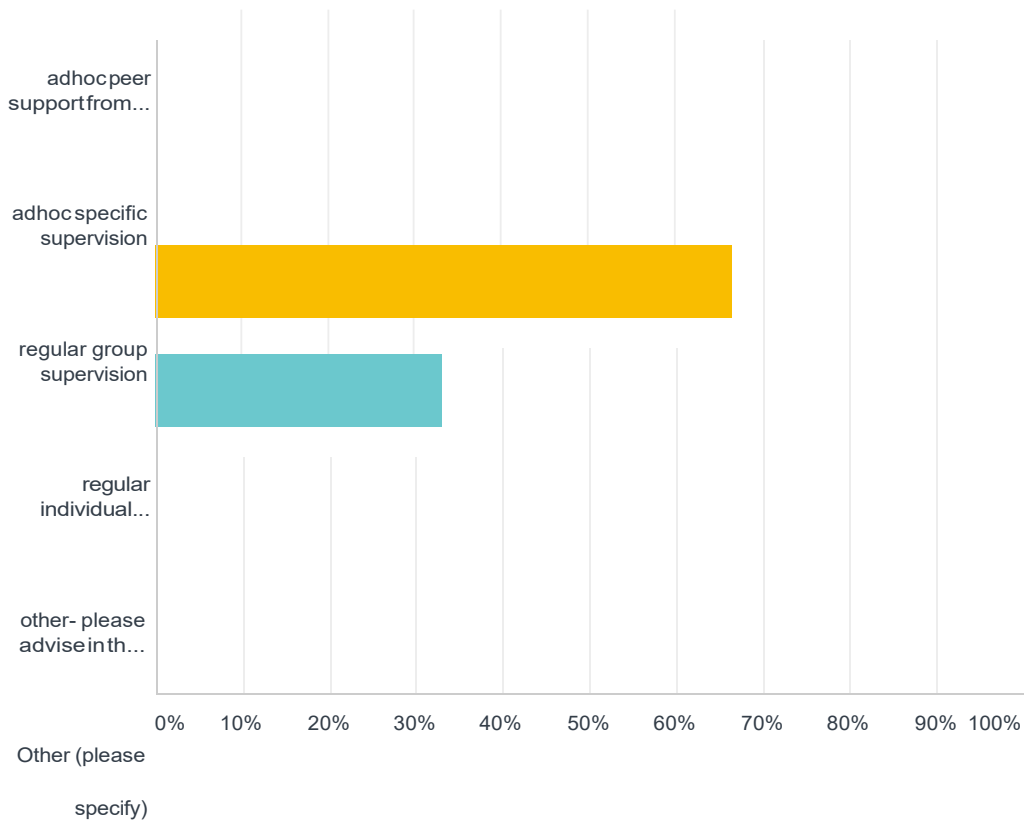


ANSWER CHOICES	RESPONSES	
Yes	22.22%	2
No	77.78%	7
TOTAL		9

Level 2 supervision groups for attenders

Q12 What support do you currently get?

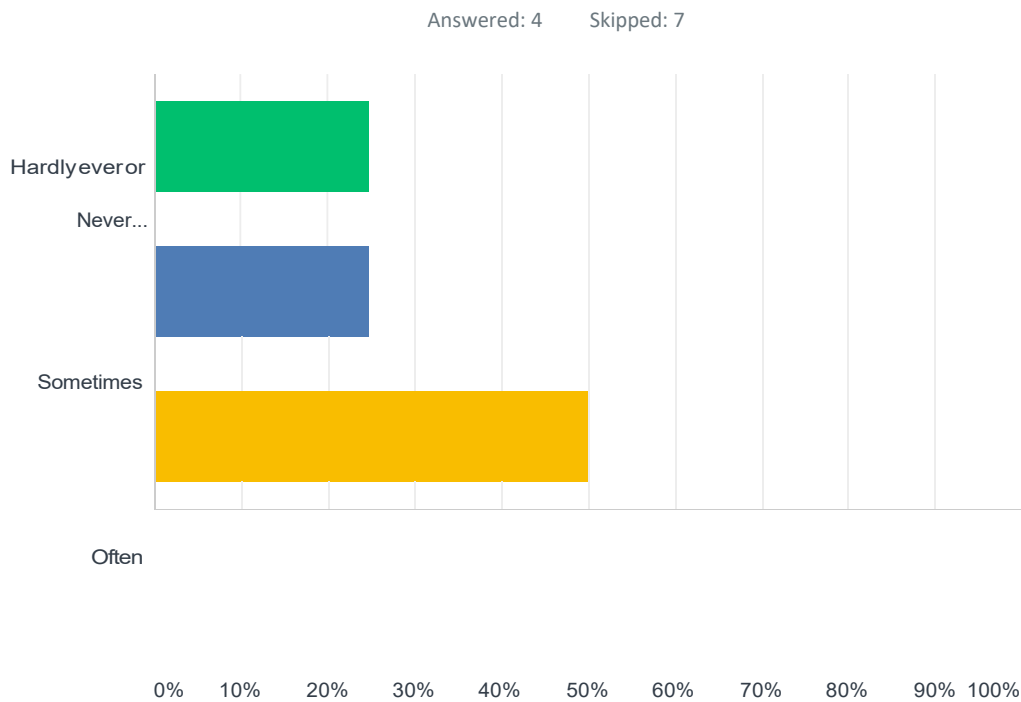
Answered: 3 Skipped: 8



ANSWER CHOICES	RESPONSES	
ad hoc peer support from team/individuals	0.00%	0
ad hoc specific supervision	0.00%	0
regular group supervision	66.67%	2
regular individual clinical supervision (not managerial)	33.33%	1
other- please advise in the other box below	0.00%	0
Other (please specify)	0.00%	0
TOTAL		3

Level 2 supervision groups for attenders

Q13 How often are you able to find the types of support mentionedabove when you need them?

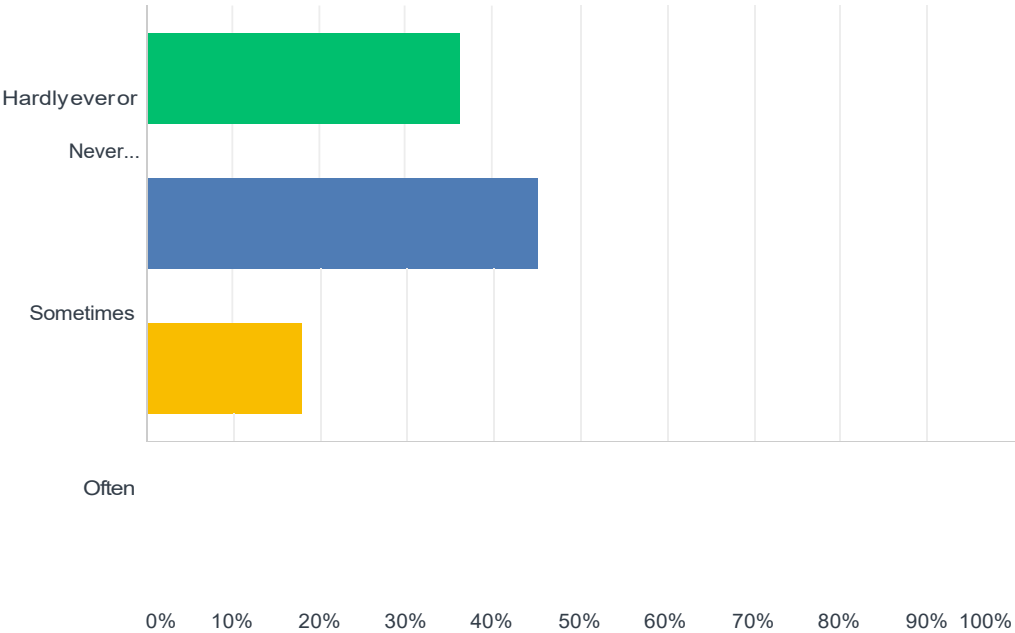


ANSWER CHOICES		RESPONSES	
Hardly ever or Never		25.00%	1
Sometimes		25.00%	1
Often		50.00%	2
TOTAL			4

Level 2 supervision groups for attenders

Q14 How often do you feel that you lack companionship?

Answered: 11 Skipped: 0

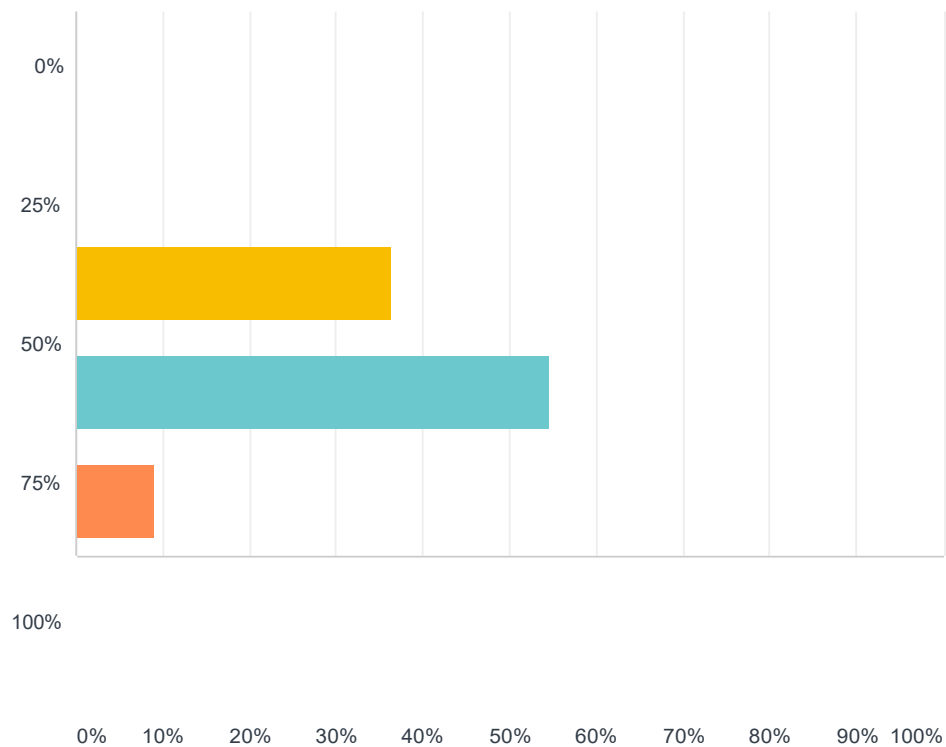


ANSWER CHOICES		RESPONSES	
Hardly ever or Never		36.36%	4
Sometimes		45.45%	5
Often		18.18%	2
TOTAL			11

Level 2 supervision groups for attenders

Q15 How many of your patients present with emotional distress and psychological difficulties (e.g. depression, poor wellbeing, stress)?

Answered: 11 Skipped: 0

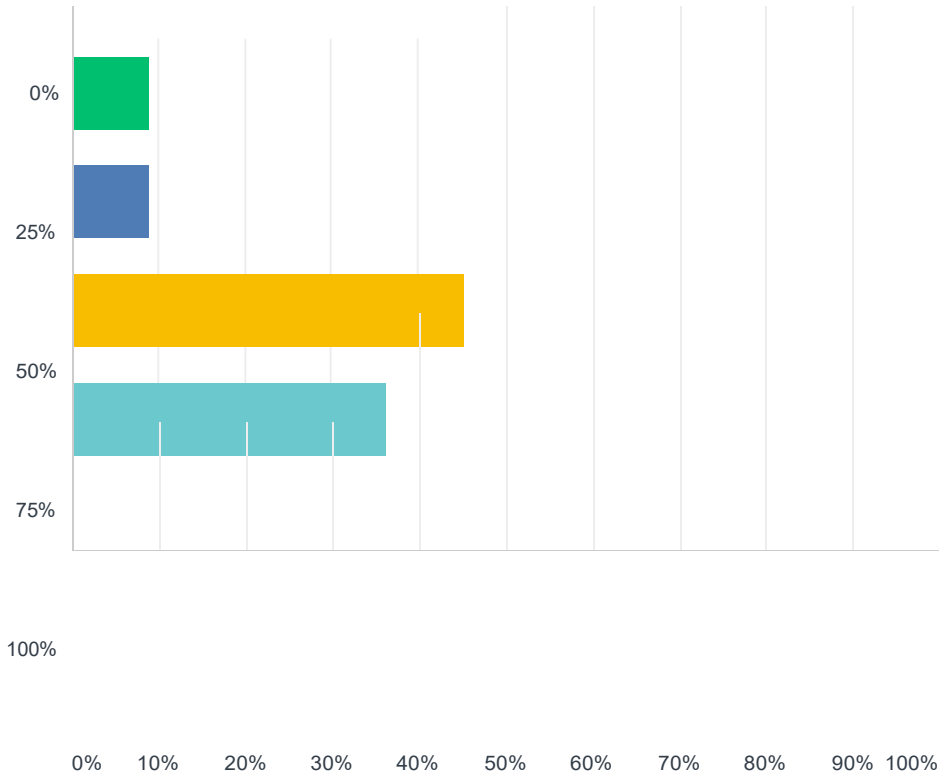


ANSWER CHOICES	RESPONSES	
0%	0.00%	0
25%	0.00%	0
50%	36.36%	4
75%	54.55%	6
100%	9.09%	1
TOTAL		11

Level 2 supervision groups for attenders

Q16 How many of your patients present with couples or familyrelated difficulties in the context of their health condition?

Answered: 11 Skipped: 0

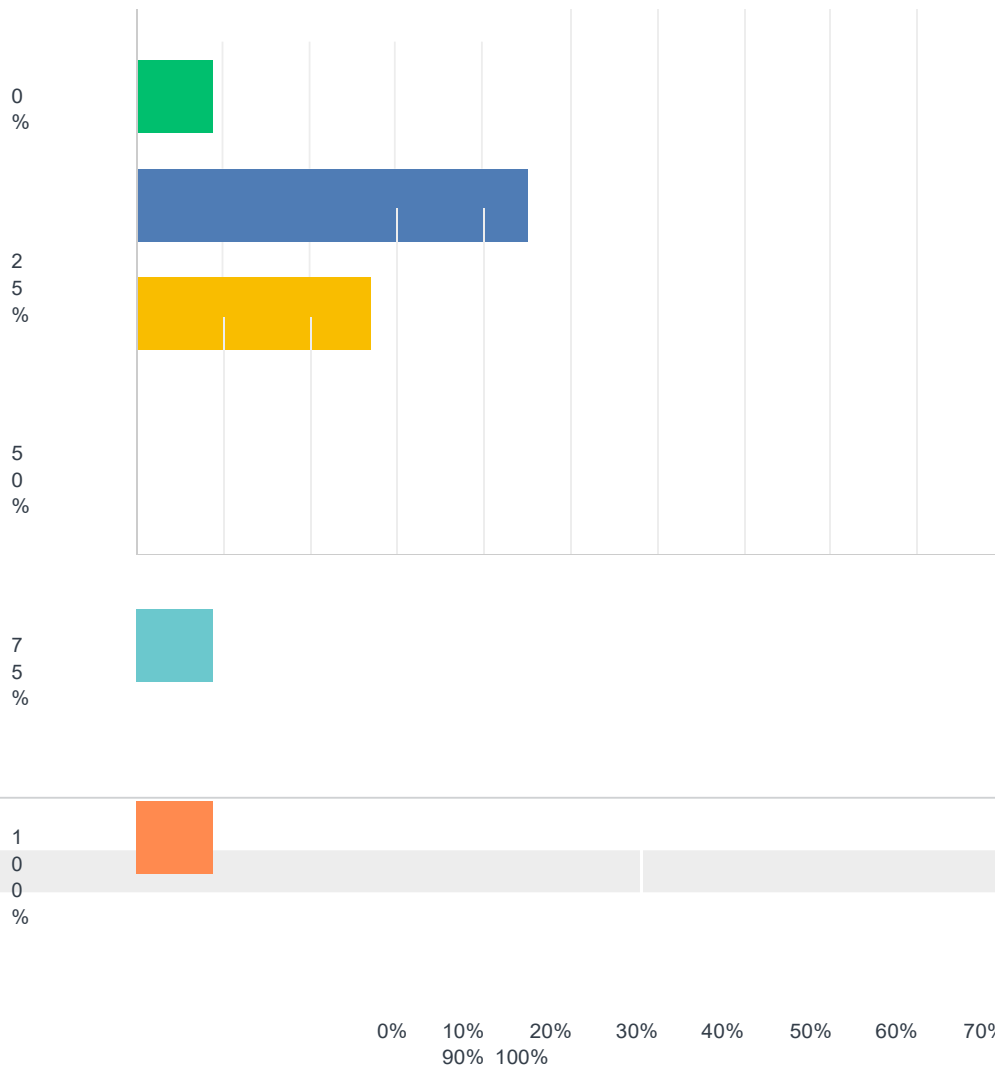


ANSWER CHOICES	RESPONSES	
0%	9.09%	1
25%	9.09%	1
50%	45.45%	5
75%	36.36%	4
100%	0.00%	0
TOTAL		11

Q17 How many of your cases have a child/adolescent component, e.g.as a close relative?

Answered: 11

Skipped: 0



Appendix 14: Testimonial from Angela Witham

From: Witham Angela (5NA)
Sent: 14 April 2020 13:46
To: Kingsley Marc
Subject: RE: Level 2 summary

Hi Marc

Hope you are well

Please see paragraph below

Having level 2 supervision as a Clinical Nurse Specialist has been vital in enabling me to continue to support my patients throughout their journey. It allows us protected time to address concerns and issues and we receive excellent guidance and advice on coping mechanisms. Level 2 supervision has definitely enhanced my practice allowing me to provide a more holistic approach to palliative care, whilst feeling valued and well supported.

Kind Regards

Angela Witham
Clinical Nurse Specialist

Appendix 15: Feedback from lecture ‘clinical risk: the role of meaning in despair’ July 2017

From: Shanthini Avorgbedor
Sent: 10 July 2017 16:52
To: Kingsley Marc
Subject: RE: Marc Palliative Care 2017 UPDATED NEW.pptx

Dear Marc,

THANK YOU very much for your input on Friday. Thank you for all the effort you had taken to deliver an excellent presentation as always! We had such excellent feedback and below is the collated feedback for your session. I hope you would be able to come and teach in the future for our Masters programme students which we do jointly with London South Bank University.

Speaker / Content & Delivery of session	Overall rating (1 = Poor 4 = Excellent)			
Clinical Risk: the role of meaning in times of despair Marc Kingsley	N=20			
Very pertinent and useful.	1	2	3	4
Good general information to be aware.			5	15
Very interesting, especially hopelessness.				
Would have loved more time here. Very interesting. Great speaker.				
Lovely voice! Bit of a dry subject but made interesting.				
Very interesting information.				
Lots of facts and figures, maybe am not pm, but very interesting.				
Excellent, very well presented.				
Great to think about. Insightful facts and figures.				
An interesting observation on palliative care vs suicide.				
Well presented & with professionalism, clear information.				
Very interesting talk.				
A wonderful heartfelt talk – so interesting & thought provoking about a very difficult, complex & deep topic.				
Very good but once again could have been longer – a little rushed towards the end.				
Suicide risk – so many points explained a real eye opener.				

Thank you .

PS: Just a little reminder about the study day in Jan 2018 on the nutrition study day, where you kindly agreed to come or arrange a colleague to present.

Kind regards,
Shanthini.

Shanthini Avorgbedor
Lecturer in Palliative Care
Saint Francis Hospice
The Pepperell Education Centre
Havering-atte-Bower
Romford, Essex RM4 1QH



WALK WITH US

Saturday 8th July 2017

Join us for the biggest pyjama party in town!
Click here for more information and to sign up.

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Saint Francis Hospice, The Hall, Havering atte Bower, Romford, RM4 1QH. Registered charity number 275913.

Appendix 16: Feedback from study day for palliative care team at Barts hospital December 2017

----- Original message -----

From: "AVORGBEDOR, Shanthini (BARTS HEALTH NHS TRUST)"

Date: 09/12/2019 11:38 (GMT+00:00)

To: Kingsley Marc <Marc.Kingsley20@nhs.uk>

Cc: "EVANS, Philippa (BARTS HEALTH NHS TRUST)" Royan Lindsay
Subject: Feedback

Dear Marc

Thank you so much for helping to organise such a successful study day. The general feedback was we need more mental health study days and certainly for many it was the first they have attended and found it really useful. So certainly I'm going to trouble you again to help organise another study again.

Thank you also for your enlightening session too. Please see feedback of the attendees

Poor	Satisfactory	Good	Very Good	Excellent
		1	4	16

Below quotes taken from the feedback forms:

Multiple examples based on practice made it very real
Discussion and sharing about experiences opened up lots of discussion points
Well delivered
Found it very useful for my own practice
Was an eye opener as I didn't realise that is was "so common" in Palliative care
Well delivered and good pace
Knowledgeable
Engaging and enthusiastic
Came across as very enthusiastic and knowledgeable on the subject

My feedback in general :

It has been a pleasure to have been able to host the topic "Suicide in Palliative care". The written and verbal feedback from the staff who attended clearly showed that they found it very beneficial and the need to have more of these sessions has been realised. I have asked the speaker to do a grand round in our hospital for the same topic as many of our healthcare professionals are not aware of these risks involved and how we need to possibly look be more vigilant in our care. Thank you once again for such a thought provoking session. Looking forward for more.

Please can I ask; if you could kindly do a grand round for us at Whipps Cross. This is certainly something our generalist doctors need to be aware about. Can I find the potential dates ?

Looking forward to hearing from you

Thank you

Kind regards

Shanthini

Shanthini Avorgbedor

End of Life Care Education Facilitator

*Whipps Cross University Hospital
Barts Health NHS Trust*

Appendix 17: Feedback from presentation at Redbridge conference 2018

From: Jan Scott
Sent: 06 December 2018 14:10
To: Kingsley Marc
Subject: Redbridge EofL conference 22 / 17

Dear Marc

On behalf of Saint Francis Hospice and the Redbridge Macmillan team may I thank you for presenting 'suicide in palliative and end of life care' at the conference in Redbridge on Tuesday. As ever Marc you were great and very well received. We had 130 people attend the event and we have received very good feedback, the outcomes will be recorded in excel and sent out to you as soon as we can.

With our thanks and appreciation, and an invite to visit the hospice whenever you are nearby, I remain

Yours sincerely

Jan Scott
Service Development Manager
Saint Francis Hospice
The Hall, Broxhill Road,
Havering Atte Bower, Romford. RM4 1QH
www.sfh.org.uk

Appendix 18: Testimonial from Patricia Aveling

Best care by the best people


NHS Foundation Trust

Clinical Lead for Mental Health Outcomes
Emerald Room
Maggie Lilley Suite
Goodmayes Hospital
Barley Lane
Ilford
IG3 8XJ
Telephone: 07949 045609
patricia.aveling@nelft.nhs.uk

Appendix 19: Testimonial from Dr Richard Graham

From: richardgraham]
Sent: 24 February 2020 11:40
To: Kingsley Marc
Subject: RE: Digital Risk

Marc Kingsley has undertaken pioneering research and clinical service development to identify better and support those who may be at risk of self-harm and suicide due to online influences. His work has included a detailed literature review that has helped those working in clinical services understand better the motives behind online searches for methods of self-harm or to form suicide pacts. This in turn informed a revised clinical risk assessment in his mental health trust, to ensure all clinicians do assess online risks, especially in relation to self-harm. This development has prevented a number of suicide pacts, which may have otherwise passed undetected.

Marc has presented the outputs of his work at many national and international conferences, including to the Child & Adolescent Faculty of the Royal College of Psychiatrists, influencing the practice of clinicians beyond his own mental health trust.

Thanks,

Richard

Dr Richard Graham

Consultant Psychiatrist

Clinical Director, Good Thinking: The London Digital Mental Well-being Service
Mental Health Programme

Appendix 20: Digital risk conference feedback

FOCUS ON RISK:

EATING DISORDERS AND SELF-HARM ONLINE

Number of evaluation forms returned: 20

1) How would you rate the conference?

55% (11) of respondents rated it as 5/5

45% (9) of respondents rated it as 4/5

Comments:

- *Excellent*
- *Really interesting topics*
- *Great discussions*
- *Good verbal as well as online data presentation*
- *A topical day, rich in content; well organised and thoughtful choice of presentations*
- *Started out general but got nice and specific in the last two talks*

2) What did you enjoy most about the conference?

- *Thoroughly stimulating and engaging range of contexts and speakers; sense of joining up and widening out the dialogue*
- *Hearing the real examples and seeing examples of online content*
- *The topic area*
- *Diversity of speakers and breadth of experience*
- *Presentation about conceptual 'schism' of parts of self in relationship to sites on suicide*
- *The content – all of it!*
- *Very informative and much needed*
- *Range of speakers and topics*

- *It was very informative*
- *Risks in children's hospital*
- *I enjoyed every aspect of the conference; I am particularly drawn to the theory of online life, the NSP and SP, and it's clinical implications*
- *The last two speakers – gave me some useful things to keep in mind in clinical work*
- *All of the topics*
- *Very useful when working with people*
- *Range of topics*
- *Hearing conversations after the talks*
- *The use of real life examples that are current and relevant to topics*
- *The different topics that are linked to Risk! in eating, self-harm and suicide*

3) What did you least enjoy/think could be improved about the day?

- *Possibly including tips/training links/opportunities following specific advice on online supervision*
- *More content specific to the topic – too much general cyber risk*
- *The air condition! Ha! Ha!*
- *Data and written info given out beforehand can help*
- *Nothing that stands out; maybe better regulating temperature in the lecture hall; hands [sic, handouts?] can be made available on the day*
- *Have Dr Nash in person*
- *Give handouts to attendees*
- *2 x Air con*
- *More about the research and its implications; re: why people go online!*

4) How would you rate the individual sessions?

Introduction to the day (Dr Richard Graham)

65% (13) of respondents rated it as 5

35% (7) of respondents rated it as 4

Evaluating online risk and harm for children and young people (Dr Victoria Nash)

45% (9) of respondents rated it as 5

40% (8) of respondents rated it as 4

15% (3) of respondents rated it as 3

Comments:

- *Finished early*

Working with online risks in a children's hospital (Dr Jon Goldin)

75% (15) of respondents rated it as 5

15% (3) of respondents rated it as 4

10% (2) of respondents rated it as 3

The other in the room: Reducing risk by unravelling hidden online influences (Marc Kingsley and Dr Tom Stockmann)

80% (16) of respondents rated it as 5

10% (2) of respondents rated it as 4

10% (2) of respondents rated it as 3

Virtually Anorexic – Where's the harm? (Dr Emma Bond)

70% (14) of respondents rated it as 5

30% (6) of respondents rated it as 4

5) How would you rate the structure and format of the conference?

45% (9) of respondents rated it as 5

5% (1) of respondents rated it as 4-5

50% (10) of respondents rated it as 4

Comments:

- *Excellent. Well-paced. Room for thought and rich with information and detail*
- *Very well organised*
- *Good*
- *Well-presented and organised; excellent professional involvement*

6) How would you rate the provision of conference materials?

35% (7) of respondents rated it as 5

35% (7) of respondents rated it as 4

15% (3) of respondents rated it as 3

5% (1) of respondents rated it as 2

10% (2) of respondents did not rate it

Comments:

- *Would help to have literature on slide-sheets at start of talk*
- *Would be good to get the slides later*
- *Slide handouts to write notes and to keep for reference*
- *Not enough info*
- *The PP have not be [sic] made available so can't comment on this*

7) How relevant was this conference to your current work practice?

65% (13) of respondents rated it as highly relevant

35% (7) of respondents rated it as relevant

8) Will you take any aspect of this conference back to your workplace and share it with your colleagues?

- ☐ *Yes – on-line relationships factored in general risk assessments*
- ☐ *Yes, especially the inclusion of risk assessment of online use*
- ☐ *Yes*
- ☐ *Yes – already planning to present to my clinical team*
- ☐ *Yes, all the content will be shared with my colleagues at Childnet*
- ☐ *Yes, especially risk assessment and focusing online risk [sic]*
- ☐ *Yes!*
- ☐ *Would like to share presentations and comments*
- ☐ *Most definitely. There have been a lot of points, resources and feedback that will be of great help*
- ☐ *All*
- ☐ *Definitely*
- ☐ *Yes*
- ☐ *Developing the risk assessment to include questions about digital life*
- ☐ *Very much*
- ☐ *To assess/ask about online site use/online risk*
- ☐ *No*

9) How would you rate the registration and booking procedure?

65% (13) of respondents rated it as 5

10% (2) of respondents rated it as 4

15% (3) of respondents rated it as 3

5% (1) of respondents rated it as 2

5% (1) of respondents did not rate it

Comments:

- *I didn't book it*
- *I didn't receive info or confirmation until the day before – after I contacted*
- *Poor*

9) How would you rate the catering and facilities?

35% (7) of respondents rated it as 5

45% (9) of respondents rated it as 4

20% (4) of respondents rated it as 3

Comments:

- *Had more tea-coffee breaks today than I have in a normal working week*
- *Tasty sandwiches 😊*

Further comments

- *Thank you*
- *Great! Thanks*
- *More clinical examples re: good practice about how to engage with patients/young people about their digital lives*
- *Please could we have a day on: Meaning, Metaphor and Modern Day Archetypes in connection with online world and Dark Net Adolescence today*
- *More time for group discussion might have mitigated bloviating among conference attendees who wanted to be heard. Or maybe you could introduce a rule that people could only ask questions and not make self-indulgent comments*

Thank you! Very valued and informative

Appendix 21: Testimonial from Dr Simon Holmes

-----Original Message-----

From: Simon Holmes

31 / 17

Sent: 16 September 2020 16:11

To: Jones Vanessa

Subject: statement

Hi

I should like to thank the psychology team for all of their hard work which is so gratefully received by our patients and the surgical teams. The need for psychological support is well understood and published on in this cohort of patients. We have a very vulnerable group with often marked psychological needs pre injury, and this is exacerbated by poor coping strategies and social support. The embedding of the team within the outpatient setting allows prompt assessment and targeted support - and the work should simply be described as transformational. This group will simply make so many patient's lives better and break the vicious cycle of descent into psychological distress and reinjury. The support that the teams give us as clinicians is also incredible - we should not forget that the harrowing stories and witness the torment that our patients undergo also leaves its fingerprints on our souls - I am personally grateful for this support;

S

Appendix 22: Testimonial from Dr Zahra Syed

From: SYED, Zahra (BARTS HEALTH NHS TRUST)

Sent: 03 September 2020 10:15

To: Jones Vanessa

Subject: RE: Psychology testimonials

Hi Vanessa hope you are good

I have written a little paragraph below hope this is what you were looking for

The dental psychology service have provided both staff and our oral medicine patients the support they needed to be able to continue working and improve their conditions with the added stresses of the COVID -19 Pandemic. Their adaptability, care and professional attitude has allowed us to support our patients as best possible under difficult circumstances and improved the quality of care for our patients significantly. Their joining of our dental services has brought us one step closer to our goal of holistic excellent world class care for our patients and the trust as a whole

zahra

Appendix 23: Testimonial from Dr Joe McQuillan

From: MCQUILLAN, Joe (BARTS HEALTH NHS TRUST) [

Sent: 22 September 2020 18:12 33 / 17

To: Jones Vanessa

Subject: RE: Testimonial - deadline

Please find below.

“ as Clinical Director for the dental hospital network I have been able to work with the psychology team as both a clinician, and in my management role with staff support. The support they have offered to our patients has revolutionised the care we provide for our patients. Working in the trauma clinic, their expert guidance and support has allowed patients to access mental health support which previously they have struggled to access. I have seen patient outcomes improve significantly as we are now able to offer this valuable resource. The support the team has offered to their dental colleagues during the covid -19 pandemic ,through working groups and individualised sessions has meant staff have felt supported and well looked after throughout”

Hope it's useful

Joe McQuillan
Clinical Director for Dentistry, OMFS & Ophthalmology
Head Orthoptist
4th floor Dental Hospital
The Royal London Hospital
E1 1FR
Barts Health NHS Trust

i) Volume 2: Public Works

Public Works 1: Best Practice Pathways East London

Orthognathic Service & Clinical Health Psychology

Best Practice Pathways East London

Marc Kingsley	Consultant Clinical Psychologist/ Registered Adult Psychotherapist Care Pathway Care Pathway Lead for Clinical Health Psychological Services	North East London Foundation Trust
Lindsay Royan	Consultant Clinical Psychologist/Trust Lead CHPS	
Dr Nicola Taylor	Highly Specialist Clinical Psychologist Clinical Health Psychological Services Waltham Forest	North East London Foundation Trust
Dr Christine Casey	Consultant Orthodontist	Barts Health
Mr Stewart Cooper	General Manager	Barts Health

Date:

September 2017

Public Works 2: Programme

Programme

PUBLIC WORKS 2

Friday 23 February

Saturday 24 February

Lectures will be held in the Bearsted Lecture Theatre on the basement level of the Dental School. Registration, refreshments, the Trade Show and the evening drinks reception will be held in the Old Library on the ground floor of the Garrod Building.

All events will take place in the Perrin Lecture Theatre, Blizzard Building, Newark Street, E1 3AT.

08.45 Coffee and Registration

14.15 'Going straight - one man's jaw-dropping journey to a better face'

08.45 Coffee and Registration

09.15 'Cosmetic injectables - creating

11.30 Presentations from the 2016-17
Malcolm Jenkins and John

PUBLIC WORKS 3



Psychology Orthognathics Service at Barts NHS Trust

A proposed business case/ Presentation to NHSE

Marc Kingsley, Consultant Clinical Psychologist /Care Pathway Lead NELFT

Lindsay Royan, Consultant Clinical Psychologist / Trust Lead for Clinical Health and Specialist Services,
NELFT

Christine Casey, Consultant Orthodontist

Nicola Taylor, Highly Specialist Clinical Psychologist

Brief history of clinical psychology input to orthognathics service

- 3 pilot projects at Whipps Cross Hospital
 - 2004 – 2011
 - 2014 – 2015 (1 day/week increasing to 2-3 days/week)
 - September 2016 – January 2017 (1 day / week)
- Demonstrated demand for the service



Impact of facial 'disfigurement'

- People with jaw position discrepancy teased more often and elicit less sympathy (Williams et al., 2005)
- Orthognathic patients risk of experiencing increased social anxiety and low mood (Cunningham, 2000)
- Patients show increased risk of experiencing poorer body and facial body image and there is increased prevalence of Body Dysmorphic Disorder in this patient population – a serious psychiatric condition
- Orthognathic treatment has impact on function but...
- For many it is the aesthetic outcome from treatment rather than functional improvement that will determine their satisfaction with treatment (Morris, 2006)

Challenges of the orthognathic treatment journey

- Decision to undergo an elective treatment impacting on facial appearance
- Wearing braces
- Major surgery and inpatient stay
- Post surgery recovery
- Length of treatment
- Coping with pain
- Degree of support from social/family network
- The 'new me'

Patient stories / quotes

- **HK** – “surgical shopper”
- **IQ** – cancelled her operation on the morning and demanded to have her braces removed
- **AD** – Body Dysmorphic Disorder
- **FP** – Cannot accept new face post surgery
- **CT** – 17 year old who wants to throw himself off a bridge/ cannot look in the mirror and would shout at his own face
- **MB** – breakdown of her relationship and felt anxious as so much positive feedback post surgery

Clinical Psychologist's Role – Adding Value

- Assessment of psychological needs and expectations and availability of psychological support **at initial stage** of treatment pathway (recommended in national guidance):
 - Identifying those unsuitable for orthognathic treatment and triage to other mental health services e.g. IAPT, secondary mental health
 - Identifying those requiring psychology support as an integrated part of orthognathic treatment
 - Advice re. psychological aspects of patients' care, especially those with additional needs e.g. learning disabilities
- Evidence-based psychological treatment for identified patients
- Increasing psychological skills of MDT by attendance at clinics and providing training
- Staff support (reflective practice groups) to enhance emotional resilience of staff
- Research and audit
- Service development

Why a Clinical Psychologist?

- Skilled to assess and manage psychological distress and mental health concerns in patients up to a higher tier in complexity
- Core training placements in child and adolescent services, learning disabilities (as well as adult and older adult placements)
- Training in neuropsychological assessment
- Training and experience in doctoral level research
- Clinical Psychologists identified in NICE guidance as key in the mental health assessment and management of patients seeking elective surgery (eg in bariatric surgery)

Financial & Service Quality Implications

- Reduce number of appointments with orthodontists and surgeons
- Reduce number of lengthy appointments
- Reduce number of unattended appointments
- Reduce risk of patients cancelling surgery
- Reduce medical input post surgery
- Achieving an integrated approach to healthcare provision (DoH; NICE; RCS)
- Increased patient satisfaction
- Increased staff satisfaction
- Increased research profile of the service
- Interface with other psychology services e.g. IAPT; secondary mental health

Projected figures over 12 month period

Based on 2014-2015 pilot at Whipps Cross Hospital

- 78 new patients (1-3 appointments per assessment depending on complexity)
 - 27 of these patients are under 18 years old (incurring higher costs)
- Adjunct psychological treatment
 - 5 patients requiring average 10 sessions (plus assessment session)
 - 1 of these patients under 18 years (incurring higher costs)
- Post-operative psychological treatment
 - 5 patients requiring average 4 sessions
- Individual psychology session during joint clinic
 - 6 patients in significant distress required ad hoc session

Public Works 4a: Job Description and Specification

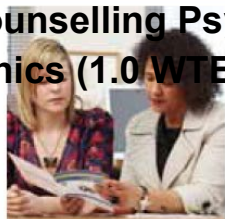


Job description and specification



HCPC registered Highly Specialist

**Clinical/Counselling Psychologist in
Orthognathics (1.0 WTE)**





JOB DESCRIPTION

JOB TITLE: HCPC Registered Highly Specialist
Clinical/Counselling Psychologist in Orthognathics

BAND: 8A (1.0 WTE)

HOURS: 37.5 HOURS/ 1.0 WTE

DURATION: 12 MONTH CONTRACT WITH A VIEW TO EXTENSION WITH ONGOING FUNDING APPROVAL.

RESPONSIBLE TO: Clinical Leads Orthognathics, Barts Hospital (Royal London and Whipps Cross Hospital sites)
Specialist Pathway Lead for Clinical Health Psychological Services, NELFT.

KEY RELATIONSHIPS:

Internal	External
Line Manager Care Pathway Lead CHPS Trust Lead CHPS Clinical Health Psychology Service Consultant Orthodontists/Restorative Dentistry Consultant Surgeons Nurses and HCP's 43 / 17	GP Collaborative Care Social Services Community services CH and MH outside of NELFT

Community services CH and MH	
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CONTROLS ASSURANCE STATEMENT:

The purpose of this job description is to outline the level of responsibility and accountability of this post. This will ensure that all work undertaken by our staff is clearly identified and carried out under clear lines of accountability.

Aim of the role:

The post holder will be expected to support their team, department and organisation to achieve the Trust's Values in their day to day work. These are the 5P's:

- Putting people first
- Prioritising quality
- Being progressive, innovative and continually improve
- Being professional and honest
- Promoting what is possible – independence, opportunity and choice

The post holder will achieve this by working closely alongside the specialist multidisciplinary (MDT) assessment and treatment Orthognathics service at Barts Hospital (Royal London and Whipps Cross sites), by supporting the development of a newly formed evidence-based, highly effective psychological assessment and treatment service for patients/carers referred to the Orthognathics Service.

The post holder will be responsible for line managing, and overseeing the psychological role and development of the Band 7 psychological therapist, as well as doctoral trainee psychologists and assistant psychologists. There will be a strong leadership role, with experience required in triage and signposting, as well as managing caseloads, risk assessment/management and individual/group psychology programmes within a timely and professional manner. The post holder will form a key function in providing consultation and liaison to consultant orthodontists, surgeons, nurses and other HCP's offering a specialist orthognathic service, as well as training and supervision to non-psychological staff working within the orthognathics and dental specialism.

The post holder will show a highly developed ability to work autonomously as an independent practitioner within defined aims and professional guidelines, fully accountable for professional actions. This is a key requirement, as the post holder will need to work effectively across two different hospital sites, and several teams.

Key Responsibilities:

1. To provide specialist psychological assessments, psychological interventions and psycho-education to patients and carers referred to the orthognathics team. This will include:
 - Clinical excellence and experience in delivering comprehensive clinical health psychological assessments and formulations, and working with a range of clinical aetiologies, including facial disfigurement, changes in appearance, body-image disturbance, trauma, and acute and persistent pain.
 - Expertise in working with psychological assessments for suitability for elective surgery, especially in highly sensitive body areas, such as the face and mouth.
 - Clinical skill and experience in the provision of evidence-based psychological treatments within a specialist physical health outpatient and inpatient acute hospital setting- orthognathics/specialist dentistry.
 - Work with teenagers and young adults from within a developmental framework, as well as family interventions with this population group.
2. To function as a core, fully integrated member of the comprehensive orthognathics MDT. To provide excellent, and innovative psychologically informed input, to the interdisciplinary team as a key component of the treatment of patients referred to the service. To attend the multidisciplinary team (MDT) Combined Case clinics at least twice weekly (Tuesdays and Wednesdays) and case reviews representing a psychological perspective of care for patients and their families across Royal London and Whipps Cross Hospital Sites.
3. To be responsible for managing and supervising the newly developed Band 7 psychologist role within the Orthognathics service, as well as doctoral trainee psychologists, health psychology trainees and assistant psychologists who may be on placement within the orthognathics team.
4. To be responsible for the triage and signposting of patients referred for psychological treatment and follow up where required. This will include liaising between primary care, secondary care within NELFT, and Barts as well as other NHS services.
5. To support the clinical caseload by allocating work appropriately with the other psychologist in the service.

5. To provide consultation, liaison and teaching to consultant orthodontists, surgeons, nurses, colleagues and team members of the orthognathics team, regarding the psychological treatment and management of issues relating to orthognathic treatment. This will include specialist knowledge and experience in working within a broadly cognitive-behavioural model, which is the gold standard for appearance-related distress and body dysmorphic treatment..
6. To liaise closely with other disciplines responsible for a patient's care, when necessary, and to offer joint assessments of patients and carers with other key members of the MDT where appropriate.
7. To provide advice on a range of mental health concerns, and mental health difficulties, including clinical risk.
8. To provide information on psychological issues arising with other physical health conditions as well as pain management.
9. To promote positive psychological lives of teenagers and young people and to help develop specialised programmes for this patient group.
10. To undertake psychological assessments for suitability for highly complex elective facial surgery in lines with NICE guidelines.
11. To provide training and workshops to appropriate health professional colleagues at Barts/ NELFT on the treatment and management of the psychological dimensions of orthognathics.
12. To enhance the profile of the psychological care of patients and carers in the Orthognathics service by attending and contributing both to clinical health psychological services meetings and external specialist interest groups. This will include working with national experts such as the Centre for Appearance-Related Research and the DCP.
12. To employ core professional skills in carrying out service evaluation, service review and audits, as well as research developments. Use of evidence-based outcome measures will be standard practice. These should include assessing changes in function, psychological well-being, appearance- related distress, body dysmorphic concerns, healthcare use, quality of life and work status where relevant.
13. To deliver a culturally and ethically sensitive, equitable psychological therapy service to all minority groups regardless of race and, ethnicity, age, gender, sexual orientation, culture, religion, and disability; including service users in the design and delivery of the service. To be mindful and consider diversity within psychological practice as the

population group attending clinics comes from a wide range of the East London population.

Leadership

1. To participate in the development of an effective team and the development of productive working relationships throughout Barts orthognathics service, NELFT clinical health psychological service and broader Barts/ NELFT services.
2. To actively promote integrated health professional working internally and externally.
3. To facilitate the development of a positive and supportive team culture by taking responsibility for dealing effectively with potential conflict and differences of professional and personal opinions.
4. To support the development of a highly skilled supervision and consultation service, in which non-psychological orthognathic team members are skilled up in the detection and management of psychological distress and mental health concerns in their patient population, as well as regular training events on the psychology of orthognathics.
5. To take an active interest in working parties and groups within both Barts and NELFT Trusts to develop and improve on service delivery, protocols and guidelines.
6. To participate in the audit process, linking in with the clinical governance agenda.
7. To advise, encourage and share knowledge utilising the latest research and practice development, through literature and peer reviews.

Clinical Skills

1. To provide specialist psychological assessments of patients, carers and families referred to the orthognathics service. These assessments should be based upon the appropriate use, interpretation and integration of complex data from a variety of sources including self-report measures, rating scales, direct and indirect structured observations and semi-structured interviews with patients , family members and others involved in the client's care. This will be carried out within a multidisciplinary framework.

2. To formulate and implement plans for the formal psychological treatment and / or management of the cognitive, emotional, behavioural, physical and psychological health of people with psychological distress in orthognathics, utilising a bio-psycho-social model, based upon an appropriate conceptual framework of the patient's difficulties and presentation.
3. To implement a range of psychological interventions both therapeutic and psycho-educational, for individuals, families and groups, using evidence-based interventions and best practice guidelines.
4. To provide psychological interventions targeted at appearance-related distress, psychological distress related to adjustment in facial features and intrusive surgery, and possible body-dysmorphic presentations.
5. To show clinical expertise in the area of individual and group therapeutic techniques, as well as a strong clinical background in CBT.
6. To show expertise, familiarity and comfort in working with a range of psychological presentations, as well as flexibility in adapting clinical practice to suit the service and patient requirements.
7. To show clinical expertise and sensitivity in the psychological management of acute distress, anxiety and despair related to orthognathics. This would include experience in working with depression and anxiety, suicide risk, hopelessness, post-traumatic stress disorder and other trauma related symptoms, as well as a highly skilled ability to assess and manage deterioration in mental state.
8. To show professional skill and autonomous professional responsibility when evaluating and making decisions about psychological treatment options taking into account both theoretical and therapeutic models and highly complex factors concerning historical and developmental processes that have shaped the individual, family or group.
9. To show professional skill and experience/knowledge about psychological factors related to patient selection for orthognathic elective surgery and complex facial treatment and to form part of the multidisciplinary assessments of all patients entering the orthognathics service.
10. To show confidence and flexibility in providing individual psychological treatment when required before, during or after orthognathic surgery.
11. To see people referred by the orthognathic service with their families when required, and where appropriate, to provide psycho-education and brief couples/ family interventions, to help all members minimise

the negative impact of their condition on their lives, and to maximise the families' and the individuals' potential to cope positively and improve their quality of life.

12. To assess and manage clinical risk and mental health conditions, where appropriate, and to liaise with other mental health services (such as IAPT, secondary mental health and psychiatric liaison) to be able signpost patients to such services when indicated. To advise team colleagues on the psychological aspects of clinical risk and its management.
13. To work closely and within a consistently high and finely skilled professional framework with members of the orthognathics service to ensure effective multi-professional communication and decision-making.
14. To show highly developed skill and capability in working with a broad range of professionals and teams, from several areas of Barts and North East and East London, This would require that the post holder shows expertise in fostering, developing and maintaining relationships with a broad range of staff, patients and carers from a diverse group of acute, community and mental health services, in accordance with NELFT policies and Professional Codes of Practice.
15. To communicate skilfully, highly complex and sensitive information, to people referred by the orthognathics service, their carers, families, and other professionals, taking account of sensory and cultural challenges to communication.
16. To provide specialist assessment and therapy to non-English speaking patients with the use of an interpreter, when necessary, communicating with a high degree of clarity and sensitivity to cultural and linguistic differences.
17. To attend and participate in clinical health psychological services team meetings, special interest groups and events.

Computer/Administration

1. To ensure accurate recording of actions, and updating patient's records, maintaining confidentiality at all times in both NELFT and Barts settings.
2. To take responsibility for ensuring caseloads are regularly managed and updated

3. To oversee and support the Band 7 in maintaining their clinical caseloads and professional development

Communication

1. To have a wide range of knowledge in approaches to communicating and managing patient care.
2. To be able to effectively communicate with colleagues, peers, senior managers and clinical leads within Barts, and CHPS NELFT services.
3. To be able to communicate complex patient related information facilitating positive outcomes and ensuring collaborative working.
4. Participate in the review and development of clinical practice in lines with NICE evidence-based psychological treatment and identify any improvements to service provision.

Training

1. To receive regularly agreed (monthly) managerial supervision from the care pathway lead for clinical health psychology or a designated senior clinical psychologist.
2. To receive at least once monthly clinical supervision from an HCPC-registered senior practitioner psychologist/ BABCP registered psychological therapist within NELFT with experience in interdisciplinary pain management, group interventions and CBT.
3. To ensure that all statutory and mandatory training is regularly undertaken and up to date, and reviewed in managerial supervision. Furthermore, to show dedication and commitment to furthering clinical and specialist skills training through in-house and external training opportunities.
4. To be responsible for the line management and clinical supervision of the Band 7 psychologist providing 2 hours of supervision per month (1 hour management, 1 hour clinical)..
5. To provide specialist psychological advice, consultation and supervision opportunities to multidisciplinary staff working in the Pain Management Service within the boundaries of their professional framework.

6. To provide supervision and support to trainee clinical or counselling psychologists/ psychotherapists or counsellors on accredited training courses.
7. To contribute to the pre- and post-qualification teaching of clinical and/or counselling psychology, psychotherapy and counselling, as required by the care pathway lead for clinical health psychology and the professional lead for clinical health psychological service.
8. To provide supervision and support to assistant and honorary psychologists
9. To manage the workloads of assistant psychologists, within the framework of the team/service's policies and procedures.
10. To be involved, as appropriate, in the shortlisting and interviewing of assistant psychologists to work within the service.
11. To provide training, support and consultation to broader NELFT IAPT services, and Clinical Health Psychological Services when required.
12. To attend and contribute to Clinical Health Psychological Services group meetings,
13. To gain additional specialist experience relevant to the post and to keep up to date and abreast of, evidence based practice and CPD, as agreed with the Professional Lead and the care pathway lead for Clinical Health Psychological Services.
14. To attend training opportunities, conferences and specialist interest groups relevant to work, maintaining up to date psychological knowledge and skills.
15. To join and attend relevant professional and clinically relevant meetings, such as the BPS Faculty of Clinical Health Psychology and relevant specialist interest groups.

Management, Policy and Service Development

1. To contribute to the development, evaluation and monitoring of psychological services through the deployment of professional skills in research, service evaluation and audit.
2. To work alongside, the Care Pathway Lead for Clinical Health Psychological Services, and the Professional Lead for Clinical Health

Psychological Services to develop a high quality psychology service along agreed principles and guidelines.

3. To identify areas for development in the service and advise on how these might be achieved, and participating in their implementation.
4. To include, consult and engage with service users and carers in planning and developing psychology services..
5. To participate in integrated governance initiatives, providing a psychological perspective.
6. To attend service development and planning meetings and participate in shaping new initiatives for the service.

Research and Service Evaluation

1. To utilise theory, evidence-based literature and research to support evidence based practice in individual work and work with other multidisciplinary team members.
2. To undertake appropriate clinically relevant research and provide research advice to other staff undertaking research.
3. To support and advise the team on the design and analysis of audit and research projects.
4. To undertake audit, collect appropriate service data and complete annual and bi-annual service reports, as part of evaluating the current provision of psychological services.

Additional Information

Health & Safety

Employees must be aware of the responsibilities placed upon them under the Health & Safety at Work Act (1974) and subsequently published regulations to ensure that the Trust's Health and Safety policies and procedures are complied with to maintain a safe working environment for patients, visitors and employees.

Infection Control

Each staff member has a duty to take personal responsibility for the prevention and control of infection, in accordance with Trust Infection Prevention and Control Policies, which reflect the statutory requirements of the Health Act 2006 – Code of Practice for the Prevention and Control of Healthcare Associated Infection. They must attend mandatory training in Infection Control and be compliant with all measures required by the Trust to reduce HCAs.

Risk Management

You will be responsible for adopting the Risk Management Culture and ensuring that you identify and assess all risks to your systems, processes and environment and report such risks for inclusion within the Trust Risk Register. You will also attend mandatory and statutory training, report all incidents/accidents including near misses and report unsafe occurrences as laid down within the Trust Incidents

Safeguarding Children and vulnerable adults

NELFT is committed to safeguarding and promoting the welfare of children and adults and to protecting them from the risks of harm. The Trust recognises its responsibility to ensure that safe working conditions and systems are in place for staff working with children, adults and families in their care. Staff are required to comply with Trust policies on Safeguarding.

Standards of Business Conduct & Conflict of Interest

The NHS Code of Conduct and Standards of Business conduct for NHS Staff require all employees to declare all situations where you or a close relative or associate has a controlling interests in a business [such as a private company, public organisation or other NHS or voluntary organisation] or in any activity which may compete for any NHS contracts to supply goods or services to the

Trust. All such interests must be declared in the Trust's register of interests either on appointment or when such interests are gained.

As an employee you are required to make yourself aware of and adhere to the Trust's governance policies, such as Standing Orders and Standing Financial Instructions.

Sustainability

All staff has a responsibility for delivering high quality healthcare in a low carbon environment, where energy is used wisely and not wasted. It is the responsibility of all staff to minimise the Trust's environmental impact by recycling where possible, switching off lights, computers, monitors and equipment when not in use, minimising water usage and reporting faults promptly.

Smoking Policy

It is the Trust's policy to promote health. Smoking, therefore, is actively discouraged. It is illegal within the Trust buildings and vehicles.

Codes of Conduct

NELFT requires the highest standards of personal and professional conduct from all of its employees. All employees must comply with the Code of Professional Conduct appropriate to their professional governing body.

As an NHS employee, you are required to observe the following principles:

- Make the care and safety of patients my first concern and act to protect them from risk;
- Respect the public, patients, relatives, carers, NHS staff and partners in other agencies;
- Be honest and act with integrity;
- Accept responsibility for my own work and the proper performance of the people I manage;
- Show my commitment to working as a team member of working with all my colleagues in the NHS and the wider community;
- Take responsibility for my own and continuous learning and development

Data Protection

Personal data is protected under the Data Protection Act (1999) and the post holder will ensure that it is securely held and that the requirements of the Act are followed. It is the responsibility of all staff whose jobs requires them to record information in Trust Computer systems (e. g RIO and ESR) to ensure that the data entered into these systems is of high data quality and that

information is recorded correctly and in a timely manner. Failure to adhere to this requirement could be considered a disciplinary matter

Information Security and Confidentiality

All employees are required to observe the strictest confidence with regard to any patient/client information that they may have access to, or accidentally gain knowledge of, in the course of their duties.

All employees are required to observe the strictest confidence regarding any information relating to the work of the Trust and its employees.

You are required not to disclose any confidential information either during or after your employment with the Trust, other than in accordance with the relevant professional codes.

All person identifiable information must be held in the strictest confidence and should be disclosed only to authorised people in accordance with NHS Confidentiality Guidelines [Caldicott] and the Data Protection Act 1998 unless explicit written consent has been given by the person identified, or where information sharing protocols exist.

Failure to comply with these regulations whilst in the employment of the Trust could result in action being taken under the Trust Disciplinary Policy and Procedure.

Equality and Diversity

NELFT is committed to the implementation of the Equality and Diversity at Workplace policy which ensures equal opportunities for all. NELFT is also committed to embracing diversity and eliminating discrimination in both its role as an employer and as a provider of services. It aims to create a culture that respects and values each other's differences, promotes dignity, equality and diversity and encourages individuals to develop and maximise their potential. The Trust will ensure that it provides equal and fairness for all, and not to discriminate on the grounds of gender, marital status, race/ethnicity, disability, sexual orientation, religion, transgender or gender reassignment status, age, marriage or civil partnership/same sex marriage, and because of you being pregnant or being on maternity/paternity leave. All staff are required to observe this policy in their behaviour to employees and patients/service users.

Key Performance Indicators (KPI)

Each individual and service will be set KPIs and achievement against these will be regularly reviewed. Performance against individual and service KPI's will be routinely monitored by your manager.

Review of this Job Description

This job description is intended as an outline of the general areas of activity and will be amended in the light of the changing needs of the organisation. To be reviewed in conjunction with the post holder.

Other Duties

There may be a requirement to undertake other duties as may reasonably be required to support the Trust. These may be based at other Trust managed locations.

For HR Use Only:

Date of template: 1 January 2015

Version: 1

For Manager Use Only:

Date last reviewed: Insert date job description approved by panel

Date to be reviewed: Insert date job description to be reviewed by manager

Signed: **Dated:**

(Manager)

Signed:

(Employee)

Guidance

- Information already listed in the person specification should remain.
- All rows that are marked with a * and highlighted in yellow can have information added to them.

Guidance

- Information already listed in the person specification should remain.
- All rows that are marked with a * and highlighted in yellow can have information added to them.

	Essential	Desirable	Measurement
Demonstration of Trust Values			
Putting people first	✓		Application Form Interview
Prioritising quality	✓		Application Form Interview
Being progressive, innovative and continually improve	✓		Application Form Interview
Being professional and honest	✓		Application Form Interview
Promoting what is possible,	✓		Application Form Interview

independence, opportunity and choice			
Qualifications			
NVQ level 2 or equivalent standard of literacy and numeracy	✓		Application Form Interview
Doctoral level training in clinical or counselling psychology, or equivalent accredited by the BPS	✓		Application Form
HCPC registration as a practitioner clinical psychologist.	✓		Application Form
Advanced CBT skills and professional registration with the BABCP		✓	Application Form Interview
Additional specialist training in advanced group and individual and family interventions		✓	Application Form Interview
Experience			
Experience of delivering NICE endorsed evidence-based individual and group based psychological interventions including CBT	✓		Application Form Interview
Demonstrate further specialist training/ experience through having received a minimum of 30 hours clinical supervision working as a specialist psychologist over a minimum of 18 months	✓		Application Form Interview

Experience of delivering psychological therapy to a wide variety of client groups and presenting problems, reflecting the full range of clinical severity, across a range of care settings, including outpatient, community, and in patient settings, within the NHS.	✓		Application Form Interview
Experience of working with client groups and MDT's within physical health settings		✓	
Able to maintain a high degree of professionalism and competence when presented with complex, emotive and distressing problems.	✓		Interview
Ability to work with a high level of autonomy and flexibility within the bounds of the job description and professional competence	✓		Application Form Interview
Expertise and enthusiasm in line management and clinical supervision of psychologists, trainees and assistant psychologists		✓	Application Form Interview
Experience of undertaking		✓	Application Form Interview

neuropsychology assessments			
Sensitivity to issues of equality with experience of the application of clinical or counselling psychology in different cultural contexts	✓		Application Form Interview
Experience of delivering psychological assessment and interventions with patients presenting with acute and chronic pain		✓	Application Form Interview
Experience working with appearance-related distress, body image disturbances		✓	Application Form Interview
Ability to work with expertise within a multidisciplinary team, and with consultants, nurses and other HCP's; demonstrate consistency and professionalism in working with non-psychology team members	Interview		
Well-developed ability to communicate effectively, orally and in writing, complex, highly technical and/or clinically sensitive information to clients, their families, carers and other professional colleagues within and outside the NHS	Interview		

Able to work effectively in a team forming good working relationships with staff of all professions, working within the service and broader Clinical Health Psychology Service.	Interview
Other	
To be aware and demonstrate NELFT and Barts Trust Values	Interview
To be able to travel efficiently throughout the area required including Royal London Hospital, Whipps Cross Hospital and NELFT community sites.	Interview
To be able to attend at least twice weekly MDT combined clinics at both Royal London Hospital, Whitechapel and Whipps Cross Hospital, Leytonstone (Tuesdays and Wednesdays)	Interview

Public Works 4b: 8a Orthognathic 2018 advert



Job Advert: HCPC registered Band 8A Clinical/ Counselling Psychologist (1.0 WTE)

An exciting opportunity has arisen for an HCPC registered Band 7 Clinical/ Counselling Psychologist to join the innovative and fast growing Orthognathic service at Barts Health/NELFT. This is a one year (12 month) contract with the likelihood of an extension into a permanent post with further funding.

The post holder will offer a qualified highly skilled psychological service to patients, carers, and families across two hospital sites (Whipps Cross Hospital, Leytonstone and the Royal London hospital, Whitechapel). This will include the provision of specialist psychological assessments (including elective assessments for suitability for surgery) and psychotherapy to patients referred for orthognathic surgery, at both a pre and post –surgery level. The post holder should be able to offer at least two evidence-based psychological interventions for individuals and have an interest in working with adolescent and young adults, who form a large percentage of the patient group. The post holder should also be interested in developing their clinical skills in the area of appearance-related distress and body dysmorphia.

It is essential that the post holder is registered with the HCPC as an HCPC Registered Clinical/Counselling Psychologist, and has experience or specialist interest in working within clinical health psychology. A key component of the service will be attendance at multidisciplinary Combined Clinics and case reviews, and hence a dedication to working with multidisciplinary team members, and the provision of consultation and training to non-psychological colleagues within physical health settings is essential.

A robust understanding and capacity to manage clinical risk and crisis interventions is a vital component of this post, due to the variation of complexity of patients, carers and families presenting to the Service.

The post holder will be managing a complex caseload, where there may be elements of trauma. It is hence important that the post holder can hold their own emotional well-being in mind, with links to regular supervision and other support systems to help manage the demands of the service.

As a key member of the broader NELFT clinical health psychology themes, the post holder will play a significant role in service evaluation, including research, as well as the training and development of honorary assistant psychologists, health psychologists and other similar training groups.

The closing date of the advert is Wednesday 28th February 2018.

For informal enquiries, please feel free to contact

Marc Kingsley, Consultant Clinical Psychologist/ Care Pathway Lead for Clinical Health Psychological Services.

Mobile: 07967380685

Email: Marc.Kingsley@nelft.nhs.uk

and

Lindsay Royan, Consultant Clinical Psychologist/ Trust Lead for Clinical Health and Specialist Psychological Services.

Mobile: 07958 699 871

Lindsay.Royan@nelft.nhs.uk

Public Works 4c: 7 Orthognathics 2018 advert

Job Advert: HCPC registered Band 7 Clinical/ Counselling Psychologist (1.0 WTE)

An exciting opportunity has arisen for an HCPC registered Band 7 Clinical/ Counselling Psychologist to join the innovative and fast growing Orthognathic service at Barts Health/NELFT. This is a one year (12 month) contract with the likelihood of an extension into a permanent post with further funding.

The post holder will offer a qualified highly skilled psychological service to patients, carers, and families across two hospital sites (Whipps Cross Hospital, Leytonstone and the Royal London hospital, Whitechapel). This will include the provision of specialist psychological assessments (including elective assessments for suitability for surgery) and psychotherapy to patients referred for orthognathic surgery, at both a pre and post –surgery level. The post holder should be able to offer at least two evidence-based psychological interventions for individuals and have an interest in working with adolescent and young adults, who form a large percentage of the patient group. The post holder should also be interested in developing their clinical skills in the area of appearance-related distress and body dysmorphia.

It is essential that the post holder is registered with the HCPC as an HCPC Registered Clinical/Counselling Psychologist, and has experience or specialist interest in working within clinical health psychology. A key component of the service will be attendance at multidisciplinary Combined Clinics and case reviews, and hence a dedication to working with multidisciplinary team members, and the provision of consultation and training to non-psychological colleagues within physical health settings is essential.

A robust understanding and capacity to manage clinical risk and crisis interventions is a vital component of this post, due to the variation of complexity of patients, carers and families presenting to the Service.

The post holder will be managing a complex caseload, where there may be elements of trauma. It is hence important that the post holder can hold their own emotional well-being in mind, with links to regular supervision and other support systems to help manage the demands of the service.

As a key member of the broader NELFT clinical health psychology themes, the post holder will play a significant role in service evaluation, including research, as well as the training and development of honorary assistant psychologists, health psychologists and other similar training groups.

The closing date of the advert is Wednesday 28th February 2018.

For informal enquiries, please feel free to contact

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Email: Marc.Kingsley@nelft.nhs.uk

and

Lindsay Royan, Consultant Clinical Psychologist/ Trust Lead for Clinical Health and Specialist Psychological Services.

Mobile: 07958 699 871

Lindsay.Royan@nelft.nhs.uk

Public Works 4d: Job Description and Specification



Job description and specification

HCPC Registered Clinical
/Counselling Psychologist in
Orthognathics

Internal	External
67 / 17	

Line Manager Consultant Orthodontists Consultant Surgeons Dentists Nursing staff Allied health professionals, Hospital matron, Multidisciplinary Teams and other Barts hospital professionals, Mental Health Services (ranging from IAPT , through to secondary and specialist mental health services, Psychiatric Liaison Services and Clinical Health Psychological Services staff, Reception and Administrative staff.	Relevant services including local dental services; local GPs, Social Services, Voluntary Sector staff and Organisations and local support groups.
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CONTROLS ASSURANCE STATEMENT:

The purpose of this job description is to outline the level of responsibility and accountability of this post. This will ensure that all work undertaken by our staff is clearly identified and carried out under clear lines of accountability.

Aim of the role:

The post holder will be expected to support their team, department and organisation to achieve the Trust's Values in their day-to-day work. These are the 5P's:

- Putting people first
- Prioritising quality

- Being progressive, innovative and continually improve
- Being professional and honest
- Promoting what is possible – independence, opportunity and choice

The post holder will achieve this by:

Providing a qualified psychological service to patients, carers and families with orthognathic presentations; To provide specialist psychological assessment, design and delivery of individual and group therapy as needed; To offer clinical supervision, teaching, training and consultation on patients' psychological care to non-psychologist colleagues and to other non-professional carers, as appropriate. The post holder should demonstrate the ability to work flexibly and autonomously within professional guidelines and the overall framework of the team's policies and procedures; To work effectively with colleagues within orthognathics services at Barts and NELFT NHS Trusts and the broader Clinical Health Psychological Service at NELFT; To utilise evidence-based outcome measures and treatment approaches to ensure a consistent and high level of quality is provided to the Orthognathics Service; To utilise research skills for audit, policy and service development, service evaluation and research within the area served by the team/service.

Key Responsibilities:

1. To provide a highly skilled psychological service to the Orthognathics Service /Clinical Health Psychological Service involving: psychological assessment, and therapeutic interventions (individual, couple, family, carers and group) to people with orthognathic presentations. This role will include the provision of enhanced specialist psychological clinical assessment, psycho-education and evidence-based therapeutic interventions, working within the policies, procedures and protocols applicable to the service.

2. To offer advice and consultation on patients' psychological care to psychology and non-psychology colleagues and to other, non-professional carers, working autonomously within professional guidelines and the overall framework of the service's policies and procedures.

3. To show skill in working effectively within multidisciplinary team settings as a key role will be to work closely with the Orthognathics MDT across two hospital sites (Royal London Hospital, Whitechapel and Whipps Cross Hospital, Leytonstone)

4. To work closely with the 8A Highly Specialist Orthognathics Psychologist for CHPS in providing a high standard clinical health psychological service in Orthognathics.

5. To work closely with other psychologists and non-psychology colleagues in the clinical health psychology team, and to demonstrate a high standard of clinical skill, multidisciplinary engagement and flexibility in working across the full spectrum of Orthognathics diagnosis.

6. To supervise assistant psychologists.

7. To actively contribute to the development and delivery of group intervention programmes for people with orthognathic presentations.

8. To utilise research skills for audit, policy and service development and research. To enhance the psychological profile of orthognathic/dental care by attending and contributing to both in-house clinical health psychology meetings and external specialist interest groups.

9. To employ core professional skills in carrying out outcome measures, risk assessments, service evaluation, service review and audits.

To deliver a culturally and ethically sensitive, equitable psychological therapy service to all minority groups regardless of race and ethnicity, age, gender, sexual orientation, culture, religion, and disability; to include service users in the design and delivery of the service.

Leadership

1. To deploy professional skills in research, service evaluation and audit.

2. To work closely with the Orthognathics MDT to develop best practice for working with Orthognathics, along agreed principles and national guidelines.
3. To be involved, as appropriate, in the shortlisting and interviewing of assistant psychologists.
4. To manage the workload and contribute to the appraisal of assistant psychologists
5. To identify areas for development in the service, and advise on how these might be achieved, participating in their implementation.
6. To engage with service users in planning and developing psychology services for people with orthognathics presentations.

Clinical Skills

Clinical:

1. To provide specialist psychological assessments of patients with orthognathic dental presentations, their families and/or carers, within the acute hospital settings at the Royal London Hospital, Whitechapel and Whipps Cross Hospital, Leytonstone. . These assessments should be based upon the appropriate use, interpretation and integration of complex data from a variety of sources including psychological and neuropsychological tests, self-report measures, rating scales, direct and indirect structured observations and semi-structured interviews with clients, family members and others involved in the client's care.
2. To conduct psychological assessments flexibly on an inpatient and/or outpatient basis, attending at least twice weekly multi-disciplinary combined clinics (Tuesdays and Wednesdays) and consultant led clinics, as required.
3. To formulate and implement plans for the formal psychological treatment and / or management of the cognitive, emotional, behavioural, physical and psychological health of people with orthognathics, working

across the condition spectrum, based upon an appropriate conceptual framework of the patient's problems, employing psychotherapeutic methods based upon evidence of efficacy, across the full range of care settings.

4. Offer psychological assessments and recommendations of the appropriateness of complex elective medical/surgical interventions and suggesting possible alternatives to clinical staff where appropriate.

5. To be responsible for implementing of at least two evidence-based psychological interventions, both therapeutic and psycho-educational, for individuals, carers, families and groups, employed individually and in synthesis, adjusting and refining psychological formulations drawing upon different explanatory models and maintaining a number of provisional hypotheses.

6. To see people with orthognathic presentations with their carers and/or families when required; to provide psycho-education, brief family interventions, and carers support for families, to help all members minimise the negative impact of their condition on their lives, and to maximise the families' and the individuals' potential to cope positively and improve their quality of life.

7. To provide group interventions for people to enhance self-management and improved mental and physical health through mutual support and sharing of good practice.

8. To undertake neuropsychological screenings/ assessments, where indicated, given evidence of compromised cognitive functioning. To liaise with the local memory service to optimise the support available to manage such complications.

9. To work sensitively with people who may be facing the prospect of surgical procedures due to complications in their orthognathic presentation, to assess such matters as psychological preparedness for surgery, issues of anticipatory loss and adjustment, and to work with them post-treatment to help with the recovery process.

10. To have highly developed skills in the assessment and management of clinical risk and mental health conditions, and to undertake risk assessments and risk management for patients when required, providing expert advice to colleagues on the psychological aspects of psychological risk and its management, referring on, and effectively documented in a timely manner when needed. To provide advice to other professionals on psychological aspects of risk assessment and management.

11. To work closely with multidisciplinary members of the Orthognathics service to ensure effective multi-professional communication and decision making.

12. To communicate skilfully, whether through written or oral or other means, highly complex and sensitive information concerning the assessment, formulation and treatment plans as required, to people with orthognathic presentations, their families, and other professionals, taking account of sensory and cultural challenges to communication.

13. To provide specialist assessment and therapy to non-English speaking Clients with the use of an interpreter, when necessary, communicating with a high degree of clarity and sensitivity to cultural and linguistic differences.

14. To provide specialist psychological consultation and supervision to colleagues and others in the wider health care setting and to contribute to the effective working of the psychology service and multi-disciplinary health teams in order to deliver comprehensive clinical care and ensure that psychological wellbeing is central to the planning and delivery of health care.

15. To attend and participate in Orthognathics Psychological Therapies Service and Clinical Health Psychology Service team meetings, as well as other special interest groups and events.

16. To liaise and work closely when necessary with other key health teams, including mental health liaison and dental services.

Computer/Administration

4. To be computer literate and encourage implementation of the Trust's IM&T Strategy.
5. To ensure accurate recording of actions, and updating patient's records, maintaining confidentiality at all times on both NELFT and Barts computer systems.
6. To take part, and assist, in the planning and administration relating to day to day running of the caseload.

Communication

5. To have a wide range of knowledge in approaches to communicating and managing patient care.
6. To be able to effectively communicate with colleagues, peers, senior managers and clinical leads.
7. To be able to communicate complex patient related information facilitating positive outcomes and ensuring collaborative working.
8. Participate in the review and development of clinical policies and identifies improvements to service provision.

Training

1. To receive regularly agreed (i.e. at least once monthly) managerial and clinical supervision from a more senior psychologist according to HCPC, BPS and Trust guidelines.
2. To ensure that all statutory and mandatory training is regularly undertaken and up to date, and reviewed in managerial supervision. Furthermore, to show dedication and commitment to furthering clinical and specialist skills training through in-house and external training opportunities.
3. To provide specialist psychological advice, consultation, training and supervision opportunities to multidisciplinary staff working in orthognathics within the boundaries of their professional framework, including contributing to the delivery of training and workshops.
4. To contribute to the support of trainee clinical, or counselling psychologists, or psychotherapy trainees on accredited training courses, or counsellors on placement.
5. To provide supervision and support to assistant or honorary psychologists.

6. To provide training, support and consultation to broader NELFT and Clinical Health Psychological Services when required.

7. To regularly attend and contribute to Clinical Health Psychology group meetings and meetings when requested.

8. To gain additional specialist experience relevant to people diagnosed with dental and orthognathic concerns, appearance-related distress and body-image presentations and to keep up to date and abreast of, evidence based practice, as agreed.

9. To attend training opportunities, conferences and specialist interest groups relevant to work with people with orthognathic/ appearance-related distress and body-image presentations maintaining up to date psychological knowledge and skills.

10. To utilise theory, evidence-based literature and research to support evidence based practice in individual work and work with other multidisciplinary team members.

11. To undertake appropriate clinically relevant research and provide research advice and supervision to other staff undertaking research on psychological aspects of relevant to people with cancer, their carers and families.

12. To support and advise the team on the design and analysis of audit and research projects.

Additional Information

Health & Safety

Employees must be aware of the responsibilities placed upon them under the Health & Safety at Work Act (1974) and subsequently published regulations to ensure that the Trust's Health and Safety policies and procedures are complied with to maintain a safe working environment for patients, visitors and employees.

Infection Control

Each staff member has a duty to take personal responsibility for the prevention and control of infection, in accordance with Trust Infection Prevention and Control Policies, which reflect the statutory requirements of the Health Act 2006 – Code of Practice for the Prevention and Control of Healthcare Associated Infection. They must attend mandatory training in Infection Control and be compliant with all measures required by the Trust to reduce HCAs.

Risk Management

You will be responsible for adopting the Risk Management Culture and ensuring that you identify and assess all risks to your systems, processes and environment and report such risks for inclusion within the Trust Risk Register. You will also attend mandatory and statutory training, report all incidents/accidents including near misses and report unsafe occurrences as laid down within the Trust Incidents

Safeguarding Children and vulnerable adults

NELFT is committed to safeguarding and promoting the welfare of children and adults and to protecting them from the risks of harm. The Trust recognises its responsibility to ensure that safe working conditions and systems are in place for staff working with children, adults and families in their care. Staff are required to comply with Trust policies on Safeguarding.

Standards of Business Conduct & Conflict of Interest

The NHS Code of Conduct and Standards of Business conduct for NHS Staff require all employees to declare all situations where you or a close relative or associate has a controlling interests in a business [such as a private company, public organisation or other NHS or voluntary organisation] or in any activity which may compete for any NHS contracts to supply goods or services to the Trust. All such interests must be declared in the Trust's register of interests either on appointment or when such interests are gained.

As an employee you are required to make yourself aware of and adhere to the Trust's governance policies, such as Standing Orders and Standing Financial Instructions.

Sustainability

All staff has a responsibility for delivering high quality healthcare in a low carbon environment, where energy is used wisely and not wasted. It is the responsibility of all staff to minimise the Trust's environmental impact by recycling where possible, switching off lights, computers, monitors and equipment when not in use, minimising water usage and reporting faults promptly.

Smoking Policy

It is the Trust's policy to promote health. Smoking, therefore, is actively discouraged. It is illegal within the Trust buildings and vehicles.

Codes of Conduct

(NELFT requires the highest standards of personal and professional conduct from all of its employees. All employees must comply with the Code of Professional Conduct appropriate to their professional governing body.

As an NHS employee, you are required to observe the following principles:

- Make the care and safety of patients my first concern and act to protect them from risk;
- Respect the public, patients, relatives, carers, NHS staff and partners in other agencies;
- Be honest and act with integrity;
- Accept responsibility for my own work and the proper performance of the people I manage;
- Show my commitment to working as a team member of working with all my colleagues in the NHS and the wider community;
- Take responsibility for my own and continuous learning and development

Data Protection

Personal data is protected under the Data Protection Act (1999) and the post holder will ensure that it is securely held and that the requirements of the Act are followed. It is the responsibility of all staff whose jobs requires them to record information in Trust Computer systems (e. g RIO and ESR) to ensure that the data entered into these systems is of high data quality and that information is recorded correctly and in a timely manner. Failure to adhere to this requirement could be considered a disciplinary matter

Information Security and Confidentiality

All employees are required to observe the strictest confidence with regard to any patient/client information that they may have access to, or accidentally gain knowledge of, in the course of their duties.

All employees are required to observe the strictest confidence regarding any information relating to the work of the Trust and its employees.

You are required not to disclose any confidential information either during or after your employment with the Trust, other than in accordance with the relevant professional codes.

All person identifiable information must be held in the strictest confidence and should be disclosed only to authorised people in accordance with NHS Confidentiality Guidelines [Caldicott] and the Data Protection Act 1998 unless explicit written consent has been given by the person identified, or where information sharing protocols exist.

Failure to comply with these regulations whilst in the employment of the Trust could result in action being taken under the Trust Disciplinary Policy and Procedure.

Equality and Diversity

NELFT is committed to the implementation of the Equality and Diversity at Workplace policy which ensures equal opportunities for all. NELFT is also committed to embracing diversity and eliminating discrimination in both its role as an employer and as a provider of services. It aims to create a culture that respects and values each other's differences, promotes dignity, equality and diversity and encourages individuals to develop and maximise their potential. The Trust will ensure that it provides equal and fairness for all, and not to discriminate on the grounds of gender, marital status, race/ethnicity, disability, sexual orientation, religion, transgender or gender reassignment status, age, marriage or civil partnership/same sex marriage, and because of you being pregnant or being on maternity/paternity leave. All staff are required to observe this policy in their behaviour to employees and patients/service users.

Key Performance Indicators (KPI)

Each individual and service will be set KPIs and achievement against these will be regularly reviewed. Performance against individual and service KPI's will be routinely monitored by your manager.

Review of this Job Description

This job description is intended as an outline of the general areas of activity and will be amended in the light of the changing needs of the organisation. To be reviewed in conjunction with the post holder.

Other Duties

There may be a requirement to undertake other duties as may reasonably be required to support the Trust. These may be based at other Trust managed locations.

Guidance

- Information already listed in the person specification should remain.
- All rows that are marked with a * and highlighted in yellow can have information added to them.

	Essential	Desirable	Measurement
Demonstration of Trust Values			
Putting people first	✓		Interview
Prioritising quality	✓		Interview
Being progressive, innovative and continually improve	✓		Interview
Being professional and honest	✓		Interview
Promoting what is possible, independence, opportunity and choice	✓		Interview
Qualifications			
NVQ level 2 or equivalent standard of literacy and numeracy	✓		Interview
HCPC registration as a practitioner psychologist	✓		Application Form

Level 2 supervision groups for attenders

Doctoral level training in Clinical/ Counselling psychology accredited by the BPS	✓		Application Form
Additional specialist training in advanced therapy skills, such as CBT, motivational interviewing, family interventions		✓	Application Form Interview
Experience			
Experience of specialist psychological assessment and treatment of clients across the full range of care settings, including outpatient, community, primary care and inpatient settings, within the NHS.	✓		Application Form Interview
Experience of delivering psychological therapy in physical health services		✓	Application Form Interview
Experience of delivering psychological therapy to a wide variety of client groups, ages, contexts and presenting problems, reflecting a range of clinical severity.	✓		Application Form Interview
Experience of delivering group work / family work		✓	Application Form Interview
Experience of teaching, training, and/or supervision.		✓	Application Form Interview

Level 2 supervision groups for attenders

Experience of developing and carrying out research projects, audit and service evaluation.	✓		Application Form Interview
Knowledge			
An awareness of NHS Plan, NICE and clinical governance priorities	✓		Application Form Interview
Knowledge and enthusiasm for working psychologically with people with physical health presentations	✓		Application Form Interview
Knowledge of acute hospital settings.	✓		Application Form Interview
Knowledge of the theory and practice of highly specialised psychological therapies and models of health and illness.	✓		Application Form Interview
Knowledge of legislation and national policy in relation to patients within physical health settings..		✓	Application Form Interview

Level 2 supervision groups for attenders

Skills			
Basic awareness of IT and IT skills	✓		Application Form Interview
Ability to maintain a high degree of professionalism and competence when presented with complex ,emotive and distressing problems.	✓		Interview
Ability to work with autonomy and flexibility within the bounds of the job description and professional competence.	✓		Interview
Ability to work with client groups across the range from pre-operative consultation for orthognathics through to post-surgery treatment.		✓	Interview
Sensitivity to issues of equality with experience of the application of clinical psychology in different cultural contexts	✓		Interview
Well -developed skills in the ability to communicate effectively, orally and in writing, complex, highly technical and/or clinically sensitive information to clients, their families, carers and other professional colleagues within and outside the NHS.	✓		Interview
Skills in providing consultation to other professional and nonprofessional groups.		✓	Interview
Ability to work effectively in a team forming good working relationships with staff of all professions, people with cancer and their families/carers.	✓		Interview
Other			

Level 2 supervision groups for attenders

To be aware and demonstrate the Trust Values	✓		Application Form Interview
To be able to travel efficiently throughout the area	✓		Application Form Interview
Highly organised and effective time management	✓		Application Form

Public Works 5a: Orthognathics leaflet

Paragraph

Styles

Editir

This information is available in alternative formats. For more information- please ask to speak to the PALS office.

PUBLIC WORKS 5a

WHERE IS THE TEAM BASED?

Royal London Hospital

Dr. Charlotte Priestley
Clinical Psychologist

Whipps Cross Hospital

Dr. Emily Kenefick
Clinical Psychologist

Contact us on: 020 359 42749

This service has appointments Monday - Thursday 9am-5pm and you can be seen at Whipps Cross Hospital or the Royal London Hospital



Orthognathic Psychology Service

Paragraph

Styles

Editir

WHO IS IT FOR?

Our service is open to those who have been referred for or have had orthognathic surgery. This includes those who are currently undergoing fixed appliance treatment and are due to have surgery or who have already undergone surgery. You can come as a family, couple or on your own.

WHAT DO WE OFFER?

As a team we recognise that a complete package of care contains not only physical but psychological wellbeing too. We understand that choosing to undergo orthognathic treatment is a big decision and you may feel worried or unsure about what will happen and how you will cope.

We also acknowledge that the face is one of the most visible aspects of our personal appearance. Therefore, having concerns about our facial appearance and undergoing treatment that alters our appearance, can impact upon how we feel about ourselves, how we behave and how we interact with others.

We offer a space to talk about any worries and concerns you may have about your current appearance and treatment. This can help to relieve any difficult feelings and distress, improve your treatment experience and assist you in adjusting to the physical and emotional changes that may arise. We can also help you with your decision to proceed with surgery. This is to ensure that treatment is the right choice for you at this time.

WHAT ARE SOME OF THE ISSUES WE CAN HELP WITH?

- Setting realistic expectations about treatment and helping you cope with any setbacks
- Coping with the treatment journey and the impact on your life, your relationships, and your emotional wellbeing
- Addressing any worries and distress you experience relating to your facial appearance, e.g. low mood, anxiety, low self-esteem

- Adjusting to physical and emotional changes as a consequence of treatment

HOW CAN I BE REFERRED?

Your consultant surgeon or orthodontist can refer you.

What may be discussed during a psychology appointment?

Our aim is to try to understand your concerns and experiences within the context of your treatment and to consider possible ways in which psychological support could help improve your orthognathic journey. Your personal history and background information is often considered to help us better understand your specific needs and concerns. Therefore, we may touch on delicate issues that are difficult to discuss. It is helpful to inform the psychologist if you find talking about particular areas of your life distressing, so that they can support you with this. We take confidentiality very seriously, appointments are private but we may share information with other health care professionals if it is necessary. If there are any specific issues you prefer not to be shared with the wider team, please discuss this with your psychologist.

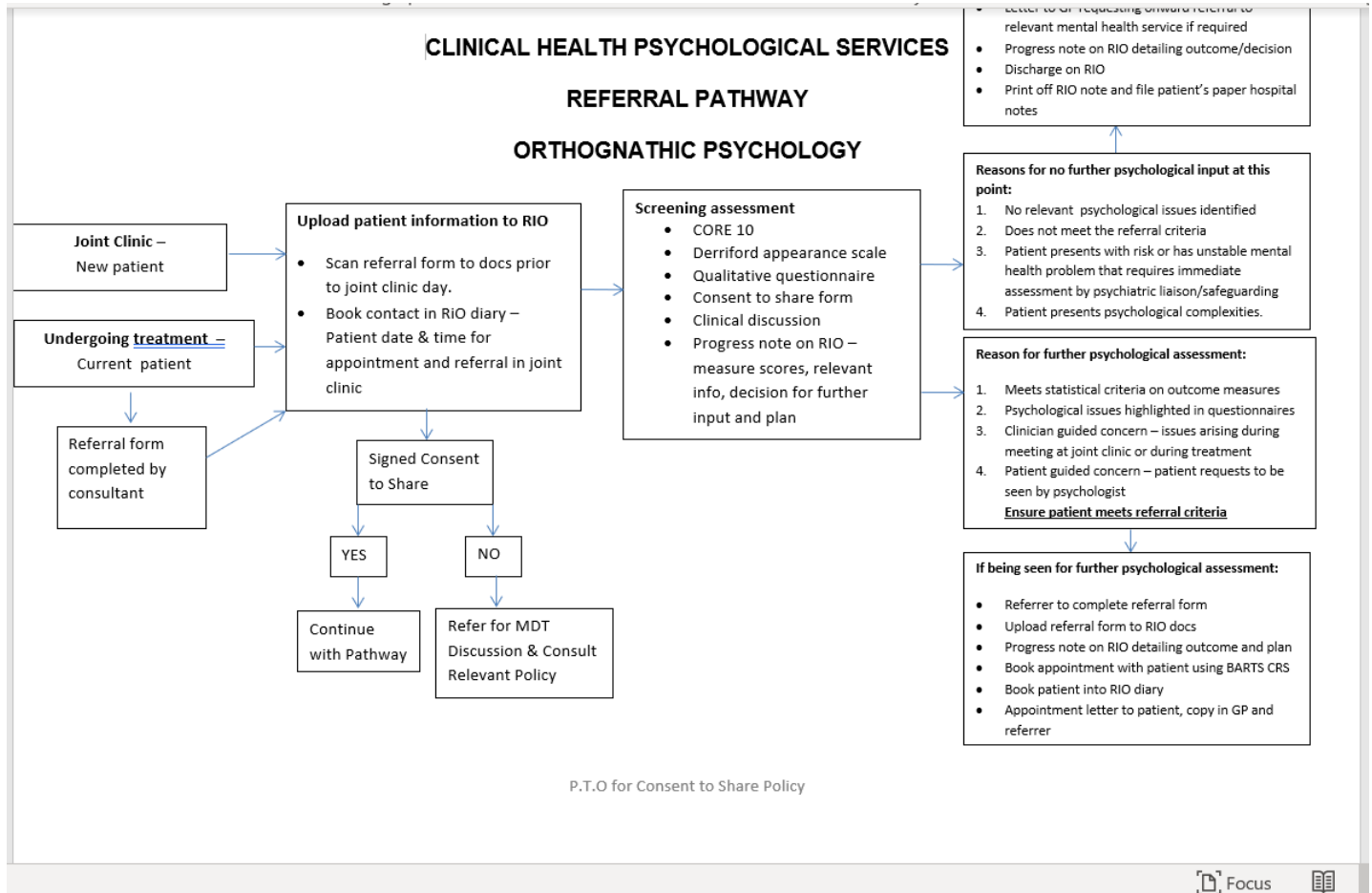
WHAT WILL HAPPEN NEXT?

When we receive the referral, a psychologist will contact you and offer an assessment appointment.

During this appointment, you will be able to talk about your concerns. We will then decide together whether further appointments might be helpful and what might be the best way forward for you.

The number of appointments offered will depend on your need, which we will discuss with you and the team.

Public Works 5b: Orthognathic Referral Pathway



Public Works 5c: Orthognathic Psychology Screening

Orthognathic Psychology Service

Welcome to the Orthognathic Psychology Service (OPS) for individuals undergoing Orthognathic treatment, which may include fixed appliances and surgery.

As a team we recognise that such surgery does not just affect people physically, but also psychologically and socially. Our service aims to offer all individuals considering this surgery an individual consultation and assessment. This is an opportunity to consider if a person has any concerns or is experiencing any psychological distress related to their treatment.

At the end of the consultation, time is given to summarise the person's current psychological needs related to orthognathic treatment. If requested, further psychological support can be offered from our team. If the Orthognathic Psychology Service is not the best place to meet your psychological needs, then the team will do their best to sign-post you towards appropriate help.

To help assist us before meeting you, we request individuals to complete the following Service Pack. This information helps us understand your current situation and collect basic demographic information about the people using the service (such as age groups and ethnicity). Please be assured that all information is treated confidentially and is recorded in keeping with the Trust's Information Governance Policies. However, if there are any questions you do not feel comfortable answering please discuss with a member of the team or leave blank. Please note the final questionnaire requests your consent to share information with your G.P.; this is to help your G.P. continue to hold an up-to-date medical record of the care you receive from us.

Many thanks for your time in reading this and in completing the rest of this pack.

Yours sincerely,

Orthognathic Psychology Service Team (OPS)

Name of assessing Psychology Team member:

Date _____ **of**
assessment: _____ -

Part 1: Please can you complete the following information

Patient Name :		Contact telephone numb
Address :		Preferred language: Is an interpreter required
Date of birth:	Disability :	Sexuality :
Marital Status :	Religion :	Ethnicity :
Gender	Smoking Status :	
GP Name, Address and Contact Number :		
<i>Next of Kin Name :</i>		<i>Relation :</i>
<i>Next Of Kin Address :</i>		<i>Contact Numbers :</i>

Part 2: Please can you tell us about your experiences of seeking Orthognathic Treatment

Where are you in your orthognathic treatment?

☐ New Patient

- ☐ Awaiting Operation Date
- ☐ Operation Date upcoming
- ☐ Post Operation

1. Please could you tell us about why you are seeking Orthognathic Treatment now?
2. Have you experienced any significantly unpleasant dental related experiences prior to starting your orthognathic treatment?
3. Please could you comment on what you expect from undergoing Orthognathic Surgery and the challenges you think you may encounter?
4. Do you have any specific concerns about undergoing treatment (e.g. living with fixed appliances or undergoing jaw surgery) and if so, please explain what these are?
5. Do you have any specific concerns about your current mental health or psychological well-being? (e.g. depression, low-mood, anxiety, difficult thoughts and feelings you struggle to cope with
6. Have you ever been diagnosed with a mental health problem and/or have been supported by a mental health team or other support service?

7. Do you have any concerns or issues that you would like to discuss further in private with a psychologist?

YES or NO

If 'yes', there will be an opportunity to do this away from the medical team

Part 3: Service questionnaires

Please read the following first:

This questionnaire has 10 statements about how you have been **OVER THE LAST WEEK**. Please read each statement and think how often you felt that way last week. Then tick the box which is closest to this. Please use a dark pen (not pencil) and tick clearly within the boxes.

		Not at all	Only occasionally	Sometimes	Often	Most or all of the time
1	I have felt tense, anxious or nervous	0	1	2	3	4
2	I have felt I have someone to turn to for support when needed	4	3	2	1	0
3	I have felt able to cope when things go wrong	4	3	2	1	0
4	Talking to people has felt too much for me	0	1	2	3	4

5	I have felt panic or terror	0	1	2	3	4
6	I made plans to end my life	0	1	2	3	4
7	I have had difficulty getting to sleep or staying asleep	0	1	2	3	4
8	I have felt despairing or hopeless	0	1	2	3	4
9	I have felt unhappy	0	1	2	3	4
10	Unwanted images or memories have been distressing me	0	1	2	3	4

CORE-10 Questionnaire (Clinical Outcomes in Routine Evaluation)

The following questionnaire is concerned with how you feel about your appearance

(Derriford Appearance Scale – DAS 24)

The first part of the scale is designed to find out if you are sensitive or self-conscious about any aspect of your appearance (even if this is not usually visible to others).

(a) Is there any aspect of your appearance (however small) that concerns you at all?

Yes / No

If No, please turn to the next Page

If Yes, please continue:

(b) The aspect of my appearance about which I am most sensitive or self-conscious is

.....

.....

.....

.....

From now on, we will refer to this aspect of your appearance as your 'feature'

c) The thing I don't like about my feature is

.....

.....

.....

.....

(d) If you are sensitive or concerned about any other features of your body or your appearance, please say what they are

.....

.....

.....

.....

Instructions: The following questions are concerned with the way you feel or act. They are all simple. Please tick the answer that applies to you. If the item does not apply to you at all, tick the N/A (not-applicable option). Don't spend long on any one question.

a) How confident do you feel?

Not at all	Slightly	Moderately	Extremely....
4	3	2	1

b) How distressed do you get when you see yourself in the mirror/window?

Extremely Distressed....	Moderately....	A Little	Not at all
4	3	2	1

c) My self-consciousness makes me irritable at home:

N/A Almost always..	Never/Almost never	Sometimes	Often
0	1	2	3
4			

d) How hurt do you feel?

Extremely	Moderately	Slightly	Not at all
4	3	2	1

e) At present my self-consciousness has an adverse effect on my work:

Almost always never....	N/A Often....	Sometimes	Never/almost
4	3	2	1
0			

f) How distressed do you get when you go to the beach?

N/A Extremely....	Not at all	A little	Moderately.....
0	1	2	3
4			

g) Other people mis-judge me because of my feature:

Almost always never	Often N/A	Sometimes	Never/almost
4	3	2	1
0			

h) How feminine/masculine do you feel?

Not at all	Slightly....	Moderately	Extremely....
4	3	2	1

i) I am self-conscious of my feature:

N/A Almost always....	Never /Almost never	Sometimes	Often
0	1	2	3
4			

j) How irritable do you feel?

Not at all	Slightly	Moderately	Extremely....
1	2	3	4

k) I adopt certain gestures (e.g. folding my arms in front of other people, covering my mouth with my hand):

Never/almost never	Sometimes	Often
Almost always...		
1	2	3
4		

l) I avoid communal changing rooms:

Almost always	Often	Sometimes....	Never/almost never
N/A			
4	3	2	1
0			

m) How distressed do you get by shopping in department stores/supermarkets?

N/A	Not at all	Slightly.....	Moderately...	Extremely
0	1	2	3	4

n) How rejected do You feel?

Not at all	Slightly...	Moderately.....	Extremely.....
1	2	3	4

o) I avoid undressing in front of my partner:

N/A	Never/almost never	Sometimes	Often
Almost always			
0	1	2	3
4			

p) How distressed do you get while playing sports/games?

Extremely	Moderately	Slightly....	Not at all.....
N/A.....			
4	3	2	1
0			

q) I close into my shell:

Almost always....	Often....	Sometimes....
Never/Almost never...		
4	3	2
		1

r) How distressed are you by being unable to wear your favourite clothes?

Extremely	Moderately	Slightly....	Not at all.....
N/A.....			
4	3	2	1
			0

s) How distressed do you get when going to social events?

N/A.....	Not at all....	Moderately....	A fair amount....
Extremely....			

0	1	2	3	4
t) How normal do You feel?				
Not at all	Slightly	Moderately.....		
Extremely.....				
4	3	2	1	
u) At present my self-consciousness has an adverse effect on my sex life:				
Almost always	Often	Sometimes....	Never/almost	
never	N/A			
4	3	2	1	
0				
v) I avoid going out of the house:				
Almost always....	Often....	Sometimes....	Never/almost	
never....				
4	3	2	1	
w) How distressed do you get when other people make remarks about your feature?				
N/A	Not at all ...	Moderately.....	A fair amount.....	
Extremely				
0	1	2	3	
4				
x) I avoid going to pubs/restaurants:				
Almost always	Often	sometimes....	Never/almost	
never	N/A			
4	3	2	1	
0				
 ❖ My feature causes me physical pain/discomfort:				
Never/almost never.....	Sometimes	Often.....	Almost	
always.....				
 ❖ My feature limits my <u>physical</u> ability to do the things I want to do:				
Almost always	Often....	Sometimes.....	Never/ almost	
never.....				

Thank you for taking the time to complete this form

**Public Works 5d: Orthognathic Psychology Young People Adolescent Patient
Assessment Pack**

Welcome to the Orthognathic Psychology Service (OPS) for individuals undergoing Orthognathic treatment, which may include fixed appliances and surgery.

As a team we recognise that such surgery does not just affect people physically, but also psychologically and socially. Our service aims to offer all individuals considering this surgery an individual consultation and assessment. This is an opportunity to consider if a person has any concerns or is experiencing any psychological distress related to their treatment.

At the end of the consultation, time is given to summarise the person's current psychological needs related to orthognathic treatment. If requested, further psychological support can be offered from our team. If the Orthognathic Psychology Service is not the best place to meet your psychological needs, then the team will do their best to sign-post you towards appropriate help.

To help assist us before meeting you, we request individuals to complete the following Service Pack. This information helps us understand your current situation and collect basic demographic information about the people using the service (such as age groups and ethnicity). Please be assured that all information is treated confidentially and is recorded in keeping with the Trust's Information Governance Policies. However, if there are any questions you do not feel comfortable answering please discuss with a member of the team or leave blank. Please note the final questionnaire requests your consent to share information with your G.P.; this is to help your G.P. continue to hold an up-to-date medical record of the care you receive from us.

Many thanks for your time in reading this and in completing the rest of this pack.

Yours sincerely,

Orthognathic Psychology Service Team (OPS)

Name of assessing Psychology Team member:

Date of assessment: _____ - _____

Part 1: Please can you complete the following information

Patient Name :		Contact telephone number (s):
Address :		Preferred language: Is an interpreter required?
Date of birth:	Disability :	Sexuality :
Marital Status :	Religion :	Ethnicity :
Gender	Smoking Status :	
GP Name, Address and Contact Number :		
Next of Kin Name :		Relation :
Next Of Kin Address :		Contact Numbers :

Part 2: Please can you tell us about your experiences of seeking Orthognathic Treatment

Where are you in your orthognathic treatment?

- ☐ New Patient
- ☐ Awaiting Operation Date
- ☐ Operation Date upcoming
- ☐ Post Operation

8. Please could you tell us about why you are seeking Orthognathic Treatment now?
9. Have you experienced any significantly unpleasant dental related experiences prior to starting your orthognathic treatment?
10. Please could you comment on what you expect from undergoing Orthognathic Surgery and the challenges you think you may encounter?
11. Do you have any specific concerns about undergoing treatment (e.g. living with fixed appliances or undergoing jaw surgery) and if so, please explain what these are?
12. Do you have any specific concerns about your current mental health or psychological well-being? (e.g. depression, low-mood, anxiety, difficult thoughts and feelings you struggle to cope with)

13. Have you ever been diagnosed with a mental health problem and/or have been supported by a mental health team or other support service?

14. Do you have any concerns or issues that you would like to discuss further in private with a psychologist?

YES or NO

If 'yes', there will be an opportunity to do this away from the medical team

Part 3: Service questionnaires

Please read the following first:

This questionnaire has 10 statements about how you have been **OVER THE LAST WEEK**. Please read each statement and think how often you felt that way last week. Then tick the box which is closest to this. Please use a dark pen (not pencil) and tick clearly within the boxes.

		Not at all	Only occasionally	Sometimes	Often	Most or all of the time
1	I've felt edgy or nervous	0	1	2	3	4
2	I haven't felt like talking to anyone	0	1	2	3	4
3	I've felt able to cope when things go wrong	4	3	2	1	0

4	I've thought of hurting myself	0	1	2	3	4
5	There's been someone I felt able to ask for help	4	3	2	1	0
6	My thoughts and feelings distressed me	0	1	2	3	4
7	My problems have felt too much for me	0	1	2	3	4
8	It's been hard to go to sleep or stay asleep	0	1	2	3	4
9	I've felt unhappy	0	1	2	3	4
10	I've done all the things I wanted to	4	3	2	1	0

CORE-10 Questionnaire (Clinical Outcomes in Routine Evaluation)

The following questionnaire is concerned with how you feel about your appearance

(Derriford Appearance Scale – DAS 24)

The first part of the scale is designed to find out if you are sensitive or self-conscious about any aspect of your appearance (even if this is not usually visible to others).

(a) Is there any aspect of your appearance (however small) that concerns you at all?

Yes / No

If No, please turn to the next Page

If Yes, please continue:

(b) The aspect of my appearance about which I am most sensitive or self-conscious is

.....

.....

.....

.....

From now on, we will refer to this aspect of your appearance as your 'feature'

c) The thing I don't like about my feature is

.....

.....

.....

.....

(d) If you are sensitive or concerned about any other features of your body or your appearance, please say what they are

.....

.....

.....

.....

Instructions: The following questions are concerned with the way you feel or act. They are all simple. Please tick the answer that applies to you. If the item does not apply to you at all, tick the N/A (not-applicable option). Don't spend long on any one question.

y) How confident do you feel?

Not at all

4

Slightly

3

Moderately

2

Extremely....

1

z) How distressed do you get when you see yourself in the mirror/window?

Extremely Distressed....	Moderately....	A Little	Not at all
4	3	2	1

aa) My self-consciousness makes me irritable at home:

N/A Almost always..	Never/Almost never	Sometimes	Often
0	1	2	3
4			

bb) How hurt do you feel?

Extremely	Moderately	Slightly	Not at all
4	3	2	1

cc) At present my self-consciousness has an adverse effect on my work:

Almost always never....	N/A	Often....	Sometimes	Never/almost
4		3	2	1
0				

dd) How distressed do you get when you go to the beach?

N/A	Not at all	A little	Moderately.....
Extremely....			
0	1	2	3
4			

ee) Other people mis-judge me because of my feature:

Almost always never	N/A	Often	Sometimes	Never/almost
4		3	2	1
0				

ff) How feminine/masculine do you feel?

Not at all	Slightly....	Moderately	Extremely....
4	3	2	1

gg) I am self-conscious of my feature:

N/A	Never /Almost never	Sometimes	Often
Almost always....			
0	1	2	3
4			

hh) How irritable do you feel?

Not at all	Slightly	Moderately	Extremely....
1	2	3	4

ii) I adopt certain gestures (e.g. folding my arms in front of other people, covering my mouth with my hand):

Never/almost never	Sometimes	Often
Almost always...		
1	2	3
4		

jj) I avoid communal changing rooms:

Almost always	Often	Sometimes....	Never/almost never
N/A			
4	3	2	1
0			

kk)How distressed do you get by shopping in department stores/supermarkets?

N/A	Not at all	Slightly.....	Moderately...	Extremely
0	1	2	3	4

ll) How rejected do You feel?

Not at all	Slightly...	Moderately.....	Extremely.....
1	2	3	4

mm) I avoid undressing in front of my partner:

N/A	Never/almost never	Sometimes	Often
Almost always			
0	1	2	3
4			

nn) How distressed do you get while playing sports/games?

Extremely	Moderately	Slightly....	Not at all.....
N/A.....			
4	3	2	1
0			

oo) I close into my shell:

Almost always....	Often....	Sometimes....
Never/Almost never...		
4	3	2
		1

pp) How distressed are you by being unable to wear your favourite clothes?

Extremely	Moderately	Slightly....	Not at all.....
N/A.....			
4	3	2	1
			0

qq) How distressed do you get when going to social events?

N/A.....	Not at all....	Moderately....	A fair amount....
Extremely....			

0	1	2	3	4
rr) How normal do You feel?				
Not at all	Slightly	Moderately.....		
Extremely.....				
4	3	2	1	

ss)At present my self-consciousness has an adverse effect on my sex life:

Almost always	Often	Sometimes....	Never/almost
never	N/A		
4	3	2	1
0			

tt) I avoid going out of the house:

Almost always....	Often....	Sometimes....	Never/almost
never....			
4	3	2	1

uu) How distressed do you get when other people make remarks about your feature?

N/A	Not at all ...	Moderately.....	A fair amount.....
Extremely			
0	1	2	3
4			

vv)I avoid going to pubs/restaurants:

Almost always	Often	sometimes....	Never/almost
never	N/A		
4	3	2	1
0			

❖ **My feature causes me physical pain/discomfort:**

Never/almost never.....	Sometimes	Often.....	Almost
always.....			

❖ **My feature limits my physical ability to do the things I want to do:**

Almost always	Often....	Sometimes.....	Never/ almost
never.....			

Thank you for taking the time to complete this form

Public Works 6: Orthognathic Psychology Service NHS England Service Presentation (19/12/2018)



PUBLIC WORKS 6

Orthognathic Psychology Service NHS England Service Presentation (19/12/2018)

Marc Kingsley – Consultant Clinical Psychologist and Specialist Care Pathway Lead for NELFT

Lindsay Royan – Consultant Clinical Psychologist

Christine Casey and Pratik Sharma – Consultant Orthodontists

Charlotte Priestley, Emily Kenefick and Russell Jacob – Clinical Psychologists

Jamie Kapoor and Suraj Mehan – Assistant Psychologists

NELFT - open up possibilities



What is Orthognathic Treatment?

"An operation to reposition either the upper, lower or both jaws, in individuals who have a large discrepancy between the size of their jaws in relation to each other, or in whom the jaws are abnormally positioned in relation to the base of skull"

British Orthodontic Society Website

NELFT - open up possibilities



How are people with abnormal jaw relationships affected?

- Difficulty chewing or avoidance of certain foods
- Discomfort from their traumatic bite or embarrassment during speech due to difficulties in enunciating or lisping
- Masking behavior such as covering their mouths on smiling and avoidance of having photographs taken
- Appearance related distress stemming from current dissatisfaction or a past history of bullying/emotional abuse due to their appearance

NELFT - open up possibilities



What are we aiming to do?

1. Improve oral function (ability to bite and chew food)
2. Improve their facial and dental appearance through a combination treatment of orthodontics and surgery
3. Long term improvement in health-related quality of life, oral health-related quality of life and psychological well being through improved communication and understanding of patients goals and expectations

NELFT - open up possibilities



The patient journey

- New patient clinic then records then MDT clinic
- Pre Surgical Orthodontic Phase: fixed appliances fitted for a period of 18-24 months
- Facebow and review on MDT clinic for confirmation of surgical treatment plan
- Model Surgery and Wafer (surgical guide) construction
- Orthognathic Surgery
- Post Surgical Orthodontic Phase: 6 months (approx) of fixed appliances to detail occlusion
- Removal of appliances and long term follow up

NELFT - open up possibilities



Who is present on the MDT clinic?

- Consultant Orthodontist
- Consultant Maxillofacial Surgeon
- Clinical Psychology team members
- Registrars/Trainees in Orthodontics and Surgery
- Nursing staff
- Patient and their family/partner/support network

NELFT - open up possibilities



Prior Approval

[illegible]

10/10/2006 14:00:00

NHS
England

6.1 Case details

Please provide details of the clinical history of this case

--

6.2 Treatment plan

Please provide details of the proposed treatment plan

--

NA X271N

GDTX

6.3 Consultation

Has the primary dental treatment been discussed?	Yes	No	Provide details if not been discussed
There is no continuing dental history	☐	☐	
The patient has reached dental history	☐	☐	

6.4 Further information

	Yes	No	Provide details if applicable
Professional assessment confirms that treatment indicated is in the patient's best interests	☐	☐	
A multidisciplinary team including appropriate dental specialists has assessed any cases referred for dental surgery	☐	☒ N/A	
A multidisciplinary team has agreed that the case is too complex for multidisciplinary treatment	☐	☐	

Page 1 of 1

Challenges of the orthognathic treatment journey

- Decision to undergo an elective treatment impacting on facial appearance
- Wearing braces
- Major surgery and inpatient stay and post surgery recovery
- Length of treatment
- Coping with pain and “internal resilience”
- Degree of support from social/family network
- The ‘new me’

Orthognathic Psychology Service Introduction

Pre-operatively orthognathic patients are shown to have lower facial satisfaction, poorer body image and lower self esteem compared to controls (Cunningham et al., 2000; Johnston et al., 2010)

Severity of dento-facial condition associated with considering orthognathic treatment has not been found to predict psychosocial distress, and is consistent with other studies of disfiguring conditions (Grossbart and Sarwer, 2003; Thompson and Kent, 2001)

Number of reviews indicate that majority of patients derive a number of benefits including improved self-esteem, reduced appearance concern and improved quality of life (Hunt et al., 2001; Liddle et al., 2015)

There are reports of a small number of patients dissatisfied following treatment (Liddle et al., 2015)

NELFT - open up possibilities



Orthognathic Psychology Service Introduction

Why use Clinical Psychologists?

NHS England Guidance says orthognathic patients must be screened by a clinical psychologist

Skilled to assess and manage psychological distress and mental health concerns in patients up to a higher tier in complexity

Core training placements in child and adolescent services, learning disabilities (as well as adult and older adult placements)

Training in neuropsychological assessment

Training and experience in doctoral level research

Clinical Psychologists identified in NICE guidance as key in the mental health assessment and management of patients seeking elective surgery (eg in bariatric surgery)

NELFT - open up possibilities



Background 10 years prior

3 pilot projects at Whipps Cross Hospital

2004 – 2011: 1 consultant clinical psychologist (NELFT) offering 1 day a week input- special interest day

2014 – 2015 (1 day/week increasing to 2/3 days/week) 1 Highly Specialist Clinical Psychologist (NELFT) (Able to offer this as part of Clinical Health role for WF patients only)

September 2016 – January 2017: 1 Highly Specialist Clinical Psychologist (NELFT)
(1 day / week)

Demonstrated demand for the service

NELFT - open up possibilities



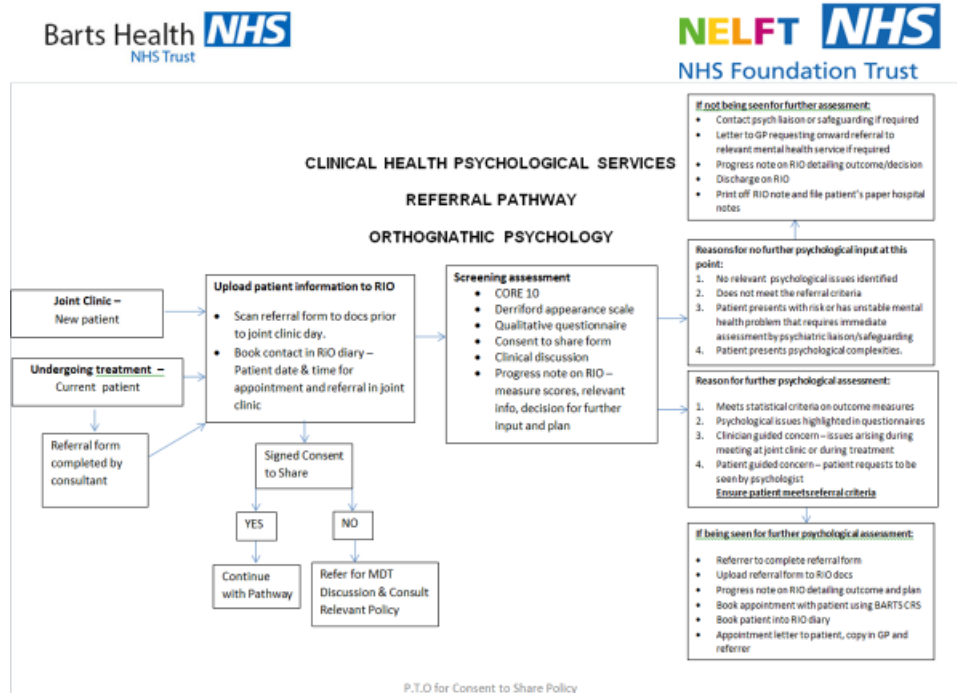
At Present

- Started developing service on (Mid September- due to delays in honorary contract logistics)
- First month focus was towards setting the foundation of the service
- Developed:

Referral Pathway
Referral Criteria and Form
Patient Screening Packs
Clinical Outcome Measures

NELFT - open up possibilities





Referral Criteria

Who can be referred?

Patients under the dento-facial deformity orthognathic service
Throughout their treatment pathway

Inclusion Criteria/What are the problems we can help with

1. Psychological Distress/Mental Health Difficulties in context of orthognathic treatment
2. Adjustment to changed appearance
3. Significant anxiety/distress in relation to appearance
4. Decision making
5. Interpersonal and relationship difficulties in context of orthognathic treatment
6. Phobia and anxiety in context of medical procedures involved in the treatment
7. Trauma or injury related to orthognathic treatment
8. Concerns about patient capacity to cope/adhere to and understand the requirements of treatment
9. Managing expectations – ensuring patient and medical teams expectations are aligned



Referral Criteria

Exclusion Criteria

1. Patients presenting with severe and enduring mental health difficulties (e.g. active psychosis)
2. We are not an emergency mental health service. We do not have capacity to safely manage the needs of patients presenting with high risk to self or others and complex safeguarding concerns (self-harm, suicidal behaviour, aggression, violence).
3. Where the primary issue is not related to orthognathic treatment e.g. psychological issues within families, post-traumatic stress disorder (PTSD) related to previous unrelated trauma, or significant mood difficulties relating to other psychosocial issues.
4. Where the patient themselves does not wish to be seen by psychology.
5. Where the patient's legal guardian does not consent to have the patient be seen by psychology.

NELFT - open up possibilities



CLINICAL HEALTH PSYCHOLOGICAL SERVICES

REFERRAL FORM

ORTHOGNATHIC PSYCHOLOGY SERVICE (OPS)

PLEASE NOTE:

1. This referral form must be FULLY completed (both pages) in order to avoid delay in processing
2. If a patient presents as being TO, DO, or UNDO, or there are SIGNIFICANT SAFEGUARDING RISKS, please refer to refer to the mental health service in your borough.
3. Please either give form directly to a member of the psychology team or email to: clinicalpsych@barts.nhs.uk (Royal London Hospital) or ops@barts.nhs.uk (Whipple Cross)
4. To send your email securely, protecting patient identifiable information, please only send from an NHS.net account

Patient Information

Complete for ALL referrals

Patient Name:		Consult Number:	
Address:		Language (if interpreter is required):	
DOB:	NHS No:	Hospital No:	
Ref No:	Referral:		

Patient Status

☐ a. Out Patient	☐ b. Routine
☐ c. In Patient - please state ward:	☐ d. High Priority

Consent

Is Patient aware of referral? YES/NO	Does Patient consent to the referral being made? YES/NO
Does the patient consent to information sharing with GPs? YES/NO (In line with NHS guidelines, we will not be able to accept referrals where we are not able to share information with the GP.)	

Referral Information

Where is the patient on the treatment pathway?		
☐ a. New patient	☐ c. Pre jaw surgery	☐ e. Outpatient
☐ b. Undergoing orthognathic treatment	☐ d. Post jaw surgery	☐ f. Inpatient - ward details

NELFT - open up possibilities



Reason for Referral including any relevant Medical information (presenting difficulties, duration of problem, impact on daily functioning, impact on mood, current support, history of mental health problems, previous psychological therapy etc)

What is your the patient's concern? Please tick the relevant boxes and provide additional information if possible:

- ☐ 1. Significant appearance related distress (possible BDD)
- ☐ 2. Decision-making for surgery
- ☐ 3. Psychological issues which may interfere with treatment compliance and which may impact on treatment outcomes (please state what specifically)
- ☐ 4. Patient has unrealistic expectations of the treatment and likely outcomes
- ☐ 5. Patient needs support to develop coping strategies to manage treatment/surgery
- ☐ 6. Patient is struggling to adjust to physical and emotional as a consequence of orthognathic treatment
- ☐ 7. Please note that this is not an exhaustive list, do highlight any areas of difficulties you have identified

Please provide further details to the purpose of referral:

What are the reasons for the patient's referral? (e.g. 'BDD', 'Anxiety', etc)

Referrer Information (for ALL referrals)

Referrer Name:	
Site:	☐ Whipple Cross ☐ Royal London
Date of Referral:	

To Be Completed by Psychologist:

Discussed with referrer	☐	Additional information: Plan:
Referral accepted	☐	
Patient contacted	☐	
Details entered onto RSC	☐	

Patient Screening Pack

Patient Demographics

CORE-10 – Subjective well-being, problems/symptoms (anxiety, depression, physical, trauma), life functioning (general, close relationships, social relationships) and risk and harm (to self and others).

YP-CORE – Same as CORE-10 but language adapted for 11-16 years old.

DAS24 – Adjustment in problems of appearance (intensity of emotional response to disfigurement, frequency of particular behaviours indicating self-consciousness, physical impact of the appearance problem e.g. functional limitation).

Qualitative questions- Motivation for surgery, expectations, previous dental experiences (idea of treatment response), current and past mental health, option to speak to psychologist in private.

Look at outcome measure scores and individual items

NELFT - open up possibilities



Patient Figures

Total No. Joint Clinic Attendees	Total No. Patients Completed Psychological Screening	Total No. Patients Offered Further Assessment	Number of Treatments
296	61	51	21

NELFT - open up possibilities



Patient Figures

Waiting time for Assessment (weeks)	Waiting Time for Treatment (weeks)
8 (Max)	0

NELFT - open up possibilities



Patient Figures

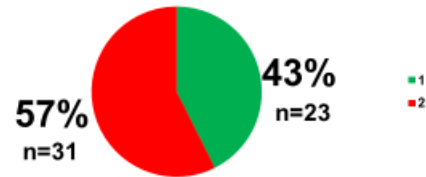
Preparing for Surgery	Undergoing the Elective Orthognathic Procedure	Post-operative Psychological Support
19	9	4

NELFT - open up possibilities

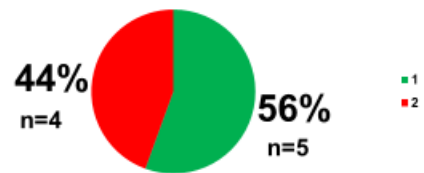


Patient Figures

CORE10 Psychological Distress
n=54



YPCORE Psychological Distress
n=9

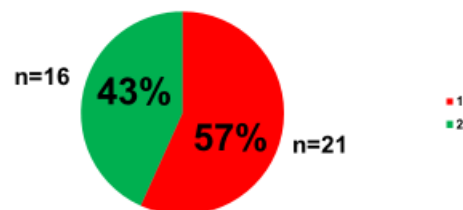


NELFT - open up possibilities



Patient Figures

DAS24 Appearance Related Distress
n=37



NELFT - open up possibilities



Patient Feedback

"Yes – psychologist attended and joint clinic and support followed from that moment"

"Staff were friendly and approachable"

"It was very useful to speak to a non-medical team member and discuss my concerns in a less intimidating setting"

"Thoroughly exceeded expectations"

"I think this service has been needed for years and it is madness, that this is a new service really"

"Staff were very kind and friendly and understanding"

"It was very easy to get in contact with the psychology team at the Royal London following my surgery"

"They were very friendly and approachable and put me at ease"

NELFT - open up possibilities



The Risk?

Risk to patients not receiving psychological care

1. Increased likelihood that patients "at risk" will be missed
2. Increased dissatisfaction with post operative result if expectations not managed
3. Patients not completing their treatment (cancelled surgery, early debond)
4. Postcode lottery and patients not receiving the same standard of care that they would at Kings College London or the Eastman Dental Hospital
5. Not meeting gold standard of orthognathic care expected of a multidisciplinary team

NELFT - open up possibilities



Financial & Service Quality Implications

- Reduce number of unattended appointments and cancelled surgery
- Reduce medical input throughout treatment process
- Achieving an integrated approach to healthcare provision (DoH)
- Increased patient and staff satisfaction
- Increased research profile of the service
- Interface with other psychology services e.g. IAPT; secondary mental health

NELFT - open up possibilities



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NELFT - open up possibilities



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Public Works 7: Dental Psychology Service
NHS England Service Presentation (10/06/2019)

PUBLIC WORKS 7



Dental Psychology Service
NHS England Service Presentation (10/06/2019)

Marc Kingsley, C. Psychol – Consultant Clinical Psychologist and Specialist Care Pathway Lead for NELFT

Lindsay Royan, C. Psychol – Consultant Clinical Psychologist and Trust Lead of the Clinical Health Psychological Services for NELFT



Dental Psychology at the Royal London Hospital (RLH)

Create a service that is quick to respond across all dental conditions, to all patients and their families, including children, who need psychological support during their dental journey.



The RLH is a regional adult and Paediatric dental hospital:

- The dental hospital saw a record 110,000 patients last year and is one of the largest outpatient departments in London.
- There is a particular focus on adult and paediatric patients who need secondary and tertiary care and there are thirteen dental specialties.
- The paediatric dentistry department sees the most patients of any of the four dental hospitals in London, including children with special needs who cannot be managed anywhere in the community.



Psychological needs of dental patients:

Psychological distress and psychopathology has been widely reported as adversely linked to the deterioration in dental/oral health (UK-based Adult Dental Health Survey).



Dental Anxiety and Dental Phobia

"Dental anxiety and phobia has been highlighted as being one of the most important barriers with regard to dental attendance, and the overall management of dental patients"

British Psychological Society

- Dental anxiety is a widespread problem, in both adults and children. It has been estimated that as many as 10-11 per cent of the UK population are phobic of dentistry and either avoid it altogether or are very distressed if they do attend a dentist.
- The diagnosis of dental phobia cannot be made solely on the basis of the presenting complaint (the patient's anxiety state) but only in conjunction with the patient's previous dental attendance history.



Dental Anxiety and Dental Phobia

- The patient who experiences a high intensity of anxiety together with a history of avoiding dental care would fulfil diagnosis of dental phobia.
- Co-morbid psychopathology (e.g. other anxiety and depressive disorders) is often seen in patients experiencing high levels of dental anxiety.
- RLH: Approximately 150-200 referrals relating to adults with dental anxiety in relation to dental treatment are accepted per year.
- They are assessed and treated on a dedicated sedation clinic.
- Patients with dental anxiety demand higher attention before, during and after the dental treatment, with higher levels of risk of complications and prolonged dental treatment.



3 Main Areas of Dental Anxiety and Dental Phobia

1. **Fear of dental pain** commonly seen within a dental setting
2. During dental treatment patients may be confronted with situations that give rise to **extreme fear of suffocating or being choked** (e.g. taking dental impressions).
3. There has been evidence that **blood injury injection fears (BI)** fears exist in the dental context, and overlap with dental phobia/fear.



Patients who are highly anxious about receiving dental treatment

They May:

Delay or cancel appointments

Have difficulty in tolerating treatment whilst in the dental chair and setting

Avoid and not access dental care at all.

May take longer to treat and treatment can become more complex as oral health deteriorates

Report significant psychological and social consequences of their anxiety or phobia



Patients who are highly anxious about receiving dental treatment

- The potential cost-effectiveness of providing a combination of psychological therapy, especially CBT, in the treatment of patients with dental anxiety and phobia has been well-documented.
- Significant improvement in undertaking dental treatment has been evidenced in patients who have undergone specialist psychological therapy treatment.
- High levels of engagement without the need for GA and sedation in patients who have undergone CBT treatment.



Successful psychological interventions for dental psychology

Will ensure:

- Less psychological distress in anticipation of dental treatment;
- Improvement in patients' oral health and reduced morbidity associated with oral and dental disease;
- More frequent attendance rates for dental care;
- Reduced avoidance in seeking dental treatment at an earlier stage of disease progression
- Reduced use of sedation and general anaesthesia
- Reduced use of secondary care services and associated costs



Sedation Clinics

“People with a dental phobia are much more likely to undergo treatment without sedation if they have had Cognitive Behavioural Therapy (CBT).”

- In one study, 79% of dental phobic went on to have dental treatment without the need for sedation after CBT (British Dental Journal)



Sedation Clinics

Referrals accepted in year	150
Reasons for referral	Dental Phobia 83% Exaggerated gag reflex 12% Dental anxiety 5%
Anxiety Score (Modified Dental Anxiety Scale)	Average score: 21 (>19= high anxiety/phobia)
Relevant medical and social history	Substance misuse 38% Generalised anxiety 43% Depression 25% Chronic pain 6% PTSD 6% Insomnia 6% Schizophrenia 6%
Failed sedation in another service	13%
GA in past due to dental anxiety	56%
Nature of treatment required	Periodontal treatment 81% Fillings 81% (range: 2-9, mean: 6) Extractions 56% (range: 1-13, mean: 4)



Sedation Clinics

- Very high levels of dental anxiety/phobia scores.
- Majority of patients do not complete dental treatment due to the crippling effect of anxiety.
- This causes much higher risks of patient oral health complications and significant expense to the trust.
- Due to anxiety, 56% of patients require GA which would otherwise be unnecessary increases risks as well as hospital expense.



Other Dental Conditions

The following chart shows a breakdown of referrals for 1 week at RLH in March 2019:

Type	Number	Percentage
Dry mouth (inc sjogrens)	6	5.3
Bullous	2	1.8
Lichenoid (autoimmune)	12	10.6
White/red patch	37 (35:2)	32.7
Lumps	17	15.0
Burning mouth	5	4.4
Neurological / facial pain	5	4.4
Pain related lesions	2	1.8
Pigmentation	7	6.2
Ulcers	10	8.9
Infective	4	3.5
Pain/Soreness	10 (2/8)	8.9
Cancer	1	0.9
Dental	2	1.8
Other	1	0.9



Orofacial Pain

'Believed to be among the most severe types of pain known to humanity, Trigeminal Neuralgia (TN) has been termed 'the suicide disease'

- Pain is one of the main causes of physical, psychological and social distress, work resignation and retirement
- Chronic pain: termed its own disease: causes intense suffering, anxiety and incapacitation.
- Patients with chronic pain are twice as likely to attempt suicide compared with those without chronic pain.
- Facial pain, especially Trigeminal neuralgia can trigger unbearable pain, which has a significantly higher risk of suicidal ideation and attempts.



Orofacial Pain

Common presentations on a weekly basis at RLH include referrals for:

- Temporomandibular Joint (TMJ).
- Trigeminal Neuralgia (TN) pain; (musculoskeletal pain).
- Persistent idiopathic facial pain of non-dental origin (previously termed atypical facial pain).
- Mixed persistent facial pains and neuropathic pain.
- Among orofacial pains, **Trigeminal Neuralgia (TN) and Temporomandibular Disorder (TMJ)** represent the worst neuropathic facial pain and one of the commonest facial pains.



Orofacial Pain

- Orofacial pain is complicated by other factors e.g. mental health issues, or chronic pain conditions elsewhere in the body.
- Psychological well-being has been identified as a key predictor of treatment outcome in patients with oral pain.
- Surgery for chronic oral pain generates great expectations especially because it is considered a hope of cure.
- Expectations of surgery to 'fix' pain when there is significant background psychological distress often lead to poor patient outcomes.
- Psychological treatments for chronic pain have a strong tradition of empirical investigation.
- There are more than 60 randomised controlled trials of cognitive behavioural (CBT) and behavioural interventions for adult chronic pain and 20 for paediatric chronic pain.



- Dental anxiety and fear-related behaviours are undoubtedly one of the most challenging aspects of paediatric dentistry
- Studies suggest that just under half of children report low to moderate general dental anxiety and between 10% and 20% report high levels of dental anxiety (e.g. dental phobia)
- At the RLH, a large percentage of paediatric cases are teenagers.
- Growing number of paediatric patients are refugees, and who have had traumatic experiences in their home countries
- RLH paediatric consultants report that as CAMHs are full, they cannot receive direct referrals any longer.
- This lack of psychological support for a very vulnerable group of paediatric patients is of great concern, and is having a direct impact on patient well-being as well as inability to proceed with vital oral health treatment.



The RLH Paediatric team has reported the following key areas of paediatric dentistry which may greatly benefit from specialist psychological support:

- The pathologically anxious –children who have failed treatment for local anaesthetic, then sedation and ultimately failed under GA as they absolutely won't engage.
- Children with amelogenesis imperfecta and other unaesthetic disfiguring disorders of enamel and dentine. This would be the biggest group for Paediatrics. Unlike cleft services they currently have no access to any psychology services.
- Children and Adolescents with co-morbid eating disorders.



Special Care Dentistry

Considered a separate group by virtue of other severe medical and behavioural complexities beyond dental anxiety.

Includes:

- Learning disabilities
- Dementia
- Severe mental health difficulties, such as psychosis and personality disorder.
- Traumatic brain injury with multiple co-morbidities.
- High levels of dental fear and anxiety have been described.

Business Options

	A) NICE Standards	B) Limited service upgrade	C) Adult limited service	D) Do nothing
In-house Clinical Psychology Support for patients with dental anxiety, phobia	👍	👍	⚠️	🚫
Rapid response to referrals	👍	⚠️	🚫	🚫
Psychological pain management for oral pain	👍	👍	⚠️	🚫
Psychological assessment of specialist dentistry	👍	⚠️	🚫	🚫
Attendance at weekly Dental clinics to offer psychological component to patient experience	👍	⚠️	🚫	🚫
Specialist paediatric psychology support	👍	⚠️	🚫	🚫
Carer support	👍	⚠️	🚫	🚫
Specialist family support	👍	🚫	🚫	🚫
Training for dentists in use of psychological level 2 skills, and supervision of dentists in use of behavioural strategies in dental anxiety	👍	⚠️	🚫	🚫
Psychology assessments for preventative surgical procedures	👍	🚫	🚫	🚫
Ongoing research and audit	👍	⚠️	🚫	🚫





OPTION 1: Fully Funded NICE compliant Clinical Psychology Service

- 1.0 WTE Band 8b Registered Principal Clinical Psychologist to provide specialist adult and paediatric assessments and evidence-based treatment, link in with dental teams, oversee the triage process into psychology as well as manage and supervise the Band 8A. Specialist pain and dental anxiety referrals, including specialist dentistry psychology assessments.
- 1.0 WTE Band 8a Registered Practitioner Psychologist specialising in cognitive behavioural therapy and family intervention work for adults and children. They would also require specialist skill of doing both MDT assessments) and multiagency working (education, community services, social care and voluntary agencies) as all care for children and teenagers is now provided locally.
- 1.0 WTE Band 5 Assistant Psychologist for support with audit/small scale research, neuropsychological assessments, supporting the clinical psychologists in MDT weekly clinics, testing, reporting, administration of psychotherapy groups.
- 1.0 WTE Band 3 Administrator.



OPTION 2: Partly-funded in-house psychology service

- 1.0 WTE Band 8b Registered Principal Clinical Psychologist to provide specialist adult and paediatric assessments and evidence-based treatment, link in with dental teams, oversee the triage process into psychology as well as manage and supervise the Band 8A. Specialist pain and dental anxiety referrals, including specialist dentistry psychology assessments.
- 1.0 WTE Band 5 Assistant Psychologist for support with audit/small scale research, neuropsychological assessments, supporting the clinical psychologists in MDT weekly clinics, testing, reporting, administration of psychotherapy groups.
- 0.5 WTE Band 3 Administrator.



OPTION 3: Assessment-only service

- 1.0 WTE Band 8A Registered Clinical Psychologist to provide specialist adult and paediatric assessments and brief interventions for patients with mild-moderate dental anxiety or pain.



Dental Psychology at the Royal London Hospital (RLH): Oral Trauma Service

Overview:

- No current clinical psychology service is available for patients, and their carers, who present to the Oral and Maxillofacial Clinic at the Royal London Hospital (RLH), as part of their specialist acute trauma pathway of care.
- This is in contradiction to national standards of care, including the NHS England framework for service delivery for major trauma.
- NHS England have emphasised that such trauma services must cross specialty boundaries with direct and immediate access to a co-located Clinical Psychology specialty.
- Our aim is to help support the Clinic and Major Trauma Centre to meet the national recommendations for a specialist acute trauma pathway of care.



Dental Psychology at the Royal London Hospital (RLH): Oral Trauma Service

Overview:

- Aim: provide timely, in-house psychological assessment and management of trauma cases who carry a risk of increased psychological morbidity
- avoids long waiting times for generic community psychology services
- Staff who work within major trauma centres will have direct access to psychology to support their own emotional well-being at work, due to the high risks of vicarious trauma, leading to burn-out and staff sickness.



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NHSE National Vision of Major Trauma Centres (MCT) and Trauma

NHS ENGLAND Standards for Major Trauma Care:

- A large number of national standards, including NICE and NHS England exist in relation to the delivery of trauma care.
- The focus for NHS England (2013) is on the delivery of a patient-centred trauma service, which considers all of the health and well-being needs of people who have sustained traumatic injuries, including mental health and psychological recovery.
- NHS England has emphasised that the standards for major trauma care must be delivered through an inclusive Trauma Network delivery model.
- The establishment of MTCs is central government policy, supported strongly by NHS England (2013).



NHSE National Vision of Major Trauma Centres (MCT) and Trauma

NHS ENGLAND Standards for Major Trauma Care:

- They state that a comprehensive trauma service should have the following:
- All aspects of patients' health, well-being, medical and non-medical needs are overseen by one multidisciplinary trauma team
- The service must cross specialty boundaries with direct and immediate access to co-located specialty services, including Clinical Psychology.
- Evaluation of services must go beyond mortality rates and focus more on assessing patients' holistic well-being in the hospital environment



Barts Major Trauma Centre Oral and Maxillofacial trauma patients The Oral and Maxillofacial Service (OMS), Royal London Hospital (RLH)

- Barts Health provides a designated Major Trauma Centre (MTC) for the population of North East London - networked into Essex.
- Barts Health is a major role model for trauma, and all subsequent MTCs have been modelled on this service structure.
- RLH is home to London's Air Ambulance and the hub of London's trauma network.
- Within the North East London demographic, the prevalence of facial trauma is high, with increasing numbers and severity of presentations.



Barts Major Trauma Centre
Oral and Maxillofacial trauma patients
The Oral and Maxillofacial Service (OMS), Royal London Hospital (RLH)

- The Oral and Maxillofacial Service (OMS), Royal London Hospital is a part of the City, East London and West Essex (CELWEX) managed clinical network for oral and maxillofacial surgery.
- OMS covers three acute NHS Trusts; Barts Health, Homerton University Hospital in Hackney, and Princess Alexandra Hospital in Harlow.
- All patients attending the OMS clinic have suffered acute facial injury and most undergo surgical treatment
- Assault accounts for almost 50% of referrals into the OMS



Barts Major Trauma Centre
Oral and Maxillofacial trauma patients
The Oral and Maxillofacial Service (OMS), Royal London Hospital (RLH)

- OMS oral and maxillofacial surgeons treat approximately 2000 complex trauma cases every year, which is more than any other centre in the UK.
- 20% of national UK orbital reconstructions are performed at Barts Health.
- Barts facial trauma patients have no direct access to a clinical psychology service as part of their specialist acute trauma pathway of care.
- This is in contradiction to national standards of care, including the NHS England framework for service delivery for major trauma.



Barts Major Trauma Centre
Oral and Maxillofacial trauma patients
The Oral and Maxillofacial Service (OMS), Royal London Hospital (RLH)

- The waiting times for community psychology services in North East London prevent immediate links into primary care, and cases may have a level of complexity which would preclude them from this service.
- Where attendance to their GP does occur, GPs are limited in their options for referral to mental health and psychological services and encounter challenges with long referral times and exclusion criteria.
- GPs may also not identify or assess patients for conditions such as PTSD following the occurrence of a traumatic event.



Psychology Pilot
Royal London Hospital (RLH)

- A project was run at the Centre for Oral and Maxillofacial Surgery at the Royal London Hospital.
- Involved developing psychological services in-house to offer assessment and signposting functions for facial trauma patients.
- Clinical psychologists worked within the medical team as it was deemed that this would be the most reliable way of identifying psychological need.
- This project screened 640 patients for common mental health conditions, during a one year clinical psychology pilot service, with a significant proportion (63%) requiring signposting for specialist intervention.



**Psychology Pilot
Royal London Hospital (RLH)**

- The psychological morbidity found in patients was consistently high, with nearly 80% of patients experiencing at least one psychological condition following suffering a facial injury.
- At one to three months post injury, nearly 40% of patients met diagnostic criteria for one or more of the following; depression, PTSD, anxiety, alcohol misuse, substance misuse, or were presenting with facial appearance distress.
- 26% of these were of a complex care nature that presented with significant risk issues including suicidality, neurological difficulties, substance misuse and previously non-disclosed domestic violence, often associated with post – injury trauma.



**Psychology Pilot
Royal London Hospital (RLH)**

- Satisfaction surveys for the clinical psychology service found a very positive impact for patients, their families and staff at the hospital.
- 78% pf patients said that the psychology service improved their experience of attending the maxillofacial trauma clinic.
- Staff felt supported, reporting higher levels of psychological understanding of patient presentations reported.



Trauma and Psychology

- Trauma patients present with high psychological morbidity that includes PTSD, depression, appearance distress, anxiety and post-operative adjustment difficulties.
- Patients are also at higher risk of trauma related to hospital stays, especially if they have been intubated or in ICU.
- The knock-on effect to health services, including GPs, physical health and mental health services, is significant.
- There are high numbers of referrals to already overstretched IAPT and secondary mental health community services.



Trauma and Psychology

Currently:

Facial Trauma patients at RLH / OMS do not have direct and in-house access to a clinical psychology service.

No Clinical Psychology service forms part of the existing MDT at the OFS.

Patients/Families need to be referred externally with very long waiting times.



Trauma and Psychology

Our Vision:

- On-site and accessible clinical psychology service for trauma patients, their carers and families
- Reduce demand on other community health services accessed by trauma patients and their families post-discharge, such as GP services and community MH services
- Provide holistic and integrated care for patients in lines with DoH and NICE and NHSE guidelines



Trauma and Psychology

Our Vision:

- Shorten waiting times for patients following a traumatic events
- Provide psychological support to staff working within the trauma centre
- Provide training to staff working within the trauma centre regarding mental health and psychological well-being.



**Business Options:
Clinical
Psychology
Provision in Oral
Trauma at RLH**

	OPTION A NHS/NHS LEVEL	OPTION B REDUCED LEVEL	OPTION C REDUCED LEVEL	OPTION D REDUCED LEVEL
In-house support for patients with complex trauma	✔	✔	⚠	✘
Consultant Psychologist level expertise in patient care, triage management and staff support	✔	⚠	✘	✘
Rapid response to referrals	✔	⚠	✘	✘
Rolling program of preventative groups and workshops aimed at reducing the risk of PTSD after exposure to a traumatic event	✔	✔	✘	✘
In-house psychology training and consultation to non-psychology members of the team	✔	⚠	⚠	✘
In-house availability of clinical psychologists for specialist intrasession focused psychotherapy	✔	✔	✘	✘
Specialist family and couples support	✔	✔	✘	✘
Care support	✔	✔	✘	✘
Neuropsychology assessments	✔	⚠	✘	✘
Paediatric support	✔	✔	✘	✘
Staff support for vicarious trauma	✔	⚠	✘	✘
Psychology assessments for appearance-altering surgical procedures	✔	✔	✘	✘
Research/audit and service development	✔	⚠	✘	✘
Specialist supervision for nurses	✔	✔	✘	✘
Support for medical	✔	✔	✘	✘
Training for staff in Level 2 psychological skills	✔	✔	✘	✘

Key: ✔ - Included ⚠ - Restricted ✘ - Not included



**Option A
(Our Recommendation)**

Option A:

1. Band 8c (1.0 wte) Consultant Clinical Psychologist
2. Band 8a (1.0 wte) Clinical Psychologist
3. Band 7 (1.0 wte) Clinical Psychologist
4. Band 5 (1.0 wte) Assistant Psychologist
5. Band 3 (1.0 wte) Administrator



**Option A
(Our Recommendation)**

Option A:

- Assessment and Treatment.
- In-house direct psychology access.
- Triage and high turn-around of seeing crisis/urgent trauma patients when referred.
- Staff actively supported to reduce risk of staff burn-out and vicarious trauma.



**Option A
(Our Recommendation)**

- Provision of a full time psychology team would bring the MDT service provision for the Centre for Oral and Maxillofacial Surgery up to the nationally recommended level for MTC's.
- NHS England have emphasized that such trauma services must cross specialty boundaries with direct and immediate access to a co-located Clinical Psychology specialty.
- Provision of a full time consultant clinical psychologist who will be able to bring specialist skills in terms of patient care, consultation with teams, as well as the coordination of a very wide range of mental health services in community and acute trusts (such as NELFT and ELFT).
- A consultant psychologist level of expertise will be provided to the service in terms of effective triage and signposting, and management of complex trauma risk, co-morbid mental health difficulties, and major incident debriefings.



**Option A
(Our Recommendation)**

- This will benefit NELFT, BARTS and the wider community in that the direct access to clinical psychology will reduce the attendance of patients in A&E (psychiatric liaison), GP appointments, or waiting long periods for IAPT or secondary MH psychology appointments.
- Carers and family members will get direct access to clinical psychology. This will reduce the risk of vicarious trauma in family and friends, a well evidenced risk of untreated trauma.
- A vital benefit will be for the MDT at the Centre for Oral and Maxillofacial Surgery to have access to clinical psychology colleagues working teams; it is well evidenced that staff may be at risk of vicarious trauma, and this level of staff support would help mediate the risk.
- It also will help to provide psychological training for staff so that they can detect and manage emotional distress in a very highly charged emotional environment.



**Orthognathic Psychology Service
NHS England Service Presentation (10/06/2019)**

Marc Kingsley, C. Psychol – Consultant Clinical Psychologist and Specialist Care Pathway Lead for NELFT

Lindsay Royan, C. Psychol – Consultant Clinical Psychologist and Trust Lead of the Clinical Health Psychological Services for NELFT

Christine Casey and Pratik Sharma – Consultant Orthodontists

Charlotte Priestley, Emily Kenefick and Russell Jacob – Clinical Psychologists

Jamie Kapoor and Suraj Mehan – Assistant Psychologists



Patient Figures September 2018 to Present

Total No. Joint Clinic Attendees	Total No. Patients Completed Psychological Screening	Total No. Patients Offered Further Assessment	Number of Treatments
848	179	59	50



Patient Figures September 2018 to Present

Waiting time for Assessment (weeks)	Waiting Time for Treatment (weeks)
8 (Max)	1



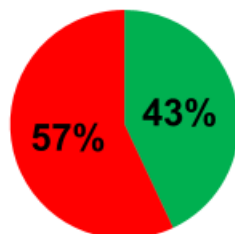
Patient Figures September 2018 to Present

Preparing for Surgery	Undergoing the Elective Orthognathic Procedure	Post-operative Psychological Support
42	9	4

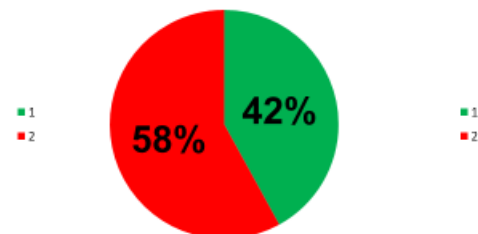


Patient Figures September 2018 to Present

CORE10 Psychological Distress
n=134



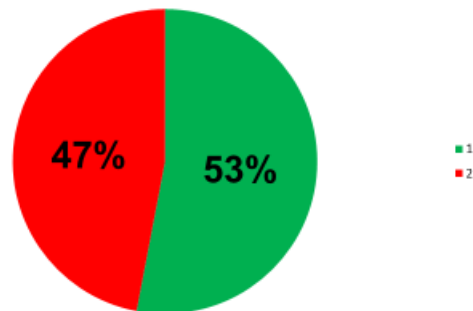
YPCORE10 Psychological Distress
n=33





Patient Figures September 2018 to Present

DAS24 Psychological Distress n=162



Patient Figures December 2018 to Present

Total No. Joint Clinic Attendees	Total No. Patients Completed Psychological Screening	Total No. Patients Offered Further Assessment	Number of Treatments
486	100	31	29



Patient Figures December 2018 to Present

Waiting time for Assessment (weeks)	Waiting Time for Treatment (weeks)
8 (Max)	1



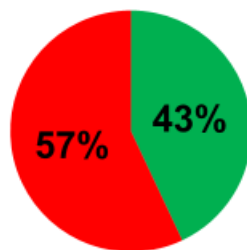
Patient Figures December 2018 to Present

Preparing for Surgery	Undergoing the Elective Orthognathic Procedure	Post-operative Psychological Support
23	0	0

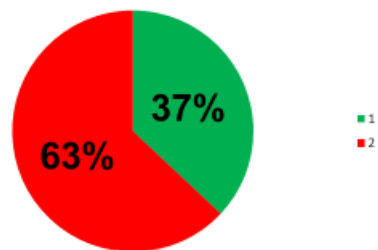


Patient Figures December 2018 to Present

CORE10 Psychological Distress
n=81

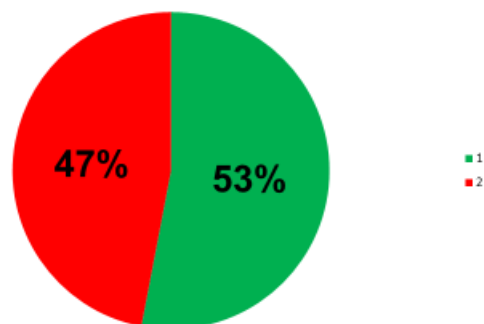


YPCORE10 Psychological Distress
n=24



Patient Figures December 2018 to Present

DAS24 Psychological Distress n=105





Patient Feedback

"Yes – psychologist attended and joint clinic and support followed from that moment"

"Staff were friendly and approachable"

"It was very useful to speak to a non-medical team member and discuss my concerns in a less intimidating setting"

"Thoroughly exceeded expectations"

"I think this service has been needed for years and it is madness, that this is a new service really"

"Staff were very kind and friendly and understanding"

"It was very easy to get in contact with the psychology team at the Royal London following my surgery"

"They were very friendly and approachable and put me at ease"

"They provided support and made it much more of a comfortable experience"

"A lot was done to ensure that I would, so I really appreciate that" In response to was it easy to get care, treatment or support from the service?

Public Works 8: PDOT Screening Form

Tel: 0300 555 1201 ext.55806

Email: nem-tr.pdotpsychology@nhs.net

**Welcome to the Paediatric Dental and Oral-maxillofacial
Trauma (PDOT) Psychology Service**



We recognise that dental and oral health does not just affect how our body feels; it can also affect how we feel emotionally. Our service offers psychological support to anyone with oral and maxillofacial under the care of Bart's Oral-Maxillofacial Trauma Service.

PDOT can help you if you are:

- * Feeling sad, fed up, worried, or scared because of uncomfortable or painful feelings around your teeth and mouth.
- * Finding it hard to understand, or make a decision about your oral treatment.
- * You are feeling scared about part of your dental treatment, and this could mean that you do not want this treatment.
- * Wanting to find out more about your dental treatment and what could happen after.

After today's appointment, we can talk about any worries you may have about your treatment. If you like, we can offer you more help after this meeting. If we are not the best people to help you, then we will refer you to another team to get you the help that you need.

Yours sincerely,

1507

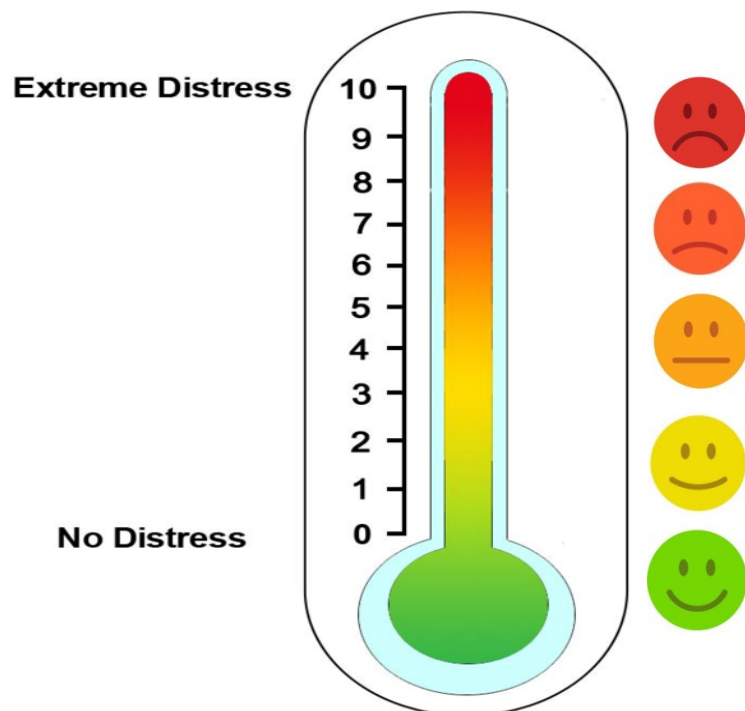
The PDOT Psychology Team

Thank you for taking the time to read and complete the rest of this pack.

Part 1: Please complete the table below*:

 Name:	 Date of Birth:
 NHS number (if known):	 Telephone Number:  Email address:

Part 2: Please circle the number (0-10) that best describes your feelings today about your dental treatment:



Please tick any of the following boxes that you feel have been a problem for you in the past week, including today:

Practical Problems

- ☐ School Work
- ☐ School Refusal
- ☐ Home
- ☐ Work

Emotional Problems

- ☐ Feeling irritable
- ☐ Feeling frustrated
- ☐ Feeling sad
- ☐ Feeling worried

Physical Problems

- ☐ Long-Term Condition
- ☐ Appearance
- ☐ Bad dreams
- ☐ Eating difficulties

☐ Treatment Decision

☐ Feeling angry

☐ Memory/concentration

☐ Feeling scared

☐ Pain

Family&Friends Problems

☐ Feeling low in mood

☐ Substance misuse

☐ Family health issues

☐ Suicidal thoughts

☐ Sleep problems

☐ Arguments

☐ Loss of interest in activities

☐ Aches (stomach/head)

☐ Divorce or separation

☐ Spiritual/Religious Concerns

☐ Bullying

☐ repetitive thoughts

Other Problems (Please Specify):

These questions are about how you have been feeling OVER THE LAST WEEK. Please read each question carefully. Think how often you have felt like that in the last week and then put a cross in the box you think fits best.

		Not at all	Only occasionally	Sometimes	Often	Most or all of the time
1	I have felt edgy or nervous	0	1	2	3	4
2	I haven't felt like talking to anyone	0	1	2	3	4
3	I have felt able to cope when things go wrong	4	3	2	1	0
4	I have thought of hurting myself	0	1	2	3	4
5	There has been someone I felt able to ask for help	4	3	2	1	0
6	My thoughts and feelings distress me	0	1	2	3	4
7	My problems have felt too much for me	0	1	2	3	4
8	It has been hard to go to sleep or stay asleep	0	1	2	3	4
9	I have felt unhappy	0	1	2	3	4
10	I have done all the things I wanted to do	4	3	2	1	0

Young Person Clinical Outcomes in Routine Evaluation (YP-CORE)

Outcome Rating Scale (ORS)

Name: _____

Session #: _____ Date: _____

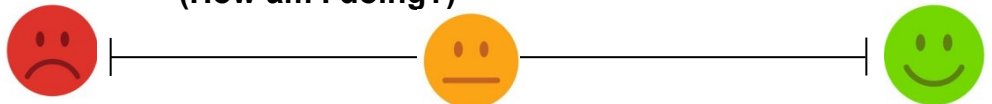
Who is filling out this form? Please check one: ☐ Self ☐ Other

If other, what is your relationship to this person? _____

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing.*

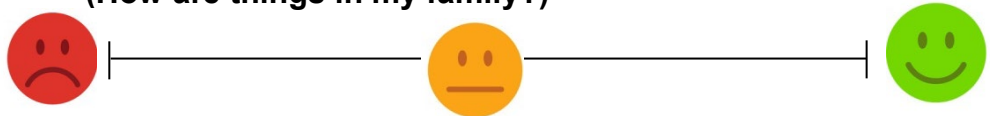
Me

(How am I doing?)



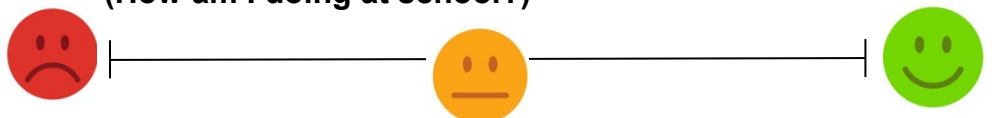
Family

(How are things in my family?)



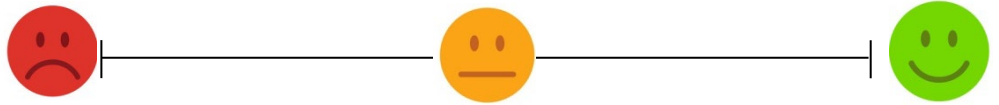
School

(How am I doing at school?)



Everything

(How is everything going?)



**Thank you for taking the time to complete these
questionnaires.**

Public Works 9: ADOT Screening Form

Welcome to the Adult Dental and Oral-maxillofacial Trauma (A-DOT) Psychology Service

We recognise that facial trauma does not just affect people physically; it can also have an impact on our emotional wellbeing and social life. Our service offers psychological support to everyone who has experienced facial trauma and is under the care of Bart's Oral-Maxillofacial Trauma Service.

We offer a range of options for psychological support including:

- Individual therapy
- Information & advice to support psychological wellbeing and help people cope with common psychological difficulties (e.g. low mood, stress, anxiety)
- Information on local services that can provide further support

If you would like more information about how we can help you or would like to consider psychological support in the future, please feel free to speak with us today, or ask one of the team to refer you to our service.

You can also call us on: **0300 555 1201 ext. 57957** or email us: nem-tr.adotpsychology@nhs.net.

[Our service is open Monday – Friday](#) (9-5pm). During your appointment today, you can meet with a member of our team to discuss if you have any psychological needs related to your facial trauma or treatment.

Thank you.

A-DOT Psychology Service:

Dr Vanessa Jones, Consultant Clinical Psychologist

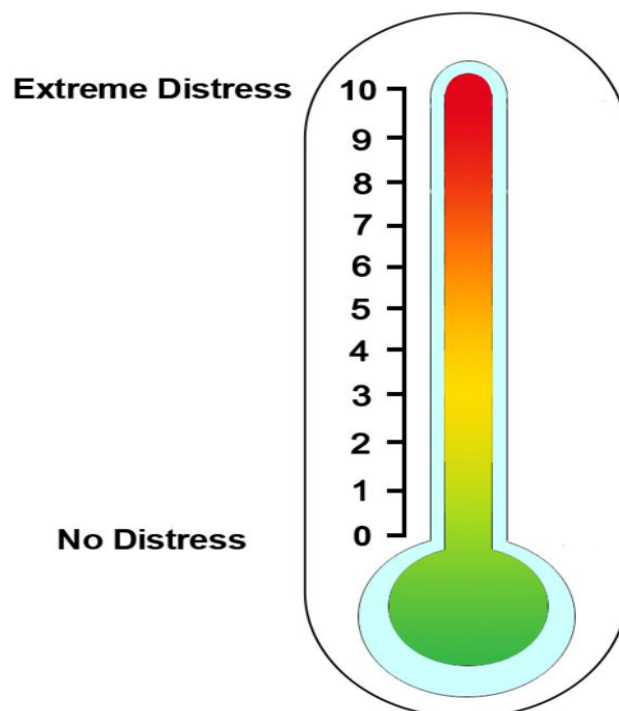
Dr Christina Collins, Principal Clinical Psychologist

Chloe Hiles, Assistant Psychologist

Name:	Date of Birth:
NHS number (if known):	☐ Telephone Number: ☐ Email address: <i>What is the best way to contact you? (Please tick one of the boxes above).</i>

**For details on how your personal information is used and stored, please see the “What happens to Patient Information” on our website: <https://www.nelft.nhs.uk/fair-processing-notice>. If you do not have access to the internet, please speak to a member of our team and we will provide you with a copy of the leaflet.*

Part 2: Please circle the number (0-10) that best describes how much distress you have been experiencing in the past week including today:



Please tick the box if any of the following has been a problem for you in the past week including today:

Practical Problems

- ☐ Child care
- ☐ Housing
- ☐ Work/school
- ☐ Finances
- ☐ Treatment decision

Family Problems

- ☐ Dealing with children
- ☐ Dealing with partner
- ☐ Family health issues

Emotional Problems

- ☐ Stress/Anxiety
- ☐ Sadness
- ☐ Worry
- ☐ Depression
- ☐ Fears
- ☐ Anger
- ☐ Loss of interest in activities
- ☐ Suicidal thoughts
- ☐ Spiritual/Religious Concerns

Physical Problems

- ☐ Appearance
- ☐ Breathing
- ☐ Eating
- ☐ Memory/concentration
- ☐ Pain
- ☐ Substance misuse
- ☐ Sleep
- ☐ Sexual

Other problems (please specify):

Thank you for taking the time to complete this information.

Level 2 supervision groups for attenders

		Not at all	Only occasionally	Sometimes	Often	Most or all of the time
1	I have felt tense, anxious or nervous	0	1	2	3	4
2	I have felt I have someone to turn to for support when needed	4	3	2	1	0
3	I have felt able to cope when things go wrong	4	3	2	1	0
4	Talking to people has felt too much for me	0	1	2	3	4
5	I have felt panic or terror	0	1	2	3	4
6	I made plans to end my life	0	1	2	3	4
7	I have had difficulty getting to sleep or staying asleep	0	1	2	3	4
8	I have felt despairing or hopeless	0	1	2	3	4
9	I have felt unhappy	0	1	2	3	4
10	Unwanted images or memories have been distressing me	0	1	2	3	4

*CORE-10 Questionnaire
(Clinical Outcomes in Routine
Evaluation)*

Date: _____

Public Works 10: ADOT Oral Trauma Referral Criteria

Our aim: To support service users in their treatment journey, and to improve surgical and psychosocial outcomes.

Overview

The Dental and Oral-maxillofacial Trauma Psychology Service (DOT-Psychology) is a service designed to meet the psychological needs of those within the Dental and Oral-maxillofacial Trauma pathways. If you think someone in your care is, or will be, at risk of experiencing significant psychological distress, we can provide specialist psychological assessment and support.

In particular, we will be working with people whose psychological distress may impact on their ability to undergo Oral-maxillofacial treatment, and people whose psychological distress has been caused or exacerbated by the traumatic event that led to their Oral-maxillofacial treatment. We can also support people who have experienced trauma related to the Oral-maxillofacial treatment itself.

We will be offering a range of psychological interventions tailored to meet the needs of individual service users. This may include:

Psychoeducation and coping strategies to manage distressing experiences

Direct 1:1 therapy

Specialist therapy for those experiencing appearance-related distress or difficulties within their relationships

Specialist neuropsychological assessment

Signposting to appropriate primary care, secondary care or third sector support in the community

Who can be referred?

Anyone fulfilling the inclusion criteria below who is currently under the care of **Barts Health Oral-maxillofacial and Maxillofacial Surgery service** can be referred by their consultant surgeon or consultant orthodontist. We are unable to accept referrals from any other speciality/service at this point.

We welcome referrals for new service users at the beginning of their Oral-maxillofacial treatment, as well as service users at other points along the pathway about whom you have concerns.

We can also meet with service users towards the end of their treatment, who present with difficulties in adjusting to their changed appearance.

Inclusion Criteria

1. Psychological distress* that interferes with upcoming or ongoing dental/Oral-maxillofacial treatment. This may include difficulties which impact on decision making regarding their treatment e.g. whether or not to proceed with treatment. For example, where there are concerns about the service users:
 - Psychological or cognitive capacity to agree to, or adhere to, a treatment plan.
 - Understanding of treatment, or the associated risks and likely outcomes.
 - Expectations and likely outcomes of treatment; aesthetic, physical and psychosocial expectations.

*Psychological distress may include: distress related to changed appearance, low mood, anxiety, phobias, self-harm, unrealistic perceptions about their body image, interpersonal difficulties.

2. Psychological distress that is caused by:
 - a) The traumatic event leading to presentation at the Oral-maxillofacial Trauma clinic.
 - b) A traumatic event related to the treatment itself, e.g. a distressing surgical or ward experience.
3. Family members, carers or other named individuals who are experiencing significant psychological distress as a result of the traumatic events experienced by their loved one*.

**We plan to offer a psychological service to family members and carers who are experiencing significant psychological distress as a result of their loved ones traumatic experiences. In line with the development of this new service, we expect this offer will become available in phase two of the service implementation process. If there*

are any families who feel they need urgent psychological assessment or input, please do speak to a member of the team who can discuss the referral with you.

Exclusion Criteria

1. Severe and enduring mental health difficulties (e.g. active psychosis, substance misuse) that are not managed elsewhere and that impact directly on service user's engagement with the Oral-maxillofacial treatment pathway or with psychological therapy.
2. Mental health needs or psychological distress that pre-dates the Oral-maxillofacial trauma and does not directly impact on the planned Oral-maxillofacial treatment (as outlined in the inclusion criteria).
3. High risk of harm to self or others which is not managed by a secondary mental health care service.
4. People who do not want to access psychological interventions, or where applicable, have a legal guardian who does not consent to have the provision of psychological input.

How to Refer:

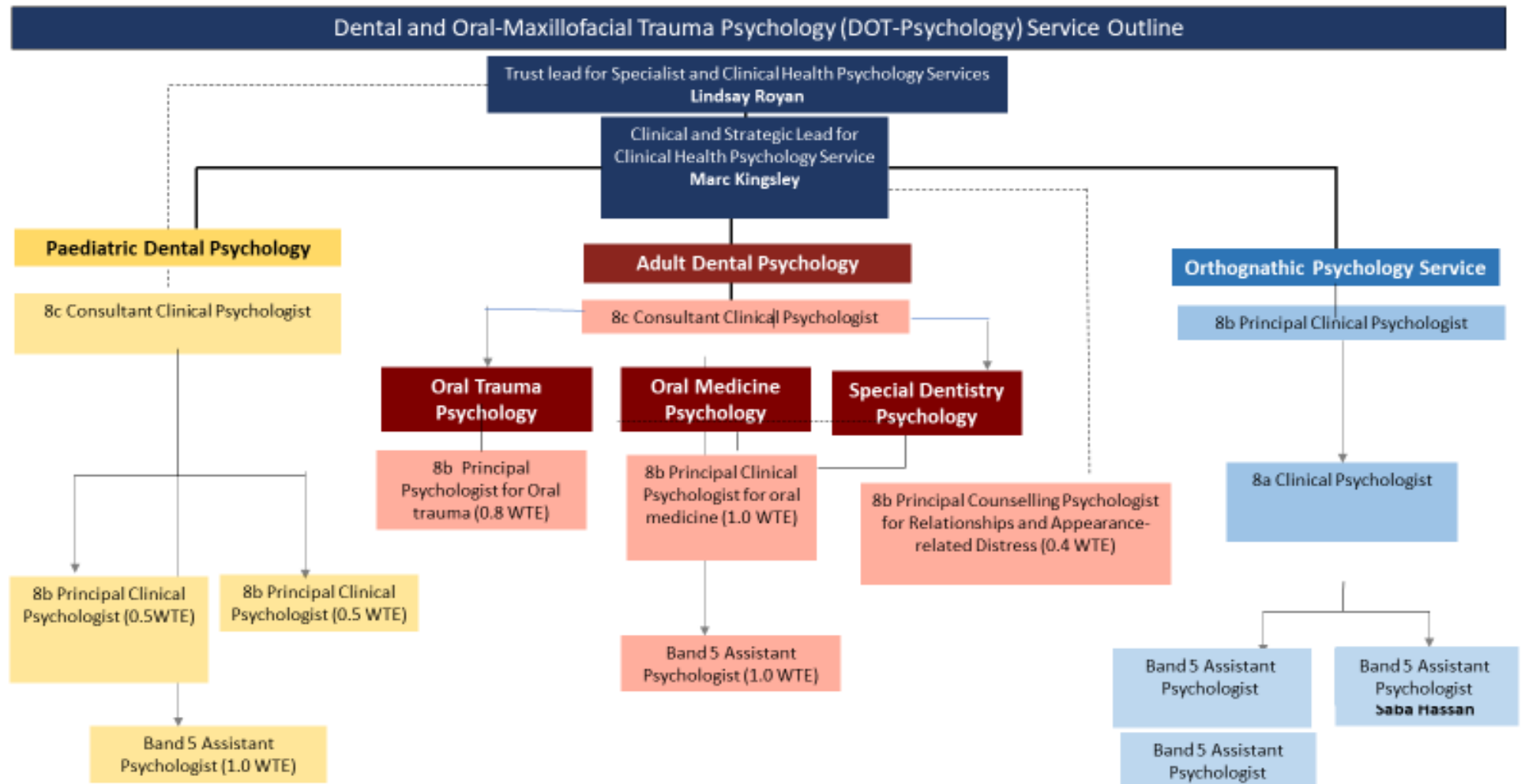
We are more than happy to discuss any potential referrals. If you are unsure or you would like to discuss a case informally please call 0300 555 1201 ext. 57957

Alternatively you can send a completed referral form to:

Under 18 years: nem-tr.pdotpsychology@nhs.net Dr. Saras Saminathan, Consultant Clinical Psychologist, Clinical Lead for Paediatric Dental and Oral-maxillofacial Trauma Psychology Service (PDOT-Psychology).

Over 18 years: nem-tr.adotpsychology@nhs.net Dr. Vanessa Jones, Consultant Clinical Psychologist, Clinical Lead for Adult Dental and Oral-maxillofacial Trauma Psychology Service (ADOT-Psychology).

Public Works 11: DOT-Psychology Service Outline



Public Works 11: Relationship Therapy Assessment Pack

Welcome to the Relationship Therapy Service

This service is for individuals undergoing oral treatment who are referred to the Oral and Maxillofacial Service Trauma Clinic at the Royal London Hospital.

We recognise that oral health does not just affect people physically, but also psychologically and socially. Our service offers psychological consultation and assessment to individuals who are experiencing difficulty in their relationships due to concerns surrounding their oral health, or the treatment itself.

During the consultation, we can discuss if you have any worries or concerns related to your oral health that are impacting on your relationship. We offer evidence-based psychotherapy (individual or relationship work). These interventions include:

Improve conflict- & problem-solving in a relationship

Provide support for a stable family life

Identify and work with issues of jealousy

Improve emotional wellbeing

Improve communication within a relationship

Improve stress management within a relationship

Improve self-confidence and relationship confidence

Provide support for managing relationship intimacy concerns

To help us make the most of the time we have together during the consultation, we ask you to please complete the following Pre-Screening Pack. This information helps us to tailor our care to meet your physical and psychological needs. Please be assured that all the information you provide is treated confidentially, and is recorded in keeping with the Trust's Information Governance Policies. However, if there are any questions you do not feel comfortable answering, please discuss this with a member of our team or leave the questions blank.

Thank you for taking the time to read and complete the personal information section, and following 3 questionnaires in this pack.

Yours sincerely,

Relationship Therapy Service

Part 1: Please complete the information below

Name:	Date of Birth:
Address:	Telephone Number(s):
GP Name:	GP Surgery Address: GP Surgery Telephone Number:
Next of Kin Name:	Next of Kin Address:
Their Relationship to You:	Next of Kin Telephone Number:
First Language: Are you comfortable speaking English? ☐ Yes ☐ No Preferred language for communicating with the DOT-P team: Is an Interpreter required? ☐ Yes ☐ No	Would you consider yourself to have a Disability? ☐ Yes ☐ No ☐ Prefer not to say If you ticked 'Yes', please specify any details below:
Gender:	Smoking Status:
Sexual Orientation:	Marital Status:
Religion:	Ethnicity:

We recognise that some people may use non-verbal techniques to communicate. If this applies to you, please tick the boxes that describe you best. You may tick as many boxes as needed:

I use these things to communicate...

British Sign Language (BSL)		Communication Board/Book	
Writing		Photo/Symbols	
Please state any other form of communication:		Communication aid	

Please see the “What happens to Patient Information” leaflet for details on how your personal information is used stored and kept safe:

<https://www.nelft.nhs.uk/fair-processing-notice>

If you do not have access to the internet, please speak to a member of our team and we will provide you with a copy of the leaflet.

1. We may need to contact your next of kin or other family members in order to provide the best possible care. If there is anyone who **do not** want us to contact or to share information with, please provide their full name and their relationship to you here:

Name: _____ Relationship to you:

2. We sometimes conduct research or are invited to take part in external clinical research opportunities. Are you happy for your data to be used for research purposes?

☐ Yes

☐ No

3. Would you like to be contact about the opportunity to take part in research?

☐ Yes

☐ No

4. We may ask your permission to record a psychology session, by means of video or audio. This is to aid the training and professional development of our clinicians. If a session is to be recorded, the clinician will discuss this with you at the beginning of the session. If you agree to a session being recorded you may change your mind at any time without this impacting on the psychological service you receive. If you do not want to be asked about the video or audio recording of sessions, please below:

- ☐ I am happy to be asked about the video or audio recording of a psychology session
- ☐ I do not want to be asked about the video or audio recording of a psychology session and I do not want any sessions to be recorded.

Part 2: Please answer the following questions

Where are you in your dental treatment?

- ☐ I am a new patient
- ☐ I am waiting for a treatment date
- ☐ My treatment date is approaching soon
- ☐ I have had my treatment

15. Do you have any specific concerns about your current mental health or psychological well-being (e.g. depression, low-mood, anxiety, difficult thoughts and feelings you struggle to cope with)?

16. Are you currently experiencing, or have you ever experienced, any thoughts or feelings about ending your life? If you have answered yes to this question, and feel comfortable doing so, please provide further information.
17. Have you ever been supported by a mental health team or other support services in relation to your mental health?
18. Have you ever experienced, or are you currently experiencing, any problems with your memory or thinking (e.g. difficulties concentrating/ learning/remembering/ planning/ organising)? If yes, please provide more information:
19. Do you currently use any legal or illegal recreational drugs? If yes, please provide further information below.
20. Do you drink alcohol? If yes, please detail below how much alcohol you drink each week, on average.

21. Do you have a history of alcohol or drug dependency? If yes, please provide further information below, if you feel comfortable doing so.

22. Has your current situation involving oral treatment had an impact on relatives, friends, or significant others (including children)? If yes, please detail below.

23. Please tick the box that best describes your current relationship status:

- ☐ Single
- ☐ Life partner (not living together)
- ☐ Life partner (living together but not married)
- ☐ Engaged
- ☐ Married
- ☐ Separated
- ☐ Divorced

If you are currently in a relationship, please answer the following questions.

24. Has your oral health, or related treatment, had any positive or negative impacts on your relationship? If you feel comfortable doing so, please provide further information below.

25.a) It is normal to have occasional disagreements within relationships. Do you currently experience disagreements in your relationship that you find difficult to resolve (e.g. areas of conflict, managing stress, communication difficulties, intimacy difficulties, relationship insecurities)? If yes, and if you feel comfortable doing so, please provide further information below.

b) Do you feel these disagreements have been caused by, or made worse by, your oral health or related treatment? If yes, please provide further information below.

26. If you do have concerns about your relationship or the impact your current situation has on you and your partner, we can offer you a private meeting with our psychologist. Would you find this helpful?

- ☐ Yes
- ☐ No
- ☐ I have no concerns

If you ticked 'yes', there will be an opportunity to have this discussion away from the medical team.

Please read the following first:

This questionnaire has 10 statements about how you have been OVER THE LAST WEEK. Please read each statement and think how often you felt that way last week. Then circle the box which is closest to this. Please use a dark pen (not pencil) and tick clearly within the boxes.

		Not at all	Only occasionally	Sometimes	Often	Most or all of the time
1	I have felt tense, anxious or nervous	0	1	2	3	4
2	I have felt I have someone to turn to for support when needed	4	3	2	1	0
3	I have felt able to cope when things go wrong	4	3	2	1	0
4	Talking to people has felt too much for me	0	1	2	3	4
5	I have felt panic or terror	0	1	2	3	4
6	I made plans to end my life	0	1	2	3	4
7	I have had difficulty getting to sleep or staying asleep	0	1	2	3	4
8	I have felt despairing or hopeless	0	1	2	3	4
9	I have felt unhappy	0	1	2	3	4
10	Unwanted images or memories have been distressing me	0	1	2	3	4

CORE-10 Questionnaire (Clinical Outcomes in Routine Evaluation)

Outcome Rating Scale (ORS)

Name: _____

Session #: _____ Date: _____

Who is filling out this form? Please check one: ☐ Self ☐ Other

If other, what is your relationship to this person? _____

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing.*

Individually

(Personal well-being)

|-----|

Interpersonally

(Family, close relationships)

|-----|

Socially

(Work, school, friendships)

|-----|

Overall

(General sense of well-being)

|-----|

Public Works 13: Dentistry Staff Support Referral Form

CLINICAL HEALTH PSYCHOLOGICAL SERVICES

STAFF REFERRAL FORM

DENTAL AND ORAL TRAUMA PSYCHOLOGY SERVICE STAFF SUPPORT

During challenging and uncertain times, there can be limited time to make sense of the impact on staff well being. The Dental Psychology Service (DPS) is offering confidential appointments to any staff members who feel they may benefit from a space to talk about their experiences and/or additional support to help them cope more effectively during this difficult time.

Please note:

- Any contact between yourself and our service will be kept confidential.
- Confidentiality will be upheld unless there are concerns for the safety of yourself or others; if this were the case we would aim to discuss this with you first.
- Your details will not be added to our clinical systems although risk information will need to be shared.
- Your contact details will be destroyed after 12months.

If you wish to have a brief discussion about what the service is able to provide, or would like to refer yourself for an appointment, please complete the form below and email to the secure email address:

nem-tr.adotpsychology@nhs.net

Contact Information

Please complete as much information as possible.

Name:
DOB:
Occupation:
Area of work: (Include previous and where you have been re-deployed)

What is your preference for contact: Phone Call ☐ Video-Call ☐

Yours sincerely

Marc Kingsley
Dental and Oral Trauma Psychology Service Clinical Lead

Dr. Vanessa Jones
Consultant Clinical Psychologist/ Lead for A-DOTS

Dr. Kirsty Collins
Clinical Psychologist (OPS).

To Be Completed by Psychologist:

Discussed further ☐

Referral accepted ☐

1st Contacted made ☐

Chair: Joe Fielder

Chief Executive: Professor Oliver Shanley OBE



Public Works 14: Dental and Oral Trauma staff support video link



[Staff Support video.mp4](#)

[Open](#)

Public Works 15: Link to Kingsley, M. (2008). Psychological approaches to the acute patient. In M. Beer, S. Pereira, & C. Paton (Authors), *Psychiatric Intensive Care* (pp. 74-88). Cambridge: Cambridge University Press. doi:10.1017/CBO9780511543593.009

<https://www.cambridge.org/core/books/psychiatric-intensive-care/psychological-approaches-to-the-acute-patient/D49FA468BA5BA74C6CCA6B18A0A878CD>

Public Works 16: Correspondence with Jessica Papworth

Dear all,

I hope this email finds you well. We're pleased that you have agreed to contribute a chapter to **Psychiatric Intensive Care 3ed** edited by **Dr Stephen Pereira, Mr Roland Dix and Dr Stephen Dye**. I am the Senior Editorial Assistant in the Medicine team at Cambridge University Press, and I'll be responsible for overseeing the preparation of this book. If you have any questions regarding the content of your chapter, please contact the volume editors. Any formatting questions should be directed to me.

With very best wishes,
Jessica

Jessica Papworth

Senior Editorial Assistant, Medicine
Cambridge University Press
University Printing House, Shaftesbury Road
Cambridge, CB2 8BS, UK

**Public Works 17: psychological gaps in cancer care implications for service
users and providers**

<https://doi.org/10.12968/bjhc.2016.22.12.607>

Public Works 18: MacMillan Palliative Care Community Team Audit 2015

Havering Oncology Community Team/ Palliative Care and Clinical Health Psychology Services: Audit

M Kingsley : Specialist Care Pathway Lead, Clinical Health Psychological Services (NELFT)

D. A. Crowe : Oncology Clinical Lead, Macmillan Community Oncology Team, Havering, NELFT

L Royan : Trust Lead for Clinical Health Psychological Services (NELFT)

December 2015.

Integrated Care Director, NELFT

Assistant Director, Psychological Services, NELFT

Director Finance (Havering), NELFT

1.Executive Summary

The patient journey during Palliative and EOL cancer care is a complex one both for the individual, their loved ones, and the health services involved.

In line with the DoH Policy of 'No Health without Mental Health' (2011/ 2013), there is a clear objective for increased parity of esteem between mental and physical health. Routine assessment for mental health difficulties, depression and anxiety risk for cancer and palliative / EOL patients have hence been identified, with an emphasis on risk management (especially the higher percentage of suicide risk), and improvement in overall quality of life (NHS Choices, 2012).

The targets set by the Government Palliative Care Strategy set out in the EOL strategy (NCPC 2012), Macmillan (Dowglass 2011 and 2015), NICE EOL guidelines (2015) and Marie Curie Report (2015) have all highlighted directly and indirectly the importance of offering a holistic care package to patients. *The reference to psychological support, as distinct to emotional support, is clearly laid out as integral to patient treatment and service development strategies.*

Patients in Palliative and EOL stages of cancer are reported to have psychological distress at all stages of diagnoses and treatment (BPS 2015). This includes problems such as depression and anxiety, treatment compliance, phobias, distress related to remission states, surgery and medication side effects, adjustment issues

related to treatment, disfigurement, lifestyle changes, relationship issues, carer support concerns by the patient and carers as well as secondary distress caused within families by lack of attention given to their concerns as co - carers of our patients. With all of this in mind the patients are not free to focus on themselves during this very difficult period in their lives.

In the interim, psychological care and treatment is offered on an ad hoc by medical and nursing staff whose roles are then compromised to incorporate this new unsupported and often untrained demands. This has resulted in a somewhat random, uncoordinated and inequitable care package (Marie Curie, 2015)

The financial and wider economic consequence of ignoring this issue is clear: the increased cost of delayed diagnosis and treatment (by staff who are engaged by having to manage psychological issues of their patients), the creation of the cost for repeat appointments for revolving-door patients who return until services are able to identify their needs and direct them accordingly (Stocker, 2015). Where the need is psychological and there is no psychological service the unnecessary financial loss to services is clearly predicted. The delays and cost do not end with Trust finances but impact on the wider economy through work absence, leaving work on the grounds of ill health and medically-led, early retirement.

In creating a designated Clinical Psychological Service for these patient groups we are strategically removing numerous obstacles in the care pathway for Palliative and EOL cancer patients, thus enabling each individual involved in the patient journey to ensure their full and undivided attention to good quality, consistent and focused patient care in the context of strategic finances and a positive economic context.

2.Introduction and Overview

a) Overview of service:

The Macmillan Community Oncology Team currently has 140 patients. The total number of contacts has increased significantly over the past three years (81% increase); this includes visits and telephone contacts. A mortality audit has identified that the majority of patients have a palliative or end of life diagnosis. A significant finding is that the majority of patients (95%) seen in this service since 2012 have been given a prognosis of less than 12 months and in the last year of life (EoL).

As patient numbers have increased in general, it follows that patients with psychological problems (diagnosed or otherwise) are also increasing, and this has been reported in a recent retrospective study to be discussed later.

The team is currently composed of three full time Cancer Nurse Specialists. There is currently no clinical health psychology cover working in the service. The local acute Trust, BHRUT, currently fund 0.9wte psychology posts for Barking, Redbridge and Havering areas. The national recommendation for the BHRUT area is 7.0 wte psychological practitioners in oncology. Consequently, patients referred into the service experience significant delays for assessment and treatment.

Patients requiring specialist psychological input are currently being referred to Havering Psychological Services (HPS), both through IAPT and Secondary Mental Health Services, unless they are at EoL (these patients are being referred to counselling services at the local Havering hospice). However, due to the speciality of clinical health referrals, the majority of referrals into the HPS are not accepted. There are no allocated Clinical Health Psychologists commissioned, within the broader HPS, to offer assessments and /or treatment, and the specialist nature of referrals makes generic referrals difficult to process. Where complexity in mental health symptoms and risk factors require immediate intervention, medical and PAM / nursing staff are expected to manage psychological concerns of patients in addition to their own work without adequate supervision. This falls short of best practice guidelines that state that psychological interventions should be delivered by a practitioner psychologist who is a core member of a physical health team and able to work closely with other team members (BPS 2015).

b) Service audit:

Patient demographic profile:

Key Findings of the Havering Joint Strategic Needs Assessment (2011/2012) found that regarding cancer alone:

- High numbers of Havering residents are diagnosed with and die from cancer each year; due in part to the older population. This will increase even further as the population continues to get older.
- The number of people living following a diagnosis of cancer has increased in Havering as a result of population ageing and improvements in survival.
- Breast, bowel, and lung cancer are the most common cancers in women in Havering, and prostate, lung and bowel cancer are most common in men.
- The prevalence of risk factors for cancer among Havering's population are similar to or greater than (in the case of obesity) the national average.
- Cancer mortality rates in Havering are similar to the national average but the cancer survival is not improving and is significantly worse than the national average
- There is evidence of inequalities in Havering regarding mortality rates and the prevalence of lifestyle related risk factors associated with levels of socioeconomic disadvantage

These results have been further reiterated by the later Havering Health and Well-being Strategy (2012-2014) suggesting little change has occurred during the past five years. The lack of change was attributed specifically to late diagnosis.

c) Havering Macmillan Oncology service

An internal audit was carried out within the existing Havering service between 2011-2014. (2.3)

There were 279 first appointments made over the 3 year period and 2448 follow up appointments indicating each patient had an average of 8.7 visits. (However some patients may have been seen once whilst other patients with complex needs would have need more support and follow up visits).

It was also noted that the team's overall contacts had increased in the last 3 years by 81% indicating the demand for this service

	2011-2012	2012-2013	2013-2014	Grand Total
First appointment	99	94	86	279
First telephone consultation	51	137	99	287
Follow-up appointment	808	765	875	2448
Follow-up telephone consultation	352	2044	1999	4395
Non face to face client related activity	0	12	57	69
Unplanned Visit	6	4	13	23
Grand Total	1396	3056	3129	7501

- The five highest referral sources are: Other source: (i.e. CNS/ hospice staff/ self), GP/Carer or relative/ Specialist Nurses/ Other community professionals.
- The five highest referral numbers came from: Haematology (33%), Bowel (24%) , Breast (9%) , Prostate (7%) and Lung (7%) followed by head and neck, ovarian and endocrine with smaller percentages (<5%)
- Total number of deaths recorded: 92 patients with an average of **95% of patients being given a prognosis of less than 12 months and in the last year of life.**

d) Profile of patients with psychological problems:

The Clinical Health Psychology Service (NELFT) carried out an additional retrospective study in 2015 to capture some of the key psychological issues found within the case notes of patient groups (n=72) as follows:

In addition to patient demographics, the range of mental health problems recorded was grouped in general categories of depression, anxiety and panic. Additionally, psychological symptoms of each problem were recorded in concordance with or in isolation to the main problems. It is important to note that any problem (main or subsidiary) contributes to psychological ill- health and distress which in turn disrupts the Palliative care / EOL patient journey

Psychology Patient Demographics:

Ethnicity:

The majority of patients fall within the broader Havering demographics of White British: 57%

Gender:

Female: 61%

Male: 39%

Marital status:

Married: 49%

LT relationship: 11%

Divorced: 6%

Single: 8%

Widowed: 8%

Not stated: 18%

Ages:

50-59 Yrs: 35%

60-69 Yrs 25%

70-79 Yrs 21%

80-89 Yrs 14%

Age groups between 20-49 and 90-99 were 1% only

Main physical health care interventions for this group:

Chemotherapy alone: 36%

Radiation and Chemotherapy: 7%

External hardships:

The most significant **external factors** impacting on patient experience included:

- ❖ **Bereavement issues** unrelated to the patient's own condition: 29%
- ❖ **Occupational stressors**: 14%
- ❖ **Social isolation**: 34%
- ❖ **Patient dependency** on others: 40%

Psychological/ Mental Health symptoms:

Depression/Low mood: 97%

Anxiety/ panic: 78%.

In terms of patients describing features of psychological distress:

Psychological despair accounted for at least 40-45% of the sample, followed by demoralisation, hopelessness and subjective incompetence at 46%.

The emotions identified above are the key risk factors requiring safeguarding in the context of suicidal risk and ideation.

The lack of a formal psychological screening process means that it is highly probable that the numbers represented may underestimate the actual figures experiencing psychological problems and those people requiring assessment and treatment.

e) Wider implications of the current service:

The patients and carers:

- Increase in psychological problems due to lack of identification so increasing suffering for patients
- On-going distress and consequential interference with treatment compliance or satisfaction where treatment is random (depending on who is on shift that day and who has time) impacting on patient dignity as well as mental health
- Expectations to manage psychological distress where it is not identified by patient / carers themselves (causing tertiary problems for them) without a clear treatment plan
- Reduced chances of a healthy recovery due to unattended mental health / psychological distress
- Inaccurate or even incorrect advice and guidance offer regarding psychological issues creating unnecessary additional problems, including increased risk (suicide or harm to self and /or from others)

The team

- Additional responsibilities in the job description for nursing staff
- Disruption to the daily working patterns due to time taken for psychological input resulting in pressure to meet targets
- No access to specialist psychological consultation, supervision or treatment

The service / financial implications

- Lack of specialist psychological knowledge and interventions
- Increased pressure on nursing staff to treat beyond the scope of practice in relation to psychological distress. Staff recognise their limited capacity to address mental health and psychological issues (re-existing or post diagnosis/ treatment) resulting in staff stress, as well as *prolonged appointments being requested*
- Failure in addressing carer issues resulting in additional resources required to make up the short-fall in carer support.
- Further cost to tertiary services post treatment where patients then need to be referred to Specialist Psychology Services
- A general lack of strategic management of limited funds by not using allocated finances for the most relevant resources.

Excluding specialist psychological service provision to patients in cancer / palliative and EOL services is clearly resulting in additional cost to commissioners, general and mental health Trusts, as well as creating an increase in clinical risk, and decrease in patient and staff satisfaction with the care provided.

f) What psychological difficulties do cancer/ palliative care and EOL patients experience?

A recent Macmillan report (2013) identified that psychological distress and mental health difficulties in cancer patients remain a significant and ongoing concern . At least 50 per cent of patients diagnosed with cancer go on to experience levels of anxiety and depression severe enough to adversely affect their quality of life. Other significant symptoms include chronic fatigue, sexual and relationship difficulties, memory deficit and body image concerns. Research shows that people diagnosed with cancer two years previously are more likely to experience anxiety than people who have not had cancer (Mitchel et al, 2013). Furthermore people living with and beyond cancer are considered to be at risk of PTSD due to the shock and trauma of being diagnosed with a life threatening disease and receiving treatment that is both mentally and physically gruelling (Macmillan Cancer Support, 2015).

A significant percentage of cancer patients continue to report significant levels of psychological distress well after treatment has been completed. Even ten years after the initial diagnosis 54 per cent of survivors still report at least one psychological issue (Macmillan Report, 2013).

These findings seem to be consistent between patients with different forms of cancer.

Furthermore, significant levels of psychological distress and higher concordance of mental health difficulties have been highlighted in carers and family members of our patients.

Cancer poses an additional dilemma for services as the treatment itself creates additional problems and can be experienced as equally traumatic as the illness itself. Furthermore, the varying stages and types of cancer and individual presentations add further complications to the patient experience of treatment.

Research findings indicate that longer waits for psychological interventions post diagnosis of cancer, can cause an increase in psychological distress making it even more difficult to tackle the issue by the time patients do receive help (BPS, 2015).

g) The role of a Clinical Psychologist in Cancer/ Palliative care and EOL:

A designated clinical health psychologist in cancer /palliative and EOL services would directly address many of the shortfalls noted by the House of Commons (2014) report by working with both staff and patients using a range of interventions. Specifically, they can offer assessments and treatment at various stages of diagnoses and treatment (i.e. diagnosis, treatment and remission, cancer /palliative support and EOL care), applying a range of evidence-based psychological treatments and research.

There is a wealth of research supporting the use psychological interventions. An extensive report by Patrick et al (2015) on psychological support on people living

with cancer highlights several examples of how psychological interventions have had a positive impact on both mental and physical wellbeing in the UK. Their results portrayed a decrease in: Psychological symptoms such as depression and anxiety as well as a further decrease in physical symptoms such as the perception of pain and fatigue, quality of life and perceived quality of depression care. Patrick et al (2015) also cited an extensive meta-analysis by Devine's (2003) which showed that psychoeducation was effective in reducing pain perceptions through an adjuvant therapy.

Furthermore, since clinical psychologists are trained in 2-3 theory based practice models they have professional flexibility to engage with a wide range of approaches in order to design individual care packages specific in patients at this challenging moment of their journey. Patrick et al (2015) cited found that Cognitive Behavioural Therapy (CBT) portrayed positive short term effects on anxiety and positive long term effects on quality of life; and Mojtabaie & Gholamhosseini (2014) found that acceptance and commitment therapy (ACT) is effective in reducing symptoms of depression in woman with breast cancer. Relaxation training and therapy also seems to reduce depression anxiety and hostility, being the most effective in patients undergoing chemotherapy, radiotherapy, bone marrow transplants and hypothermia

The roles within this services include:

Directly:

- A range of individual and group therapies ; -Assessments and treatments
- Risk assessment and triage into other psychology and mental health services
- Carer support groups
- Consultation with families

Inherent in the psychological and therapeutic process is the management and highlighting of issues related to ensuring the patient feels in control, supported – that their concerns and those of their families are acknowledged and addressed, their sense of humanity protected and maintained, that they are empowered and encouraged to continue to actively take part and live life as well as they can and to die with dignity and respect.

All of these issues are often the core of psychological assessment and intervention (as is illustrated in the range of skills a psychologist can add to the existing service) and are often fundamental to the issues patients bring to palliative and EOL services. The issues managed are reflected clearly in the Macmillan 9 outcomes (2014). Therefore, a dedicated team psychologist enables teams to address these aims by the nature of their skill set.

Indirectly:

- Consultation with medical and nursing staff
- Level 2 Supervision of medical and nursing staff regarding psychological concerns
- Staff supervision i.e. reflective clinical practice groups

Working indirectly with staff to help to develop a psychological perspective can aid interactions between the team and patient which can have a positive impact on the treatment process, helping to improve patient satisfaction, motivation and engagement. This may also result in a reduction in consultations with associated cost savings and importantly help to improve practitioner psychological working, work satisfaction, and reduce the risk of burnout by the team as a whole.

This specialist service creates a unique science-based clinical profile, bringing clinical expertise in psychological approaches to health, well-being and performance, utilising both direct and indirect applications. (DCP, BPS 2014).

h) Research and audit:

Clinical psychologists are experienced in developing, leading and conducting audits and high quality Doctoral level clinical research.

Routine audit of the prevalence/presence of mental health difficulties, patient satisfaction and psychological therapy input received or recommended can help to ensure quality of care. Auditing of the psychological needs of patients can help to ensure that an appropriate level of psychological service is provided and how services should be shaped to meet patient need. Patient feedback provides an essential insight into how a service is actually experienced by service users, is a measure of service performance and can therefore lead to service improvement.

Research expertise delivered into services creates a unique science-based clinical profile. This not only has long term benefits for our understanding of this patient population and associated service improvements but also raises the profile of the department which will help to attract more referrals and thus income for the Trust.

i) Service development:

The Leadership Development Framework (BPS, 2010) shows how highly specialist clinical psychologists are trained to work together with service directors and managers, providing leadership in service development and design, informed by scientific knowledge base. Good leadership for collaborative working will improve patient experience, protect patient safety and assist the implementation of the Department of Health's National Mental Health Strategy, 'No Health without Mental Health' (2011).

3.Strategic context: Financial and economic considerations

There are a growing number of national guidelines for the holistic assessment and treatment of patients referred to and being treated in physical health settings in England.

In line with the DoH Policy of 'No Health without Mental Health' (2011/ 2013), there is a clear objective for increased parity of esteem between mental and physical health. Routine assessment for depression and mental health risk for cancer and palliative / EOL patients have been identified, with an emphasis on risk management

(especially the higher percentage of suicide risk), and improvement in overall quality of life (NHS Choices, 2012).

The EOL report (2014) and the review carried out by the Social Care Institute for Excellence (2014) both highlighted that palliative care services in general are limited in the services they offer not only to the patient but also their families throughout the patient journey. The House of Commons report (Ingold and Hicks, 2014) stated that there are specific gaps in specialist care services essential to which are specialist Psychological Services. Whilst services may attempt to redress the balance by requesting that nursing staff highlight these issues, this has resulted in an under-diagnosis of depression and mental illness in these patient groups. (Draper (2014) suggested that this might be due to the fact that that 'interim' staff may lack the relevant skills and awareness to identify the problem). The House of Commons (2014) also highlighted that staff need increased training and support to manage these issues and consider more individual factors such as mental health capacity if they are to meet targets related to patient involvement in treatment choices. Therefore, the reliance on non-psychologists to fulfil this role comes with additional secondary problems for service delivery.

The BPS (2015) highlighted the role of Clinical health psychologists working in Cancer and palliative / EOL care settings. The report highlighted that whilst depression amongst cancer patients is significantly more common compared to the general population, as many as three quarters of palliative patients are not receiving treatment for the mental health problems. Similarly, the Macmillan report (2015) identified that at least 50% of patients diagnosed with cancer would go on to experience a psychological problem. Where patients are being identified as having a psychological need, there was a significant delay in treatment due to the limited number of resources offered resulting in further distress and increased time for recovery and management of issues.

The 'We Need to Talk' Commission (BPS 2015) stated that in not offering specific services to address the aforementioned issues, there was a wider economic effect which impacted beyond service finances to the wider economy where patients who are undiagnosed with mental health issues may result in increased time off work or leaving the jobs completely, resulting in a financial loss incurred by sick pay and increased benefits. The

YouGov Survey (2015) stated that not only were the physical and emotional effects of cancer the most common reasons for people leaving work or changing jobs but that 30% of these patients did not feel emotionally strong enough to continue, resulting in an average loss of £860 income per month. Macmillan (2013) further reported that young survivors were also more likely to drop out of formal education and so are more likely to be unemployed. Macmillan (2013) concluded that timely psychological advice and support was needed in order to address these issues through prevention and treatment strategies.

In light of strategic developments for cancer/palliative and EOL care services, the evidence suggests that attachment of designated Clinical Health Psychologists to such teams would result in increased movement towards government targets as well as reduce the considerable financial losses currently being incurred by the omission of this specialist service to not only trusts but the wider economy in general.

4.Option appraisal

CRITERIA:

OPTION 1

Do Nothing

OPTION 2

Referral into MHS Psychological Services

OPTION 3

Psychology Service (Part-time)

OPTION 4

Psychology service as part of Macmillan community oncology team (Full-time)

OPTION 1: Do Nothing

- The frequency of clinical risks reported with patients presenting with psychological problems is clearly predicted in tertiary clinical health psychology referrals.
 - The service does not have a practitioner psychologist as a key member of the multidisciplinary team, and hence the tertiary specialist service is not fully staffed, according to national guidelines.
 - The team does not feel they have the professional competence to manage these specialist psychological risks and complexity effectively. This increases vulnerability both for the clinician, patient, team and organisation.
 - Specialist assessments of key psychological/mental health components of care will not be provided. This will result in no formal service to identify core mental health issues, such as identification of depression and or anxiety, adjustment issues related to changes in lifestyle and appearance, decision making re treatment options, sexual and relationship problems and prevalence of co-morbid conditions such as chronic fatigue or other long term conditions as well as risk to self/others
 - There is a lack of specialist training, supervision, consultation and support for staff working with these patients. This results in extended nursing roles without appropriate training and experience.
- Risk to service provision by over compromising for patients with complex psychological issues, and neglecting other core physical treatment requirements.
 - Due to the service demands created by such high degrees of psychological distress in the patient group, the team is unable to offer broader training and support to other community staff groups, such as pre and post registration nursing and district nursing students and services.
- The current palliative / EOL services rely on non –psychologist staff or external mental health organisations to provide psychological support, rather than an in-house psychologist as a member of the MDT. This can have a negative effect on the

seamless provision of care for patients and carers, as well as a less cohesive MDT approach to patient care.

- Without psychological support within the team, the need for tertiary referrals to external/ third party organisations will increase at great additional cost to commissioners and the organisation.
- The financial and clinical cost of option 1 is hence outlined as higher than the benefit of a psychologist embedded within the team, either on a full time or part time basis.

OPTION 2: Referral into MH Psychological Services

- Referral into a MH Service is restricted in that Havering Psychological Services (HPS) does not have a commissioned clinical health psychologist, and the trust would need to consider the cost, both clinically and financially, on relying on an external psychology service to see cancer, palliative / EOL patients.

Current waiting lists for patients across the spectrum from primary to secondary mental health care are high, and when provision is obtained, this is usually for a time limited period. Ordinarily patients are prioritised on suicidal risk and so these groups of patients are likely not only to face delays but may miss out on treatment when it is most needed. Additionally the networking regarding their care is primarily medical and so communication between team members based in different bases will (as mentioned previously) be less likely due to an increased time factor.

- The absence of a clinical psychologist as a member of the MDT fails to meet guidelines for specialist, tertiary services. This is due to the need for a specialist practitioner psychologist to offer a broader clinical role than direct clinical interventions. This includes the ongoing and regular training, consultation and supervision offered to non-psychological team members in detecting and managing mental health and psychological presentations. With referring outside of the team, to a MH service, the regular liaison with the orthognathic team through weekly joint clinics and other team meetings is absent. This increases clinical risk, reduces holistic needs assessment and treatment of patients, and limits a stepped care and seamless model of treatment care.

OPTION 3: Psychology service as part of the Havering Macmillan community psychology service (Part-time:only)

- This option would result in a limited psychological service. The clinical psychologist would be able to create some impact on some issues and minimise the priority cases only, again creating an inequity within the service. However for other cases, this would mean a delay in any assessment and intervention creating disharmony within the service and an inequity of service.
- The availability of a psychologist in the service will enable the expansion of consultation, supervision and training opportunities for non-psychological MDT members of the orthognathic team. This will enhance psychological mindedness and confidence in team members, as well as enhancing the detection of mental health symptoms and psychological distress in a physical health population.

OPTION 4: Psychology service as part of the Havering Macmillan community psychology service (Full time only)

- This option allows equal access for all patients and carers to psychological expertise (and support to all staff) for the whole service.
- This option will significantly reduce external referrals, appointment delays and enable more people to be seen in a timely basis.
- This will help reduce clinical risk, as patients will have access to a specialist psychological assessment throughout the patient journey.
- Additionally team concerns regarding a wider range of patients can also be discussed and consultation offered in areas of individual concern for medical / nursing staff.

5.Risk and Sensitivity analysis:

An integrated, holistic, approach to the assessment and treatment of patients in Cancer / Palliative care and EOL services will enable each speciality to spend specific time on their own area of professional expertise, as mental health concerns regularly impact on broader nursing care and clinical appointments.

The continued provision of a psychological service will support the effective triage of patients into the most appropriate mental health service, hence supporting the transition of high risk crisis mental health referrals into acute services, if mental health risk and symptoms are assessed at an earlier point and contained. Since risk assessment is part and parcel of the role of a clinical psychologist this would not need specific time allocation or additional resources.

Psychological support would be crucial to identify and address issues of risk which might ordinarily be missed due to the physical health priority. A team psychologist would be able to identify those factors such as hopelessness, isolation, helplessness and depression coupled with ill health (all of which are common issues facing these populations) and be in a position to act on the information and identify the links to the appropriate services and networks.

6.Resource/ Procurement requirements and costs:

- Mid - point (36) of an 8a Clinical Psychologist
Admin Support to be provided internally
Volunteer (Honorary Assistant Psychologist)
- Access to a room to see patients and carers
- Access to computer, with all relevant electronic health record access systems
- Desk and office supplies

7.Funding source / Timing:

This business case is a pilot with NELFT NHS Trust on a trial basis on a fixed basis. The project will be evaluated to develop a new business case for continuing of funding.

8..Conclusions and Recommendations

In considering, the current national clinical recommendations regarding cancer palliative and EOL care services and specific workforce development strategies; the evidence highlights the impact on service delivery and experience of patient care by the absence of psychological services. This clearly points to the necessity of Option 4 targets being offered as the way forward to offering the best treatment for cancer, palliative and EOL care.

This option allows health services to address numerous and on-going patient concerns throughout their 'journey' therefore, not only improving and offering the best support to the individual but in turn making strategic use of services available by removing barriers to a clear treatment pathway.

Public Works 19: Title Page

Psychological support for palliative care staff in community settings: the role of Level 2 adapted clinical discussion groups

Marc. J. Kingsley^a, Ruimin Ma^b and Feryad. A. Hussain^c

- a. North East London (NELFT) NHS Foundation Trust. The West Wing, CEME Centre, Marsh Way, Rainham, RM13 8GQ, United Kingdom
- b. Institute of Psychiatry, Psychology and Neuroscience (IoPPN), King's College, De Crespigny Park, London, BOX SE5 8AF, United Kingdom
- c. Black County Foundation Trust, Delta House, Delta Point, Greets Green Road, West Bromwich, West Midlands, B70 9PL

08 February 2021

ABBREVIATIONS:

CDG'S: CLINICAL DISCUSSION GROUPS

EOL: END OF LIFE

LCA: LONDON CANCER ALLIANCE

NELFT: NORTH EAST LONDON NHS FOUNDATION TRUST

NCPC: NATIONAL COUNCIL OF PALLIATIVE CARE

NHS: NATIONAL HEALTH SERVICE

NICE: NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE

Public Works 20: Clinical Audit Report

Clinical Audit Report

N.B. Do not include any patient identifiable information in this report.

Kingsley, M.J. & Wright, D, 2011.

Audit Title

CRAG – Trends and Themes arising from Sudden Unexpected Deaths in the Community 2008-2009 from a clinical perspective

Directorate & Ward/Area of Audit

NELFT Risk and Assurance Group

Introduction

The Clinical Risk Advisory Group (CRAG) for NELFT was developed in 2009. This group was to be closely linked to the Risk Assurance group; its primary aim being to utilise the expertise of MDT clinicians to overview major incidents reported to the Trust, and to report these findings to the Risk Assurance Group.

Due to the restricted time available to clinicians in the CRAG group, a clear focus was hence discussed, and an agreement was reached by the CRAG to focus on those Sudden Unexpected Deaths that had occurred in the community, as this was the area of higher incident rating. This feedback was brought back to the Risk Assurance Group, who agreed to the CRAG focusing on this specific piece of work.

The basis of this audit was to identify any common Trends and Themes arising from Sudden Unexpected Deaths in the Community 2008-2009, an annual report produced by the G&A department providing statistical data on the number of deaths subject to a Coroner's inquest, (excluding deaths from natural causes and homicides.)

Public Works 21: Presentation: CRAG – Trends and Themes arising from suicides in the Community (2008-2009)

North East London 
NHS Foundation Trust

PUBLIC WORKS 21

CRAG – Trends and Themes arising from suicides in the Community (2008-2009)

Marc Kingsley, Consultant Clinical Psychologist



Daniel Wright, Assistant Research Psychologist

Who was involved?

North East London 
NHS Foundation Trust

■ Bullock Heather, Bansal Harjit, Capellino Laura, Crisp Charlotte, Drew Tim, Hayes Viv, Greenstone Philip, Hartie David, Kingsley Marc, Latimer Miles, Li Roy, Mess Lorna, Morris Janet, Nortman Dawn, Popoola Modupe, Ryan Patricia, Stanbury John, Smyth Susan, Wilson Marilyn, Wright Daniel



Introduction

- This audit was developed by the Clinical Risk Advisory Group (CRAG), a sub group of the Trust Risk Assurance Group (RAG).
- The CRAG was developed to utilise the expertise of a team of multi disciplinary clinicians to overview the major incidents reported to the RAG.
- The primary aim was to identify any common Trends and Themes arising from suicides in the community 2008-2009.
- An agreement was reached by the RAG to focus on those suicides that occurred in the community. This was of concern as this was an area of higher incident rating.
- The source of this information was obtained from the annual report produced by the Governance and Assurance department providing statistical data on the number of deaths subject to a Coroner's inquest, excluding deaths from natural causes and homicides.



Methodology

- Utilised the experience of various clinicians, including medical, nursing, psychology, OT.
- Audit tool i.e. checklist designed by CRAG members was used to capture the required data.
- Data was collected from patient notes/RiO/SUI file (e.g.: patient notes, care-pathway, electronic data, RiO).



Methodology

- How was the sample obtained? CRAG members used a nominal voting form to allocate a given priority to each case.
- Due to time constrictions a decision was made to focus on the top twenty cases given highest priority.
- However, out of these cases three could not be assessed mainly due to a lack of available information. One case was reassessed as death by natural causes.
- Sample of n=16 suicides 2008-2009.



Results

- The results have been divided into 2 main components:
 - Service User Risk Factors
 - Systemic Failures



Results - Demographics

North East London **NHS**
NHS Foundation Trust

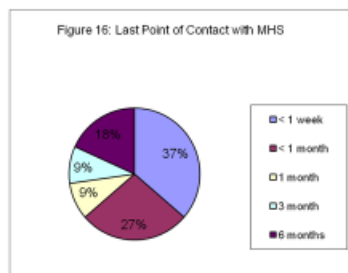
- Male (75%), White British (82%) aged 31-50 (69%). This is much in line with the growing research suggesting that men moving towards and in middle age are at increased risk of suicide.
- Of cases where sexuality was known, emotional conflict related to sexuality was reported in three male clients of the sample.
- There is clear research suggesting elevated suicide risk amongst gay and lesbian people, with gay men at the greatest risk of successful suicide.
- 60-70% were without stable long term intimate relationships.



Results-Contact with MHS

North East London **NHS**
NHS Foundation Trust

- 85% had previous contact with MHS.



- 15% self referral whilst majority by other services such as A&E (30%) and GP (20%).

- For the most recent admission the majority of the sample (62%) were not under section but were voluntarily seeking help or accepting support from MHS.

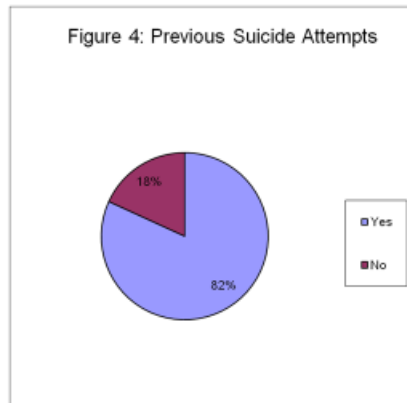
- 60% had two or more admission to psychiatric inpatient care.

- 71% of admissions occurred within the last 6 months prior to eventual suicide and all occurred within one year prior to suicide.
- These findings follow the critical period (within one year of discharge) outlined in the literature, in which the risk of suicide greatly increases.



Results-Risk factors related to Mental Health

North East London **NHS**
NHS Foundation Trust

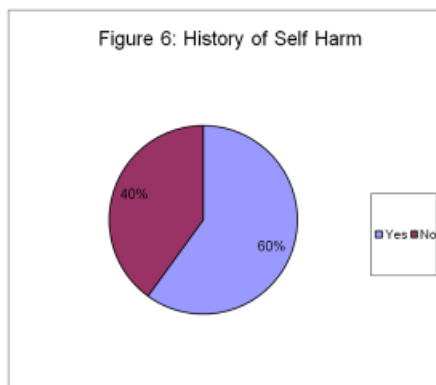


- 89% had two or more failed suicide attempts in the past.
- 42% had attempted suicide within the last year.
- And one client had attempted suicide within the last month prior to their death.
- History of repeated past suicide attempts are amongst the most significant risk factors for eventual suicide.



Results-Risk factors related to Mental Health

North East London **NHS**
NHS Foundation Trust

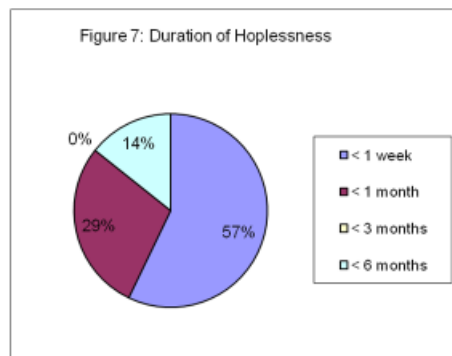


- 60% had a history of self harming behaviour.
- 75% of those clients had experienced five or more episodes of self harming.
- Patients who have engaged in multiple episodes of self harm are at significantly greater risk of suicide.



Results-Risk factors related to Mental Health

North East London **NHS**
NHS Foundation Trust



Low Mood

- All had expressed feeling more depressed or low, with a large proportion (71%) reporting sleep disturbances.

Hopelessness

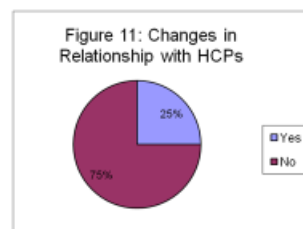
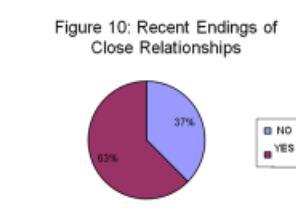
- Of those clients that were asked about hopelessness all had expressed such feelings prior to their death.



Results-Major Life Stressors

North East London **NHS**
NHS Foundation Trust

90% reported major life stressors prior to their deaths, including;



- In addition 40% reported recent conflicts with close others.
- This is in line with research emphasising the significant role that endings and changes of important relationships may have on risk of suicide.
- This is particularly important in men as separated men are four times more likely to commit suicide.



Results-Major Life Stressors

North East London **NHS**
NHS Foundation Trust

- Other Major Life Stressors that were reported included:
 - Recent contact with police force following criminal activity.
 - Risk of suicide has been reported to be higher amongst individuals who have had recent or frequent contact with the criminal justice system.
 - Recent changes in physical health (30%) with chronic pain being the major factor.
 - There is an increasing depth of research suggesting that chronic pain is a potent predictor of suicide and suicide attempts, even after mental illness has been controlled for.



Results-Systemic Failures

North East London **NHS**
NHS Foundation Trust

- 33% of the sample did not have risk assessments on RiO.
- There was a pattern of important information related to risk being omitted from client's RiO profiles (where found) and case notes. e.g. 66% did not have appropriately detailed information regarding past history of suicide/ self harm.
- No care plans were found for 36% of sample. Care plans, where available, were often inaccurate and inappropriately detailed.
- Crisis plans on RiO were often missing or did not outline clear procedures of risk management.
- This is especially worrying as these were clients that posed considerable risks in the sense that the majority had a history of admission to inpatient services with many experiencing admissions in the last 6 months, a history of self harming behaviour and a history of suicide attempts.
- There were concerns regarding the management of referrals between healthcare professionals relating to risk information.



Results-Systemic Failures

Omission or inaccurate reporting of vital information, including:

- **Demographics:** key information regarding client's sexuality, ethnicity and religion was often unrecorded. There was also a lack of information regarding the employment and financial status of the sample.
- **Changes in mental state:** information such as important changes in mood, personality and medication was lacking in some RIO profiles.
- **Lack of documentation of crucial risk factors:** Almost half (44%) had not been asked about feelings of hopelessness. There was a scarcity of vital information regarding crucial factors such as impulsivity, history of child abuse and aggression.



Conclusion

- The audit has successfully identified a number of Trends and Themes arising from Sudden Unexpected Deaths 2008-2009.
- These trends and themes are related to important patient risk factors as well as broader systemic failures.
- The audit has highlighted the need for healthcare professionals to be aware of their client's history, including previous inpatient admissions, previous suicide attempts/ self harm when considering current/future risk assessment and management.
- There is also a need to closely monitor the quality of electronic and written records, ensuring that they are up to date and reflective of the risk posed by service users.



Level 2 supervision groups for attenders

Recommendations	Significance	Proposed actions	By Whom	By when	Progress/Outcome
1. Clinical risk training to be regularly reviewed as themes and trends emerge	HIGH	Risk training structure was reviewed	MK MD LC	2010	CLINICAL RISK TRAINING PROGRAMME 2011-12 outlining specialist training (see proposed outline in Appendix A)
2. Careful analysis of the quality of risk assessments on RIO by senior members of staff	HIGH	Team briefs as to the vital requirements for risk assessments to be appropriately detailed.	Managers/supervisors	2012	Discussion has been held with Trish Aveling (RIO Manager) as to offering specialist training to staff on risk assessments. Incorporation of risk review into line management supervision
3. To ensure that vital historical information is not lost in the transition from paper notes to electronic records (RIO)	HIGH	CRAg to review improvement in quality of risk assessments on RIO	Medical Records(KN) CRAg	2011-2012	Promoting effective scanning of paper notes: examination by medical records to ensure that relevant and vital historical information is not lost

Recommendations	Significance	Proposed actions	By Whom	By when	Progress/Outcome
4. Crisis and Care Plans need to be appropriately completed and reflective of risk.	HIGH	Audit quality of RIO care/crisis planning . Ongoing training on effective use of care/crisis plans.	MK SS TA	Ongoing.	Practice Improvement/CRAg to feedback any continued deficits found in cases. Care planning audits established and ongoing. Meeting arranged with practice improvement and RIO manager to outline training in crisis planning.
5. Succinct examination of hopelessness as routine; inclusion as key question in mental state examination/ ongoing treatment.	HIGH	Monitor through supervision audits whether hopelessness is being regularly assessed.	Trust wide RIO	Ongoing.	MK has met with RIO to discuss this topic. MK conducting risk training on hopelessness.

Level 2 supervision groups for attenders

Recommendations	Significance	Proposed actions	By Whom	By when	Progress/Outcome
6. Physical Health and criminal justice settings to work alongside MHS re risk management.	HIGH	Risk Training for staff working in P.H.S/ C.J.S.	Training Dept	To be confirmed	Future clinical risk training workshops to be designed for PHS/ CJS in risk assessment and management
7. Carers/friends to be considered as vital in risk assessment and management	HIGH	Training of staff on carers views of risk. Development of complex carers group.	MD/ MK/TS/KH/DW MK/TS/PI	2011 - 2012	Carer training ongoing Safe For Caring Group has identified key themes in risk management: this will be fed back to the Carers Reference Group in 2012
8. Vital to assess sensitive information such as sexual orientation, childhood sexual abuse and domestic violence	HIGH	Training staff to enquire about sensitive risk information; Consider outside organisations within risk management	Training Dept MK	2012	Suicide Assessment and Management – Sexual Orientation- Training arranged for 2012.

Recommendations	Significance	Proposed actions	By Whom	By when	Progress/Outcome
9. Integrate CRAG findings into Zoning within Community Recovery Teams.	HIGH	Develop Risk Prompts (guidance) to supporting staff in colour coded zoning.	AD LC DW MK MD	2012	Several meetings have occurred with assistant operational director (AD), training dept. and CRAG. MK and DW to develop risk prompts to be used in teams.
10. Further training is recommended in supporting men psychologically with adverse life events.	HIGH	Training to consider this.	Training dept. CRAG	TBC	To arrange meeting between MK and training dept. (MD) to address recommendation.
11. Recognise cultural/ religious dilemmas and risk.	HIGH	Training of staff to address such issues in risk assessment.	HB MP	2012	See Clinical Risk Training Programme 2012.

Lessons Learned

North East London **NHS**
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- Consistent with research, the audit confirmed the vulnerable time between discharge period from inpatient care to community settings.
- Staff should be mindful of the increased vulnerability and risk over a longer period of transition back into community settings (up to one year post-discharge).
- Poor quality of recording key clinical information is a significant risk factor in that vital information is lost and opportunities for meaningful risk management and care planning are missed.
- The importance of investigating past history (paper notes, GP referrals, client statements etc) is a key factor in ensuring a current, well detailed and clinically sound understanding of a service user's risk.
- Link with practice improvement: Having a CRAG member from this dept (Sue Smyth) significantly helped in taking forward concerns relating to the systemic failures (such as quality of risk assessments and care plans).



Lessons Learned

North East London **NHS**
NHS Foundation Trust

- There is a vital need for clear and consistent communication between staff and between teams with regards to the sharing of risk concerns.
- Referrals of high risk clients need to be closely monitored and followed up with urgency. (eg. through zoning prompts)
- There was not enough evidence in notes as to whether carers, family members and close others were adequately involved in the risk assessment and management process.



Lessons Learned

- Staff could benefit from risk prompts. These could be used community settings.
- Discharge from inpatient setting within last 12 months vital risk factor.
- Depression/ low mood closely monitored.
- Past history of suicide attempts (even with long periods in-between),
- Self harming history : multiple episodes of self harm a significant risk.
- Hopelessness a key risk factor.
- Recent emotional conflict in intimate or important close relationships,
- Changes to close professional relationships.



Public Works 22: Update on the CRAG for Trusts Board meeting 15/01/2013

**UPDATE ON THE CRAG FOR TRUST
BOARD MEETING**

15/01/2013

PUBLIC WORKS 22

MARC KINGSLEY, CRAG CHAIR AND CONSULTANT PSYCHOLOGIST
SUPPORTED BY DR. BEN SMITH, TRUST-WIDE LEAD FOR PSYCHOLOGICAL
SERVICES & PROFESSIONAL LEAD FOR PSYCHOLOGY
AND KIRAN AZAM, RESEARCH PSYCHOLOGIST.

AGENDA

- Update of progress from the last broad presentation (2011): identifying and managing thematic risks in MHS Community Settings.
- Progress on key developments on suicide awareness in non-mental health settings. i.e. community health services.
- Feedback from Malcolm Rae's workshop: initial training of non-mental health staff on suicide risk in physical health settings.

UPDATE OF PROGRESS FROM THE LAST BROAD PRESENTATION (2011)

	Action plan requested	Update
1	Clinical risk training to be regularly reviewed as themes and trends emerge	• Training has been reviewed with the Organisational Development department. • Key training has been delivered to staff across community and acute mental health services. • Further information from slide 1
2	Careful analysis of the quality of risk assessments on RIO by senior members of staff.	• Risk training ran for Acute and Community staff on improving suicide risk assessments. • Tricia Aveling's feedback to be added • Further information from slide 2
3	To ensure that vital historical information is not lost in the transition from paper notes to electronic records (RIO).	• MK held discussions with Kim Nugent, Health Records/WinDip Manager regarding the scanning of archived records. • Assurance statement provided by Kim Nugent: • Full quality assurance check will be carried out re scanning of current paper health records to ensure that vital historical risk information is not lost in the transition from paper to electronic notes.

UPDATE OF PROGRESS FROM THE LAST BROAD PRESENTATION (2011) CONT..

	Action plan requested	Update
4	Crisis and Care Plans need to be appropriately completed and reflective of risk.	• Training has been provided by Organisational Development department. • Zoning prompts include a category on crisis/care plans and risk. • Patient Experience Department is currently auditing the quality of RIO care plans and their links to risk assessments.
5	Succinct examination of hopelessness as routine in risk assessment.	• Hopelessness as a vital clinical risk factor has been included in suicide risk training. • Hopelessness included in Zoning prompts for community and acute MHS services. • 4 main evidence based questions have been extracted from the Beck Hopelessness Scale. These have been sent out to all relevant services.

UPDATE OF PROGRESS FROM THE LAST BROAD PRESENTATION (2011) CONT..

	Action plan requested	Update
6	Criminal justice settings to work alongside MHS re risk management.	- Risk training to ensure that staff are mindful of the higher suicide risk in service users with links to the criminal justice system. - Zoning prompts mention this risk group. - MK to meet with the amalgamated Police Liaison Group (chaired by Pete Williams) in April 2013 to discuss the suicide vulnerability and management in this service user group.
7	Carers/friends to be considered as vital in risk assessment and management.	- Carers have provided training to staff. - Zoning prompts have included carers link to suicide risk assessment and management.

UPDATE OF PROGRESS FROM THE LAST BROAD PRESENTATION (2011) CONT..

	Action plan requested	Update
8	Vital to assess sensitive information such as sexual orientation, childhood sexual abuse and domestic violence	- Training on LGBT and suicide risk delivered. - Zoning prompts include these vital clinical risk factors.
9	Integrate CRAG findings into Zoning within Community Recovery Teams.	- In lines with the National Suicide Prevention guidelines on the use of Zoning Prompts, the first of a range of zoning prompts have been completed (with the support of Fiona Weir, Adrian Dorney, Laura Capellino and Daniel Wright). - Zoning prompts for community settings sent to all community MH, HTT settings. - These are now laminated and visually present and discussed in Zoning meetings. - For more information see hand-out.

UPDATE OF PROGRESS FROM THE LAST BROAD PRESENTATION (2011) CONT..

	Action plan requested	Update
10	Prompts of suicide risk to be considered for patients within acute inpatient settings.	• MK has created inpatient specific suicide risk prompts (see hand-out). • Risks of voluntary patients within inpatient settings have been highlighted as a high risk group. • Importance of observation and leave from the ward reflected upon in suicide management. • inpatient suicide risk training workshops to be considered in 2013 for ward staff.
11	Further training is recommended in supporting men psychologically with adverse life events.	• MK has presented this topic to groups such as CRTs. • Specific training to be organised in 2013.
12	Recognise cultural/religious dilemmas and risk.	• Training provided • Zoning prompts include these

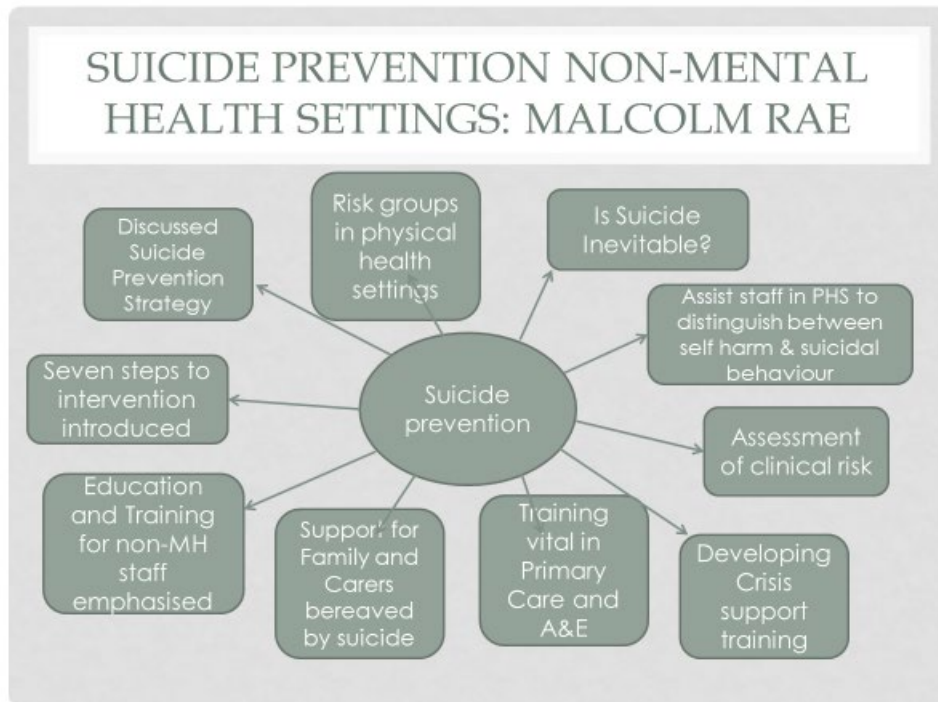
- TRICIA'S FEEDBACK (CAPTURING VITAL SUICIDE RISK INFORMATION ON RIO)

PROGRESS ON KEY DEVELOPMENTS ON SUICIDE AWARENESS IN NON MENTAL HEALTH SETTINGS.

- In line with the crucial drive within the National Suicide Prevention Strategy, and CRAG findings, NELFT is dedicated to enhancing suicide awareness and prevention work in non mental health settings.
- Encourage clinicians working across all three business units to be aware of suicide risk in service users presenting with physical health difficulties.
- **FORMATION OF NEW CRAG SUBGROUP: SUICIDE RISK IN NON MENTAL HEALTH SETTINGS.**
- Current CRAG has expanded to include a specific non-mental health subgroup
- Representatives have been invited from ONEL, SWECS and CHS
- Members include Debbie Reith (North East London Community Services, Barking), Geraldine Rodgers (Nurse Consultant, South West Essex Community Services) and Nesta Williams (Sexual and Reproductive Health Service Manager North East London Community Services, Leyton).
- **GOALS SET BY NEWLY FORMED CRAG SUB-GROUP FOR 2013-2014**
 - Consider suicide risks in all non mental health settings, ranging from community settings, such as pain management clinics, to district nurses visiting patients at home.

PROGRESS ON KEY DEVELOPMENTS ON SUICIDE AWARENESS IN NON MENTAL HEALTH SETTINGS.

- Identifying high risk patients within non mental health population, such as patients with medically unexplained conditions, long-term health conditions or chronic pain, or undetected depression.
- Consider ways of enhancing the mechanism of the reporting of any non mental health suicides as there are concerns that these may be currently underreported.
- Clinical audit team has expressed an interest in supporting the development of an audit form to be used in the investigations of SI's in non-mental health settings.
- A primary aim would be training of non- mental health staff in assessing and managing clinical risk, such as suicidal ideation, hopelessness, impulsivity, etc.
- Assist in the development of zoning prompts to be used in non mental health settings
- Aim of prompts: to familiarise clinicians working in such settings to detect high risk factors, such as depression, hopelessness and suicidal ideation, and the best practice of reporting such risk concerns.
- The initial drive towards training of non-mental health clinicians was piloted in 2012 with a half-day workshop by Malcolm Rae, OBE, specialist nurse and trainer in suicide and homicide risk.



TRAINING DELIVERED AND FEEDBACK SLIDE 1

	Training	Delivered	Feedback
1	Safe for Caring – A Carer's perspective on risk. <i>Mr & Mrs Lavery (Carers)</i> <i>Marc Kingsley (Clinical Psychologist)</i> <i>Tarek Seeraulle, Havering Carers Lead.</i>	2011/2012	- First time carers involved in risk training. - Staff found carers delivering the training especially valuable. - Home treatment representative initiated the role of being the HIT carer link. - Increased staff awareness of carers frustration of confidentiality barriers.
2	Suicide Assessment and Management – Sexual Orientation. <i>Soren Stauffer-Kruse, Clinical Psychologist</i>	2012	99.6% of the attendees strongly agreed/agreed that the course was relevant to their needs. - All of the attendees found the course interesting, stimulating and challenging. - Staff found the training of transgender risk assessment especially helpful.
3	Working with High Risk Patients (Suicide) from a particular Ethnicity/Cultural & Religious/Spirituality. Belief system	2012	92.3% of the attendees strongly agreed/agreed that the course was relevant to their needs.

TRAINING DELIVERED AND FEEDBACK

	Training	Delivered	Feedback
4	CAMHS Specific – Digital and On-line risk and suicide. <i>Acute and community CAMHS services.</i> <i>Dr Fairweather, Consultant Psychiatrist.</i>		- All of the attendees strongly agreed/agreed that the course was relevant to their needs. - All of the attendees found the course interesting, stimulating and challenging. - Staff found the training significantly increased their: - Awareness of children/adolescents access to digital chat rooms encouraging self harming / suicide. - Enhanced ability to include relevant information re digital risk in overall risk assessment/management.
5	Suicide Assessment and Management of complex clients (high suicide risk). <i>Marilyn Wilson, CBT Lead for Complex Trauma.</i>	2012	- Covered vital clinical factors such as hopelessness, effective risk history taking and management of suicide crisis. - Staff felt more skilled in formulating key risk suicide factors and outlining these in the risk assessment.

TRAINING DELIVERED AND FEEDBACK

	Training	Delivered	Feedback
6.	Suicide Assessment and Management – Dual Diagnosis. <i>Marilyn Wilson, CBT specialist.</i>	2012	Staff were introduced to relevance of substance abuse screening, interventions and approaches to assist the assessment and management of risk of chronic substance abuse and suicide risk.
7	ENQUIRING ABOUT ONLINE RISKS: WHERE VULNERABLE PEOPLE CAN GO ONLINE, AND WHAT CAN HAPPEN TO THEM <i>Marc Kingsley</i> <i>Clinical Psychologist</i>	2012	- Presented to the Quality and Safety meeting to encourage Managers to ensure that digital risk is incorporated into suicide risk screening. - Training will be disseminated across acute and community services in 2013.
8.	Suicide Risk Training A Service User Perspective	Rescheduled to 2013	

HOPELESSNESS

- **Four main questions that clinicians** should ask when assessing hopelessness have been developed.
- Service users will be required to answer the questions in TRUE or FALSE. The questions are:
 1. **In the future I expect to succeed in what concerns me most.** T/F
 2. **My future seems dark to me.** T/F
 3. **I just don't get the breaks and there is no reason to believe I will in the future.** T/F
 4. **I have great faith in the future.** T/F
- A laminated list of the questions have been sent out to members of staff in the Trust.
- Training has been provided.

FURTHER CONSIDERATIONS

- Ensuring that staff are familiar with and continue to receive training and support in identifying and managing the vital thematic clinical risk factors outlined by the DoH and through the CRAG findings.
- Providing outreach to younger/middle aged men who are now the most vulnerable patient group; we could consider particular therapeutic ideas on how to support this high risk group.
- As a Trust, we should consider the development of a support group for family and friends who are survivors of suicide. The formation of this group ties in well with the recommendations of the Prevention of Suicide in England guidelines.
- We need to provide outreach to the LGBT community in all three business units. This is one of the highest at risk groups for suicide, especially adolescent and younger adults who may be struggling with their sexuality or being bullied or ostracised.
- A continued drive to offer support and therapeutic interventions to service users who self-harm, as this group is one of the highest groups for eventual suicide.
- Physical illness and chronic pain is associated with an increased suicide risk; We need to encourage clinicians working across all three business units to be aware of the heightened risk of these vulnerable patient groups.
- People with one long-term PH condition are two to three times more likely to develop depression than the rest of the general population. People with three or more conditions are seven times more likely to have depression. Many medical treatments for long-term physical health conditions (for example, chronic pain medication, insulin treatment) also provide people with ready means to take their lives (Preventing Suicide in England, 2012)
- Ensuring that our record keeping and communication of risk is of the highest standard and that risk assessments are up to date and include a developmental approach, and assessing past suicide and self-harming attempts in the updated risk history.

Public Works 23: Letter of invitation to join NPSA 2010



National Patient Safety Agency

6th October 2010

Marc Kingsley
Consultant Clinical Psychologist
NELFT NHS Trust
marc.kingsley@nelft.nhs.uk

NPSA
4-8 Maple Street
London
W1T 5HD

Tel: 020 7927 9500
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enquiries@npsa.nhs.uk
www.npsa.nhs.uk

Dear Colleague

The National Patient Safety Agency (NPSA) has been commissioned by the Department of Health to develop a series of Suicide Prevention Toolkits for Primary Care services that include A&E departments, GP surgeries, Ambulance Trusts and Community Mental Health Teams.

The community suicide prevention toolkit aims to capitalise on what has been learned from the inpatient suicide prevention toolkit and adapt it for the community setting. It is hoped that this will help reduce the number of suicides and incidents of self-harm.

To help progress this work, the NPSA is establishing a working party to include representatives of service users, professional representation from statutory and third sector organisations, and clinical experts in the field of suicide prevention. Malcolm Rae OBE has kindly agreed to chair the group.

The NPSA would very much appreciate it if you would consider becoming a member of this working party. The initial meeting is planned for Wednesday 3rd November from 10.30am to 12:30pm with lunch included at the National Patient Safety Agency, 4-8 Maple Street, London, W1T 5HD. This will be followed by virtual meetings on line to share and disseminate information on a fortnightly basis. The details of this will be discussed at the first meeting.

Level 2 supervision groups for attenders

The focus of this group will be to comment on the standards developed and ensure that they include the latest evidence and best practice. The working group will be asked to comment on the draft standards developed so far which will be circulated after the 18th October, and ask you to provide comments at the meeting.

The NPSA is keen to draw on your experience and expertise and hope you will be able to be a member of the group and attend the first meeting.

I would be grateful if you would confirm your availability to kumba.jaiteh@npsa.nhs.uk
Team

Co ordinator and please do not hesitate to contact me vanessa.gordon@npsa.nhs.uk if you require further information.

I look forward to hearing from you.

Yours sincerely

A handwritten signature in black ink, appearing to read 'V. Gordon', with a long horizontal line extending from the end of the signature.

Public Works 24: Suicides Zoning Prompts Poster

PUBLIC WORKS 24

North East London **NHS**
NHS Foundation Trust

Promoting safer practice: suicide

When is somebody at greater risk of suicide?

Service users who are:

- male, young and middle-aged (men aged 35-49 are now the group with the highest suicide rate).
- male—aged over 75.
- an asylum seeker or from a minority ethnic group, particularly with language barrier.

Service users who have:

- past history of suicide attempts; even with long periods in-between.
- self harming history; multiple episodes of self harm a significant risk.
- recently disengaged from services e.g. not returning phone calls, cancelling/ missing appointments.
- a history of contact with the criminal justice system.
- challenging behaviour resulting in alienation/negative feelings from staff.

Service users who experience:

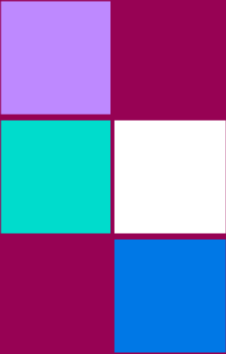
- hopelessness.
- depression/ low mood.
- relapse in mental state.
- agitation.
- impulsivity.
- chronic pain/ serious physical health conditions.
- unresolved sexuality; particularly if linked to broader cultural/ religious dilemmas.
- homophobic bullying (particularly vulnerable are LGBT adolescents and young adults)
- living alone, becoming socially excluded or isolated.
- family breakdown and conflict including divorce and family mental health.

Service users who have recently experienced:

- conflicts/ endings in intimate or important close relationships.
- changes/ endings in relationships with professionals.
- discharge from inpatient setting within last 12 months.
- changes to psychotropic medication.
- alcohol/ substance misuse.

Effective risk management

- Have you considered/ updated the service user's care plan/ crisis and contingency plan/ risk assessment with these factors?
- Do your risk assessments have detailed information regarding past risk?
- Have you communicated any concerns/ risks with all professionals involved in this case?
- If referred, have you tracked how far your service user is on the referral route?
- How are you supporting the service user with these risks?
- How are you considering carers in risk management?



North East London 
NHS Foundation Trust

Promoting safer practice: suicide

Remember your prompt tool

When is somebody at greater risk of suicide?

Service users who are: ■ male, young and middle-aged (men aged 35-49 are now the group with the highest suicide rate). ■ male—aged over 75. ■ an asylum seeker or from a minority ethnic group, particularly with language barrier. Service users who have: ■ past history of suicide attempts; even with long periods in-between. ■ self harming history; multiple episodes of self harm a significant risk. ■ recently disengaged from services e.g. not returning phone calls, cancelling/ missing appointments. ■ a history of contact with the criminal justice system. ■ challenging behaviour resulting in alienation/negative feelings from staff.	Service users who experience: ■ hopelessness. ■ depression/ low mood. ■ relapse in mental state. ■ agitation. ■ impulsivity. ■ chronic pain/ serious physical health conditions. ■ unresolved sexuality; particularly if linked to broader cultural/ religious dilemmas. ■ homophobic bullying (particularly vulnerable are LGBT adolescents and young adults) ■ living alone, becoming socially excluded or isolated. ■ family breakdown and conflict including divorce and family mental health.	Service users who have recently experienced: ■ conflicts/ endings in intimate or important close relationships. ■ changes/ endings in relationships with professionals. ■ discharge from inpatient setting within last 12 months. ■ changes to psychotropic medication. ■ alcohol/ substance misuse.
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North East London **NHS**
NHS Foundation Trust

Promoting safer practice: suicide

Remember your prompt tool

Effective risk management

- Have you considered/ updated the service user's care plan/ crisis and contingency plan/ risk assessment with these factors?
- Do your risk assessments have detailed information regarding past risk?
- Have you communicated any concerns/ risks with all professionals involved in this case?
- If referred, have you tracked how far your service user is on the referral route?
- How are you supporting the service user with these risks?
- How are you considering carers in risk management?

Public Works 25: Clinical Risk Assessment and Management Policy

Clinical Risk Assessment and Management Policy

NHSLA 3.6

LEAD EXECUTIVE DIRECTOR:	Vaughan Williams
Name of Originator / author and job title:	Marc Kingsley, Consultant Clinical Psychologist Stephanie Bridger, Head of Nursing & Practice Improvement Mental Health Services Marilyn Wilson, Cognitive Behavioural Therapy Lead for Complex Trauma Redbridge Psychological Service Tricia Aveling RiO Manager NELFT
POLICY APPROVED BY:	
DATE POLICY APPROVED:	
IMPLEMENTATION DATE:	
REVIEW DATE:	
Date equality impact assessment carried out:	
Health & Safety Assessment completed on:	

Public Works 26: Digital Lives of Vulnerable Patients Seminar Series

Seminar Series:

**The Digital Lives of Vulnerable Patients:
Understanding The Risks and Opportunities**

December 9, 2011

10am – 4.30pm

NHS Tavistock and Portman Clinic,
120 Belsize Lane,
London NW3 5BA

The Homicide Inquiries team, NHS London invites you to the first event in this seminar series, which will be held at NHS Tavistock and Portman Clinic.

Background:

The online world offers an unprecedented opportunity for those bearing the distress of an existing or emergent mental health problem to find support and information conveniently and at the earliest possible stage. No longer does the individual have to wait until they feel their suffering is serious enough to warrant professional attention, but they can explore, privately, even anonymously, those areas of their experience that trouble them, using search engines, or online mental wellbeing support services. Unfortunately, to date, there can only be a limited confidence in what they discover online, and the vulnerable person, braving recognition of a problem is left to distinguish the helpful from the less so.

The NHS is faced with the challenge of understanding both the risks and opportunities associated with the online lives of vulnerable patients and how best to support patients who interact online. Recent cases involving NHS patients use of pro-suicide, and pro-

self harm online forums that promote destructive behaviours, highlighted for staff responsible for the care of these vulnerable patients, senior management and trustees the need for dialogue about how best to manage these types of scenarios.

In one particular incident, a young adult involved in a suicide pact had told nursing staff that she was involved in a self-harm forum online, but there was a sense that the nurses didn't know how to respond, which has repercussions not only for staff and patients but also for the trust.

The purpose of this seminar is as follows:

- To utilise recent case scenarios involving patients use of the Internet in ways that raised concerns about potential and actual harmful outcomes, as a starting point for discussions about the digital lives of vulnerable patients.
- To explore the scope to develop strategies designed to take into account both the positive and sometimes negative aspects of the digital lives of patients, for example:
 - Should details of a patients' digital life inform care plans?
 - Is there a role for NHS staff to educate patients about positive use of the Internet with respect to managing mental health issues and if so, what are the related training and capacity building issues the NHS needs to consider?
 - How can NHS staff and patients identify the online mental wellbeing organisations that provide the highest quality of online support?
 - The soon to be launched *Risk Awareness and Management Programme for Delivering Online Mental Wellbeing Services Online* (RAMP)³⁷ initiative provides online mental wellbeing providers with good practice recommendations with respect to delivering services online. RAMP also provides assurance to those who wish to choose where they find support, and want to know it is of good quality. It is an important step towards reducing the uncertainty involved in seeking valuable and timely support online.

³⁷ RAMP will be launched on November 24 at the 2011 The 2011 Psychological Therapies in the NHS Conference - <http://www.newsavoypartnership.org/2011conference.htm>

- The New Savoy Partnership is supporting the development of a directory of Online Mental Wellbeing Providers. The directory will be an important resource for both NHS staff and patients, by providing a means to easily search for, identify and recommend the most suitable online providers, i.e., RAMP accredited.
- This seminar will also consider what scope exists for information exchange between NHS and technology companies so that a body of understanding about patients' use of the Internet can inform a strategic approach.
- From an operational perspective, this seminar will address the issue of how best to handle risk to life scenarios that involve the Internet. Speakers from law enforcement agencies and Internet Service Providers will discuss the protocols they utilise when responding to risk to life scenarios. The aim is to inform the development of a viable risk to life protocol for use in an NHS context.

This unique invite-only seminar will bring together a range of stakeholders including: mental health providers, policy makers, academics, internet industry and law enforcement.

Attendance at the seminar is free, by invitation-only and on a first-come first-served basis. To register yourself or an appropriate colleague please contact Karen.Green@london.nhs.uk with your name, title, organisation and contact details

Proposed Programme:

9.30am – 10.00am Registration and coffee

10.00am – 10.10am Welcome NHS Tavistock CEO

10.10am – 10.30am Dr Rachel O'Connell – *How are people are using the Internet and mobile devices today and what do research findings tell us about online digital lives?*

Q&A

10.35am - 10.55am David Watts South London and Maudsley NHS Foundation Trust, Associate Director of Patient Safety – *Lessons learned from recent cases involving vulnerable patients that discussed suicide pacts online and engaged in potentially harmful behaviours offline.*

Q&A

11.00am – 11.20am Dr. Richard Graham – *Use of the Internet by vulnerable patients who interact with others online: Implications for suicide contagion, addiction, and the promotion of destructive behaviours.*

Q&A

11.25am – 11.45am Jane Chapman, independent risk adviser to the Tavistock and Portman NHS Trust – *will lead a discussion about conducting clinical assessment of patient's 'digital lives'. The discussion will address legal, policy and regulatory issues.*

11.50am – 12.10am Law enforcement officer – RIPA, MoU and a RIPA risk response protocol

Q&A

12.15pm – 12.30pm Internet industry representative: *Describe the range of safety measures industry has put in place to mitigate online risks to users.*

12.30pm Lunch

2.00pm – 2.20pm Marc Kingsley Chartered Consultant Clinical Psychologist, North East London NHS Foundation Trust – *Outline a proposed protocol that staff can implement when handing risk to life scenarios involving vulnerable patients interacting with others online.*

Q&A

2.25pm – 2.40pm 2 speakers

Rachel O'Connell *Ways in which NHS staff can leverage the positive aspects of the Internet to promote constructive behaviours amongst vulnerable patients, in particular with respect to their Internet use.*

Chris May – *Online Mental Wellbeing Directory*

Q&A

2.45pm – 3.00pm Coffee

3.00- 3.45pm Working groups

3.45pm – 4.00pm Plenary session

4.15pm – 4.30pm Consensus about next steps

4.30pm end

Public Works 27: Link to Marc Kingsley's Blog: 'Psyche'

<https://marckingsley.blogspot.com/>

Public Works 28: Digital lives in psychotherapy

Digital lives in psychotherapy: ‘the other in the room’

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Public Works 29: Presentation at European conference on suicide Estonia 2014

PW 29 15TH EUROPEAN SYMPOSIUM ON SUICIDE North East London



NHS Foundation Trust

**‘The Other in the Room’: Considering suicide risk
by unravelling hidden online influences within the
clinical setting**

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Introduction

Aims:

- a) To raise awareness of the influence of the online world on suicide risk and behaviour
- b) To highlight the hidden world of the vulnerable person going online
- c) To explore relevance to clinical settings

Focus on:

- a) The lone online searchers
- b) Pro-suicide websites and online groups
- c) Cyber-suicide pacts

Exploration of our theory:

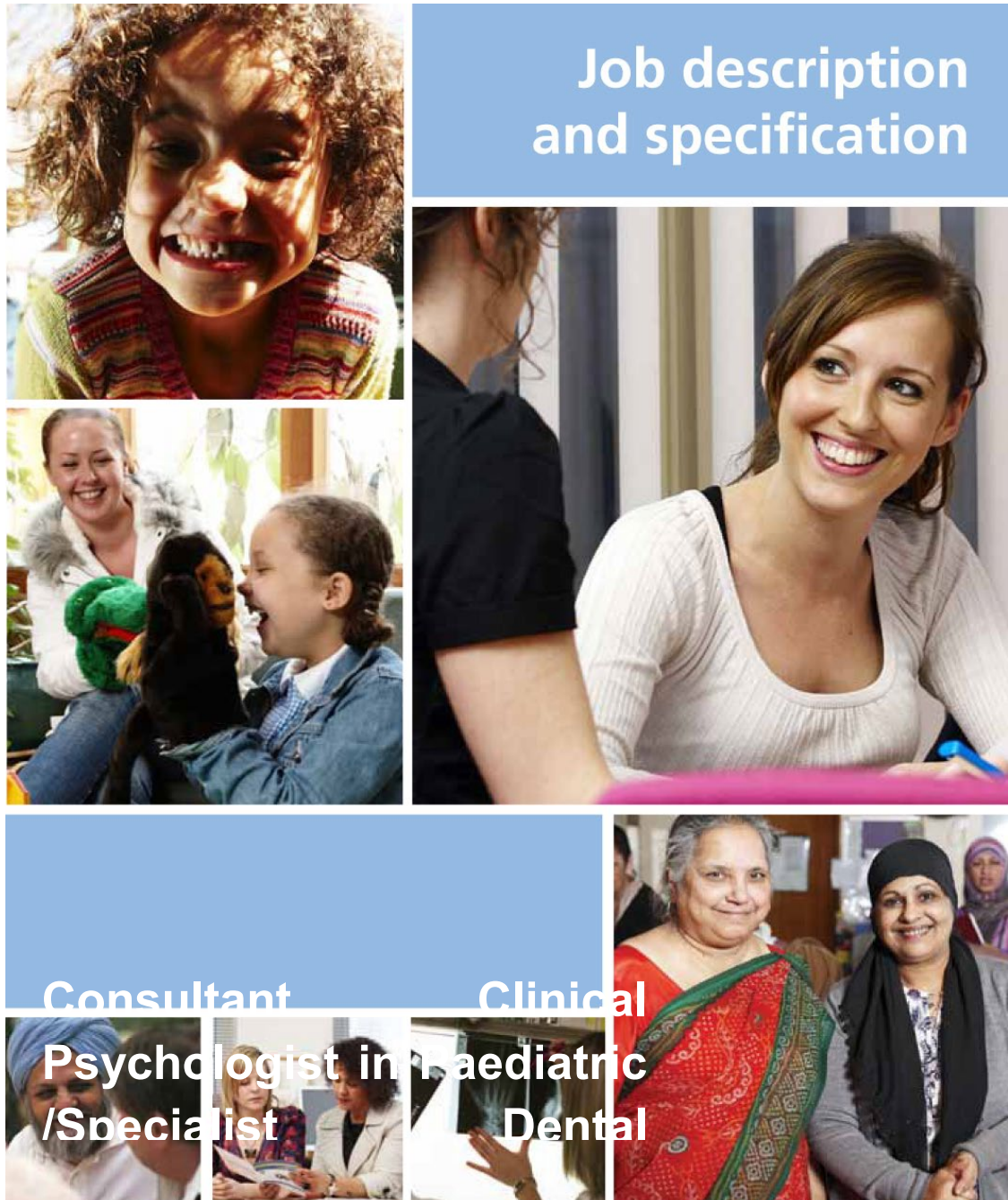
- Introduction of the role of the ambivalent part of the patient, and the
- Constituent suicidal and non-suicidal parts (SP and NSP)
- Triangular relationship between the clinician, patient, and the hidden online world

Interactive cases:

- Illustration of our theory
- Relevance to risk management

Opportunity to reflect

**Public Works 30: Job Description and Specification for Consultant Clinical
Psychologist in Paediatric Dental Service**





JOB DESCRIPTION

JOB TITLE: Consultant Practitioner Psychologist in Dental Psychology (Paediatric and Neuropsychology)

BAND: 8c

RESPONSIBLE TO: Operationally & Professionally:
Strategic and Clinical Lead for
Clinical Health Psychological
Services (NELFT)

KEY RELATIONSHIPS:

Internal	External
Strategic and Clinical Lead for Clinical Health Psychological Services (CHPS) Consultant Clinical Psychologist for Dental Psychology (NELFT/BARTS) NELFT Trust Lead for CHPS Operational & Professional Managers BARTS consultants and clinical leads Psychology Services Locality & Specialist Mental Health Services Access and Brief Intervention Teams Community Learning Disabilities Paediatric /CAMHS Teams	GP Social Services Other Local Authority Departments Employment Agencies NHS & LA Commissioning Bodies Third Sector Organisations Other NHS Trusts

CONTROLS ASSURANCE STATEMENT:

The purpose of this job description is to outline the level of responsibility and accountability of this post. This will ensure that all work undertaken by our staff is clearly identified and carried out under clear lines of accountability.

Aim of the role:

The post holder will be expected to support their teams, department and organisation to achieve the Trust's Values in their day to day work. These are the 5P's:

- Putting people first
- Prioritising quality
- Being progressive, innovative and continually improve
- Being professional and honest
- Promoting what is possible – independence, opportunity and choice

The post holder will achieve this by

1. Supporting the Strategic and Clinical Lead for Clinical Health Psychological Services and the Consultant Clinical Psychologist at the DPS in developing, co-ordinating and ensuring the systematic provision of a highly specialist paediatric psychology service to the Oral and Maxillofacial Trauma and Dental Psychology services. This will involve liaison with psychological and surgical colleagues to develop and implement paediatric patient care pathways, referral criteria and referral guidelines, to ensure the effective and safe running of the service.
2. To lead in the triage and monitoring of paediatric psychology referrals and waiting lists, and to work closely with psychology and non-psychology colleagues to ensure that NELFT/BARTS Trust targets and key performance indicators in paediatric psychology are met. This will include liaising between primary care, secondary care / CAMHS within NELFT, and BARTS, as well as other Trusts and Local Authorities to deliver effective, integrated services.
3. Implementing a range of psychological interventions for individuals, groups, carers and families within and across teams covered by the Royal London Dental Hospital.
4. Providing at least 3 evidence-based psychological treatments for paediatric dental patients presenting with a range of complexity. This will include providing specialist support to clients with an ASD (Autism Spectrum Disorder) diagnosis.

5. Providing neuropsychology assessments when required for complex cases across the lifespan, with specialist expertise in paediatric neuropsychology.
6. Providing specialist and comprehensive Autism Spectrum Disorder (ASD) Assessments for dental patients when required. A comprehensive evaluation may include assessment of a client's cognitive level, language level, and adaptive behaviour (age-appropriate daily living skills).
7. To provide paediatric and ASD consultation, liaison and psychology supervision to dental and oral medicine specialists, regarding the psychological treatment and management of issues related to oral and dental specialities.
8. Developing care pathways, facilitating cross-referrals and access for paediatric and ASD clients to dental psychology services at RLH, promoting joint working and training in the dental psychology service.
9. Ensuring appropriate supervision and management arrangements for paediatric psychology staff within the DPS CHPS Specialty.
10. Taking responsibility for R&D activities, including service audits and a range of clinical research activities for paediatric and ADL cases.
11. Interpreting national and local guidelines for best practice and initiating action as appropriate.
12. Exercising responsibility for the systematic governance of practice within the paediatric specialty including clear systems for effective recruitment, professional appraisal and the identification of CPD needs across the services.
13. Representing the psychology/psychological services in wider forums as directed by the Strategic and Clinical Lead for CHPS and Trust Lead for CHPS.

Job Role Summary:

This exciting consultant psychologist role for paediatric, ASD and complex neuropsychology assessments has been developed out of the newly formed Dental Psychology Service (NELFT/BARTS). BARTS Health dental service is a leading international specialist in dental and oral health care, offering dental care to patients from across London and surrounding counties. In addition to emergency dental care, treatment is provided for a diverse range of oral health issues, both routine and specialist. A key role is the care of patients with

multiple injuries to the neck, face, mouth and head regions, as well as patients unable to be treated effectively in community settings.

The role involves responsibility for providing clinical supervision to the 8B paediatric psychologist, as well as taking on a small caseload of complex paediatric/adult therapy and neuropsychology assessments and work with ASD autism spectrum patients (across the lifespan) referred to the Dental Psychology Service (NELFT/BARTS). There will be a need to have a solid understanding of cognitive deficits and organic presentations in paediatric referrals and undertaking neuropsychology assessments across the lifespan.

Due to the nature of the population referred to the dental hospital, the successful candidate will need to show skill and take overall responsibility in managing paediatric safeguarding concerns. A robust understanding and capacity to manage clinical risk and crisis interventions is also a vital component of this post, due to the variation of complexity of patients, carers and families presenting to the service.

The successful applicant will work closely with the newly appointed 8C Consultant Clinical Psychologist for DPS and the Strategic and Clinical Lead for NELFT to meet the Key Performance Indicators for the paediatric and neuropsychology pathway of the service.

Key Responsibilities:

1. To provide expertise in a highly specialist clinical and research area and to deliver high quality evidence-based psychological assessment, formulation and intervention for paediatric as well as ASD clients assessed and treated under the Oral and Maxillofacial Trauma Clinic, and Dental Hospital, Royal London Hospital.
2. Specifically the paediatric psychology service aims to support patients and their families/carers that experience a range of difficulties, including:
 - Children and adolescents with amelogenesis imperfecta and other unaesthetic disfiguring disorders of enamel and dentine
 - Children and adolescents with dental anxiety/ dental phobia, who do not engage with dental procedures.
 - Children and adolescents who have facial injuries related to a traumatic event, where there may be a need for family therapy approach.
 - Children and adolescents with an eating disorder that impacts on their dental engagement and hygiene.
 - Children and adolescents accessing Special Care Dentistry – Learning disabilities, ASD, traumatic brain injury and severe mental health difficulties.

3. To work closely with the Consultant Clinical Psychologist in Adult Dental Psychology in ensuring a seamless and effective transition service between paediatrics and adult services, and supporting similar models of psychological approach and treatment in both adult and paediatric psychology services.
4. To provide managerial and clinical supervision to the 8B paediatric clinical psychologist and to support the 8B paediatric psychologist's integration into the DPS.
5. To provide specialist clinical supervision and advice on any ASD related psychology referrals across the DPS.
6. To ensure, along with the band 8b paediatric psychologist, that the workload of the paediatric dental psychology team is effectively managed and that staff resources are used effectively.
7. To provide expertise in managing complex paediatric and ASD triage and referral responsibilities across several CAMHS services, as patients present from a wide catchment area.
8. To work closely with the 8C consultant psychologist to report on activity and performance of the paediatric dental psychological therapies team to the strategic and clinical lead for CHPS, and ensure that systems are developed and followed for monitoring and data reporting as required.
9. To carry a small caseload of neuropsychology assessments across the lifespan, with specific focus on providing expert consultation on children, adolescents and young people with cognitive deficits and Autism-related presentations.
10. To ensure effective safeguarding risk management at team level by incident reporting, assessing and controlling risk and ensuring residual risks are added to the Trust register
11. To deputise when required for Head(s) of Psychology Services in their absence.
12. To have organisational knowledge relating to Trust protocols and procedures and to ensure adherence to them.
13. To ensure systems for the accurate recording of information required by the NELFT and BARTS Trusts for clinical, reporting and audit purposes.

1. To work closely with the Strategic and Clinical Lead for CHPS and Consultant Clinical Psychologist in the development and co-ordination of a high quality, responsive and accessible dental paediatric and ASD-related psychology service (DPS) at the RLH for clients, carers and families. This will involve liaison with psychological and surgical colleagues to develop and implement patient care pathways, referral criteria and referral guidelines, to ensure the effective and safe running of the service.
2. To be responsible for setting the professional standards for the paediatric dental psychology service and for monitoring adherence to these standards.
3. To work closely with the Strategic and Clinical Lead for CHPS and the Consultant Clinical Psychologist in dental psychology to identify paediatric and ASD related service priorities and initiating developments in the paediatric dental psychology service to ensure a high quality service to clients and their families and carers.
4. To be responsible for planning and ensuring that the paediatric dental psychology service delivers highly responsive and consistent psychological assessments, individual and group treatment programmes. This will include skill in managing waiting lists and treatment priority.
5. To work closely with the Consultant Clinical Psychologist in DPS to ensure that the paediatric area of the Oral Trauma/Dental Psychology service meet agreed organisational targets and KPIs, ensuring effective monitoring and reporting of team activity and outcomes.
6. To promote integrated health professional working internally and externally.
7. To support a positive and 'supportive' team culture by taking responsibility for dealing effectively with potential conflict and differences of professional and personal opinions.
8. To show skill in managing the NELFT/BARTS interconnected systems and providing leadership skills in supporting the two trusts to work together with the development of the DPS.
9. To be responsible and work closely with the 8B paediatric psychologist for monitoring outcomes of paediatric dental psychology specialist assessments, paediatric evidence-based therapy, psychoeducation, cognitive assessments and other treatments within the area of

responsibility and for producing service summaries and reports as requested.

Clinical Skills

1. To provide highly specialist paediatric and ASD assessments and reports when required.
2. These assessments should be based upon the appropriate use, interpretation and integration of complex data from a variety of sources including self-report measures, rating scales, direct and indirect structured observations and semi-structured interviews with patients , family members and others involved in the client's care.
3. To be responsible for implementing a range of psychological inputs and interventions for paediatric clients, groups, carers and families within and across the DPS. This will include the provision of specialist psychological treatment of dental patients presenting with ASD spectrum conditions.
4. To implement a range of NICE endorsed psychological interventions both therapeutic and psycho-educational, for individuals, families and groups, using evidence-based interventions and best practice guidelines. In particular: To formulate and implement plans for the formal psychological treatment and / or management of the cognitive, emotional, behavioural, physical and psychological health of children and adolescents with psychological distress in dental settings, utilising a bio-psycho-social model, based upon an appropriate conceptual framework of the patient's difficulties and presentation.

This will include providing

- cognitive-behavioural interventions for of persistent-gagging and dental anxiety/phobia, and presentations related to paediatric clinic referrals.
- individual and or group support to children and adolescents struggling with psychological distress related to facial difference/ disfigurement of the face.
- evidence-based interventions for paediatric trauma, such as EMDR and/or CBT.
- a family therapy/systemic approach when required.
- expertise, familiarity and comfort in working with a range of psychological presentations, as well as flexibility in adapting clinical practice to suit the service and patient requirements.

5. To show skill in selecting the appropriate treatment protocol and show expert clinical judgement for highly complex paediatric and ASD referrals to DPS.
6. To show highly skilled recognition and management of adult and child safeguarding concerns, immediate and urgent liaison with other mental health services/ CAMHS related to risk, forensic concerns in lines with NELFT risk assessment and management and safeguarding policies.
7. To provide specialist assessment and therapy to non-English speaking patients and Refugees, with the use of an interpreter when necessary, communicating with a high degree of clarity and sensitivity to cultural and linguistic differences.
8. To conduct ongoing assessments of need and risk in relation to all clients for whom the post holder is responsible.
9. To be guided by the policies of NELFT and BARTS and relevant professional bodies, but to use own judgment of such policies to interpret them in a manner which is appropriate for the clients or families.
10. To provide expert consultation about the psychological care of the client group to staff and to other agencies such as partner organisations.
11. To maintain the highest standard of clinical record keeping, including maintaining clients' clinical files, report writing and electronic data entry, in accordance with professional codes of practice of the HCPC, BPS and Trust policies and procedures.

Management & Supervision

1. To be responsible for the line management and clinical supervision of the 8B paediatric dental psychologist.
2. To be responsible for planning and ensuring that the paediatric dental psychology service delivers highly responsive and consistent psychological assessments, individual and group treatment programmes. This will include skill in managing waiting lists and treatment priorities.
3. In conjunction with the Strategic and Clinical Lead of CHPS Services to be responsible for configuring, planning and allocating staff resources for paediatric psychology according to DPS service needs and any delivery plan.

4. In conjunction with the Strategic and Clinical Lead of CHPS Services, and Consultant Clinical Psychologist in DPS, to support the recruitment and induction of staff within paediatric Dental Psychology Service.
5. To obtain monthly managerial supervision from the Strategic and Clinical Lead for CHPS or Trust Lead for CHPS at NELFT.
6. To have monthly clinical supervision, which will cover specialist areas such as paediatric CBT, ASD presentations and neuropsychology.
7. To obtain specialist neuropsychology clinical supervision when required to manage neuropsychology and cognitive assessments/management.
8. To show highly developed skill and capability in working with a broad range of professionals and teams, from several areas of BARTS and North East and East London, This would require that the post holder shows expertise in fostering, developing and maintaining relationships with a broad range of staff, patients and carers from a diverse group of acute, community and mental health services, in accordance with NELFT policies and Professional Codes of Practice.
9. To show skill in managing staff differences, conflict and concerns and to manage these appropriately.
10. To exercise responsibility for the appropriate acquisition and safe use of specialist psychological test materials and equipment within the service.
11. To ensure that all paediatric psychology staff adhere to mandatory training requirements.
12. To provide direct specialist clinical supervision in paediatric dental psychology and broader CHPS teams, across a range of paediatric and ASD dental and oral trauma specialities. To ensure appropriate systems for the supervision of, qualified and unqualified psychological staff within the service.
13. To provide specialist clinical placements for trainee/students, ensuring that they acquire the necessary clinical and research competencies and experience.
14. To attend and participate in NELFT clinical health psychological services (CHPS) team meetings, special interest groups and events.

7. To be computer literate and encourage implementation of the Trust's IM&T Strategy.
8. To ensure accurate recording of actions, and updating patient's records, maintaining confidentiality at all times.
9. To oversee and ensure that planning and administration relating to day to day running of caseloads is in place throughout the service.

Communication

9. To have a wide range of knowledge in approaches to communicating and managing patient care.
10. To be able to effectively communicate with colleagues, peers, senior managers and other strategic/clinical leads within the NELFT and BARTS Trusts.
11. To lead in the review and development of clinical policies and identify improvements to service provision.
12. To communicate skilfully, highly complex and sensitive information, to people referred to the Dental Psychology service, their carers, families, and other professionals, taking account of sensory and cultural challenges to communication.
13. To ensure accurate recording of actions, and updating patient's records, maintaining confidentiality at all times in both NELFT and BARTS settings.
14. To ensure that information systems are monitored and information carefully shared between NELFT/BARTS and community mental health and specialist psychological services across several areas of London/SE England (according to the Information Governance policies of NELFT/BARTS).
15. To take responsibility for ensuring caseloads are regularly managed and updated.
16. To oversee and support psychological team members in maintaining their clinical caseloads and professional development

1. To provide teaching, consultation and supervision in specific assessment and treatment modalities relevant to paediatric and ASD Dental Psychology / Oral Trauma to other mental health professionals to help improve clients' functioning.
2. To be responsible for specialist paediatric and ASD consultation and training to other professionals working in various multidisciplinary teams across CHPS and broader NELFT/ BARTS Trusts.
3. To provide neuropsychology consultation and training for paediatric and ASD cases when required.
4. To develop and ensure the delivery of specialist training to members of the wider network (both within local CHPS/ NELFT structures and across a variety of different agencies).
5. To provide training, support and consultation when required to non-psychology colleagues.
6. To attend and contribute to NELFT Clinical Health Psychological Services (CHPS) group meetings.
7. To gain additional specialist experience relevant to children with psychological distress in relation to Oral Trauma /Dental Psychology and to keep up to date and abreast of, evidence based practice and CPD, as agreed with the Strategic and Clinical Lead for Clinical Health Psychological Services.
8. To attend training opportunities, conferences and specialist interest groups relevant to work with people with pain and related conditions maintaining up to date psychological knowledge and skills.
9. To join and attend relevant professional and clinically relevant meetings, such as the BPS Faculty of Clinical Health Psychology specialist interest groups
10. To undertake where agreed and appropriate formal consultation to staff from outside agencies.
11. To provide joint consultations to staff and clients / families in situations requiring additional input

Specific Tasks directly related to the post:

Audit & Research

1. To take the lead, as a senior clinician, in planning and implementing systems for the evaluation and monitoring of paediatric and ASD assessment and treatment pathways within the Dental Psychology Service. This will include meetings with the Strategic and Clinical Lead of CHPS, and the Clinical Lead for Dentistry at BARTS to look at ways to develop psychological research, audit and training into universities, such as QMUL.
2. To utilise theory, evidence-based literature and research to support evidence based practice among paediatric psychological therapy staff and across the service as a whole.
3. To undertake appropriate clinical research and provide research advice to other staff undertaking research or audit within the service.
4. To develop links with Queen Mary's University London (QMUL) in order to support the service in undertaking research in the field of dental psychology and paediatrics and contribute to the University's academic programme regarding psychological aspects of oral trauma and dental psychology.
5. To support and advise the team on the design and analysis of audit and research projects.
6. To undertake audit, collect appropriate service data and complete annual and bi-annual service reports, as part of evaluating the current provision of psychological services in the Dental Psychology service.
7. To initiate and implement project management, quality improvement projects, audit and service evaluation, with colleagues within and across the service.
8. To maintain and provide numerical and statistical information as is required locally and nationally.
9. To monitor adherence of staff to local audit and clinical governance standards.

Service and Strategic Development

1. To work with the Strategic and Clinical Lead of CHPS in developing further business cases and service structure reviews of the paediatric dental service.

2. To represent dental psychological services, when required, at relevant strategic development meetings to promote the development of psychological services within the remit of Dental Psychology/CHPS.
3. To contribute to the development, evaluation and monitoring of psychological responses to the Dental /Oral Trauma psychology service through the deployment of professional skills in research, service evaluation and audit.
4. To include, consult and engage with service users and carers in planning and developing psychology services to people cared for within the Dental / Oral Trauma psychology service.
5. To present the evidence-base for the added value of psychological services within services served by Dental Psychology.
6. To show skill in considering broader service related aims and requirements for the safe and effective management of a service developed in conjunction with two Trusts: NELFT and BARTS

Continuing Professional Development

1. To maintain relevant professional HCPC and specialist therapy registrations (such as BABCP if relevant).
2. To participate in clinical supervision in accordance with Trust policies and the requirements of the appropriate regulatory / professional body. This will include specialist supervision in trauma-related presentations such as PTSD, complex safeguarding and high risk cases.
3. To be accountable for own professional action and to seek advice and supervision from the Strategic and Clinical Lead for CHPS / Trust Lead for CHPS where needed.
4. To maintain an up to date knowledge of legislation, policies and issues relating to both the specific client group and mental health issues in general.
5. To identify own training needs and seek to find ways to meet these.
6. To share learning outcomes with colleagues in order to enhance CPD generally within the team

Other Responsibilities

1. To comply with both NELFT and BARTS Trust and local service policies and procedures.
2. To disseminate changes to relevant policies and procedures, guidelines and professional standards to staff for whom management/ supervisory responsibility is held.
3. To keep abreast of new working practices, using training opportunities to increase knowledge and skills.
4. To remain familiar with relevant professional strategy policies /guidelines and practice standards.
5. To work within the principles and guidance of the Children Act, Mental Health Act, Criminal Justice Act and current multi-disciplinary policy and guidance.
6. To ensure individual conformity to the provisions of the Health & Safety at Work Act (1974).
7. To exercise personal responsibility for ensuring all therapeutic equipment etc. is used in a safe and responsible manner so as to avoid damage/ injury.
8. Any other duties, which may arise under the direction of the Strategic and Clinical Lead for CHPS and Trust Lead for CHPS/ICD lead for B&D locality.

It is recognised that not all aspects of this job can be fulfilled in a 0.2 wte post. It will be for the post holder, in conjunction with the Strategic and Clinical Lead for Clinical Health Psychology, to prioritise tasks as and when required. More aspects of the job can be fulfilled as the number of sessions available increases.

Additional Information

Health & Safety

Employees must be aware of the responsibilities placed upon them under the Health & Safety at Work Act (1974) and subsequently published regulations to ensure that the Trust's Health and Safety policies and procedures are complied with to maintain a safe working environment for patients, visitors and employees.

Infection Control

Each staff member has a duty to take personal responsibility for the prevention and control of infection, in accordance with Trust Infection Prevention and Control Policies, which reflect the statutory requirements of the Health Act 2006 – Code of Practice for the Prevention and Control of Healthcare Associated Infection. They must attend mandatory training in Infection Control and be compliant with all measures required by the Trust to reduce HCAs.

Risk Management

You will be responsible for adopting the Risk Management Culture and ensuring that you identify and assess all risks to your systems, processes and environment and report such risks for inclusion within the Trust Risk Register. You will also attend mandatory and statutory training, report all incidents/accidents including near misses and report unsafe occurrences as laid down within the Trust Incidents

Safeguarding Children and vulnerable adults

North East London NHS Foundation Trust (NELFT) is committed to safeguarding and promoting the welfare of children and adults and to protecting them from the risks of harm. The Trust recognises its responsibility to ensure that safe working conditions and systems are in place for staff working with children, adults and families in their care. Staff are required to comply with Trust policies on Safeguarding.

Standards of Business Conduct & Conflict of Interest

The NHS Code of Conduct and Standards of Business conduct for NHS Staff require all employees to declare all situations where you or a close relative or associate has a controlling interests in a business [such as a private company, public organisation or other NHS or voluntary organisation] or in any activity which may compete for any NHS contracts to supply goods or services to the Trust. All such interests must be declared in the Trust's register of interests either on appointment or when such interests are gained.

As an employee you are required to make yourself aware of and adhere to the Trust's governance policies, such as Standing Orders and Standing Financial Instructions.

Sustainability

All staff has a responsibility for delivering high quality healthcare in a low carbon environment, where energy is used wisely and not wasted. It is the responsibility of all staff to minimise the Trust's environmental impact by recycling where possible, switching off lights, computers, monitors and equipment when not in use, minimising water usage and reporting faults promptly.

Smoking Policy

It is the Trust's policy to promote health. Smoking, therefore, is actively discouraged. It is illegal within the Trust buildings and vehicles.

Codes of Conduct

North East London NHS Foundation Trust (NELFT) requires the highest standards of personal and professional conduct from all of its employees. All employees must comply with the Code of Professional Conduct appropriate to their professional governing body.

As an NHS employee, you are required to observe the following principles:

- Make the care and safety of patients my first concern and act to protect them from risk;
- Respect the public, patients, relatives, carers, NHS staff and partners in other agencies;
- Be honest and act with integrity;
- Accept responsibility for my own work and the proper performance of the people I manage;
- Show my commitment to working as a team member of working with all my colleagues in the NHS and the wider community;
- Take responsibility for my own and continuous learning and development

Data Protection

Personal data is protected under the Data Protection Act (1999) and the post holder will ensure that it is securely held and that the requirements of the Act are followed. It is the responsibility of all staff whose jobs requires them to record information in Trust Computer systems (e. g RIO and ESR) to ensure that the data entered into these systems is of high data quality and that

information is recorded correctly and in a timely manner. Failure to adhere to this requirement could be considered a disciplinary matter

Information Security and Confidentiality

All employees are required to observe the strictest confidence with regard to any patient/client information that they may have access to, or accidentally gain knowledge of, in the course of their duties.

All employees are required to observe the strictest confidence regarding any information relating to the work of the Trust and its employees.

You are required not to disclose any confidential information either during or after your employment with the Trust, other than in accordance with the relevant professional codes.

All person identifiable information must be held in the strictest confidence and should be disclosed only to authorised people in accordance with NHS Confidentiality Guidelines [Caldicott] and the Data Protection Act 1998 unless explicit written consent has been given by the person identified, or where information sharing protocols exist.

Failure to comply with these regulations whilst in the employment of the Trust could result in action being taken under the Trust Disciplinary Policy and Procedure.

Equality and Diversity

North East London NHS Foundation Trust (NELFT) is committed to the implementation of the Equality and Diversity at Workplace policy which ensures equal opportunities for all. NELFT is also committed to embracing diversity and eliminating discrimination in both its role as an employer and as a provider of services. It aims to create a culture that respects and values each other's differences, promotes dignity, equality and diversity and encourages individuals to develop and maximise their potential. The Trust will ensure that it provides equal and fairness for all, and not to discriminate on the grounds of gender, marital status, race/ethnicity, disability, sexual orientation, religion, transgender or gender reassignment status, age, marriage or civil partnership/same sex marriage, and because of you being pregnant or being on maternity/paternity leave. All staff are required to observe this policy in their behaviour to employees and patients/service users.

Key Performance Indicators (KPI)

Each individual and service will be set KPIs and achievement against these will be regularly reviewed. Performance against individual and service KPI's will be routinely monitored by your manager.

Review of this Job Description

This job description is intended as an outline of the general areas of activity and will be amended in the light of the changing needs of the organisation. To be reviewed in conjunction with the post holder.

Other Duties

There may be a requirement to undertake other duties as may reasonably be required to support the Trust. These may be based at other Trust managed locations.

Person Specification

	Essential	Desirable	Measurement
Demonstration of Trust Values			
Putting people first	✓		Application Form Interview Assessment
Prioritising quality	✓		Application Form Interview Assessment
Being progressive, innovative and continually improve	✓		Application Form Interview Assessment
Being professional and honest	✓		Application Form Interview Assessment
Promoting what is possible, independence, opportunity and choice	✓		Application Form Interview Assessment
Qualifications			
NVQ level 2 or equivalent standard of literacy and numeracy	✓		Application Form Assessment
Post qualification training in developmental disorders/ASD assessments	✓		
Qualified Clinical Psychologist (BPS recognised) to Doctoral level or equivalent for those qualifying before 1996	✓		Application Form
Registration with HCPC	✓		
Experience			
At least 6 years recent post – qualification experience in a paediatric clinical health psychology post	✓		Application Form Interview
Post- qualification experience of working with clients with ASD and developmental disorders across the life span	✓		Application Form Interview
Experience in undertaking paediatric and adult	✓		Application Form Interview

Level 2 supervision groups for attenders

neuropsychology assessments			
Skill in managing forensic and dual diagnosis presentations (drugs and alcohol).		✓	Application Form Interview
Skill in working with learning disabilities, dementia and behaviour deemed challenging to teams		✓	Application Form Interview
Skill in working with trauma and PTSD presentations		✓	Application Form Interview
Skill in working with significant mental health difficulties	✓		Application Form Interview
Experience of supervising qualified, students / trainee psychologists	✓		Application Form Interview
Experience of managing staff / services and/or experience of holding responsibility for developing new areas of work	✓		Application Form Interview
Experience of co-working with colleagues from a variety of different disciplines and trainings	✓		Application Form Interview
Experience of post-graduate teaching, training and/or experience of developing and delivering consultation / training to a variety of audiences		✓	Application Form Interview
Experience of representing the profession in local policy fora		✓	Application Form Interview
Experience of working with individuals and families in an emotionally demanding environment.	✓		Application Form Interview
Knowledge			
A highly developed awareness of a wide range of paediatric and ASD /developmental psychological	✓		Application Form Interview

Level 2 supervision groups for attenders

interventions and theories and their practical application			
Understanding of the framework of government and national professional policy relating to conditions falling under the Oral trauma and dental services in the UK	✓		Application Form Interview
Up-to-date knowledge of strategic frameworks and relevant legislation for children and adults	✓		Application Form Interview
Knowledge, understanding and experience of working with families from diverse ethnic, economic and cultural backgrounds, including refugees.	✓		Application Form Interview
Knowledge and experience with working with Child Protection issues, safeguarding concerns and CAMHS level mental health problems	✓		Application Form Interview
Up-to-date knowledge of relevant legislation and ethical issues, together with the ability to communicate their implications for clinical practice		✓	Application Form Interview
Skills			
Basic awareness of IT and IT skills	✓		Application Form Interview
Ability to communicate relevant theoretical concepts and techniques to a variety of audiences across a number of different disciplines / service areas	✓		Application Form Interview
Skills in professional management and clinical supervision of psychological therapists	✓		Application Form Interview
Excellent written and verbal communication skills, including the preparation of highly complex clinical	✓		Application Form Interview

reports and assessments for paediatric ASD, and neuropsychology cases			
The ability to communicate complex, sensitive and potentially challenging information to clients, families and other professionals and the ability to communicate complex and specialist information in everyday language	✓		Application Form Interview
Other			
A passion and interest for developing services for children and their families within a clinical health psychology framework	✓		Application Form Interview
To be aware and demonstrate the Trust Values	✓		Application Form Interview
To be able to travel efficiently throughout the area	✓		Application Form Interview
An ability to work autonomously, setting appropriate goals, in accordance with professional ethics guidelines and NELFT and BARTS Trust policies.	✓		Application Form Interview
Ability to lead and motivate	✓		Application Form Interview
Ability to identify, and employ, as appropriate, clinical governance mechanisms for the support and maintenance of clinical practice in service	✓		Application Form Interview
Record of having published in either peer reviewed or academic or professional journals and/or books		✓	Application Form Interview

Public Works 31: Trainee Placement Letter

OUTLINE OF PLACEMENT FOR NORTH THAMES: CLINICAL PSYCHOLOGY TRAINEES:

The DOTS service welcomes the introduction of placement opportunities for second and third year Doctorate in Clinical Psychology trainees in the North Thames region. The following placements will be available for 2020-2021:

1. Paediatric Clinical Health Psychology (focus on children and adolescents with appearance related distress linked to their teeth and or face)

This could be a core or specialist child placement for 2nd or 3rd years. There may be 1 or 2 placements available as there are 3 psychologists working in the service. There are opportunities for some neurodevelopmental work. The main focus will be outpatient family work.

2. Oral Trauma service- specialist placement with trauma victims to face jaw and mouth.

This will be a specialist 3rd year placement within a multi-centre specialist trauma unit. A lot of scope to see patients with complex mental health and social difficulties that leave them open to risk of violence, as well as people randomly attacked or involved in motor vehicle accidents. It is an excellent opportunity to get trauma specific experience.

3. Oral Medicine clinical health placement with a focus on pain management, dental anxiety management and specialist dentistry (dementia, LD, head injury patients).

This is a 2nd or 3rd year health placement with opportunities to work with older adults and those with learning disabilities.

4. Couples therapy/psychosexual therapy speciality for patients referred from dentistry.

The supervisor is BABCP accredited. There are opportunities for meeting health psychology competencies and training in behavioural couples therapy (BCT), a NICE endorsed treatment modality for couples.

Please contact Marc Kingsley, Clinical and Strategic Lead for Clinical Health Psychology for further details on 07967380685 or at marc.kingsley@nelft.nhs.uk

Public Works 32: Staff Satisfaction Results OPS 2020

(CHPS)

Orthognathic Psychology Service (OPS)
Clinical Health Psychological Services

Our aim: To support patients in their orthognathic journey and to improve surgical and psychosocial outcomes.

A Staff Evaluation of the Orthognathics Psychology Service for BARTS/NELFT

March 2020:

Marc Kingsley, Charlotte Priestley and Saba Hassan

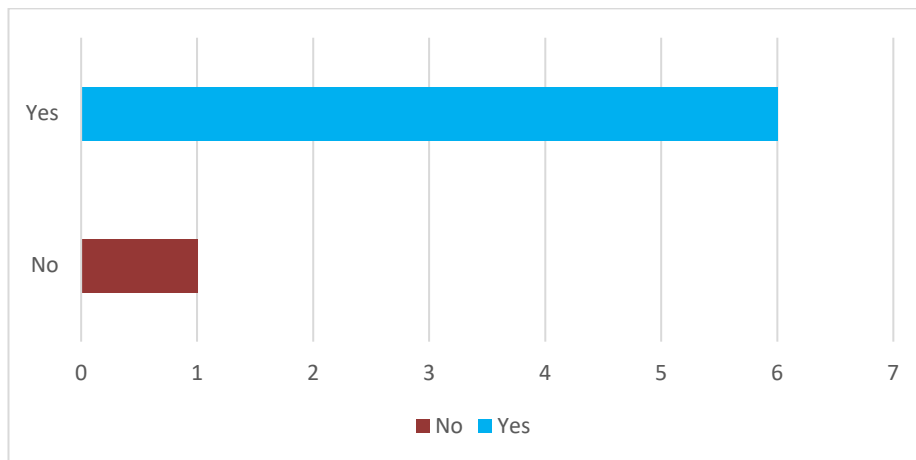
Survey was sent via email in March to members of the Orthognathic service.

Survey monkey was used to build the questionnaire.

Number of responses for each option were collected and inputted into a graph using Microsoft Excel.

Have you referred clients to the Orthognathic Psychology Service?

Level 2 supervision groups for attenders



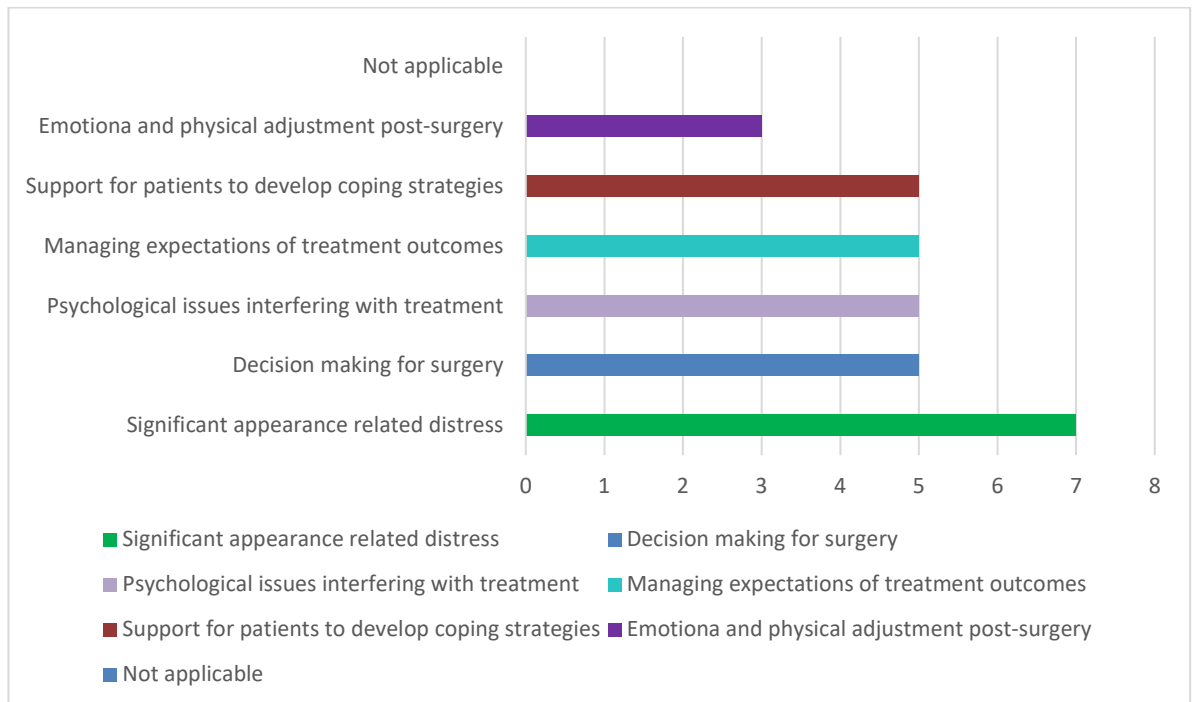
If no, please tick why:

Did not know the referral process- 1

Not applicable- 6

For what reasons do you refer clients to our service?

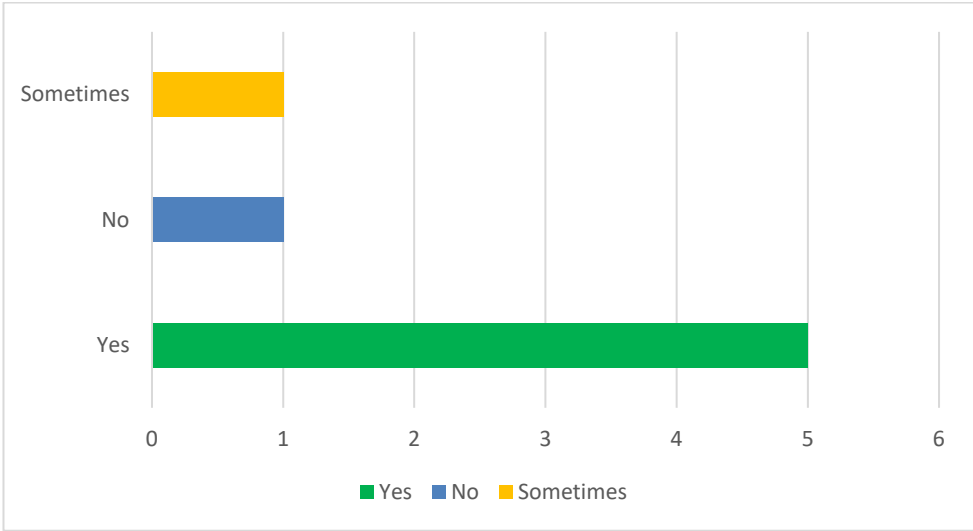
Level 2 supervision groups for attenders



Staff emotional wellbeing

Do you think your own emotional well-being at work can be affected by the nature of your orthognathic caseload?

Level 2 supervision groups for attenders



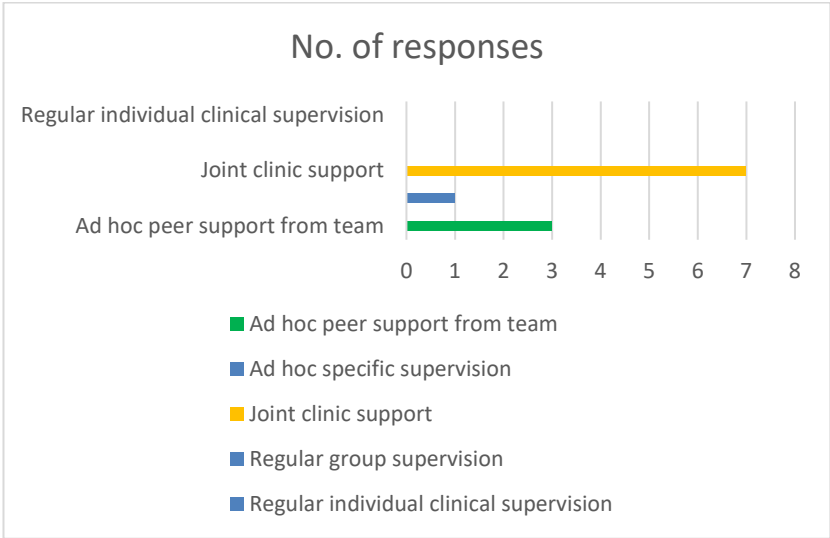
Comments:

If you feel like you have a large workload or difficult cases it can affect how you feel about coming to work and your own wellbeing.

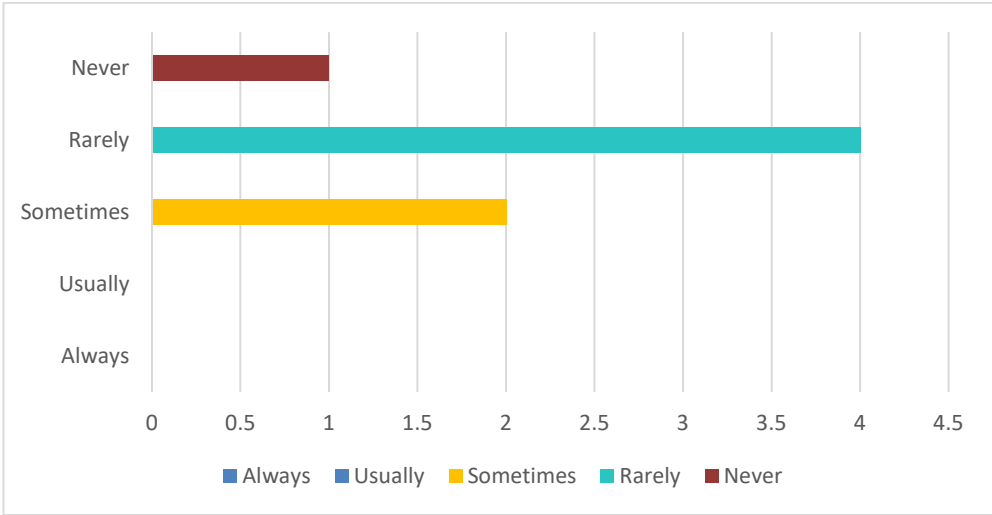
Difficult cases are hard especially when patient expectations of a service is difficult to meet in certain circumstances.

What support do you currently get with managing your patients emotional difficulties?

Level 2 supervision groups for attenders



How often are you able to find emotional support from your workplace?

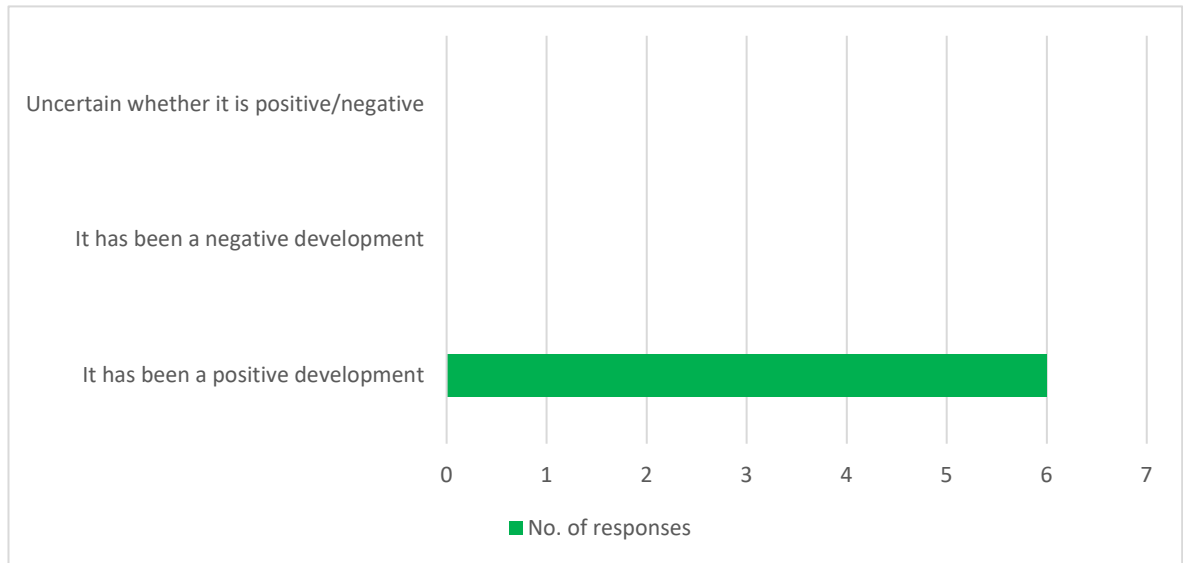


Comments:

- Not in the work culture.

Staff satisfaction

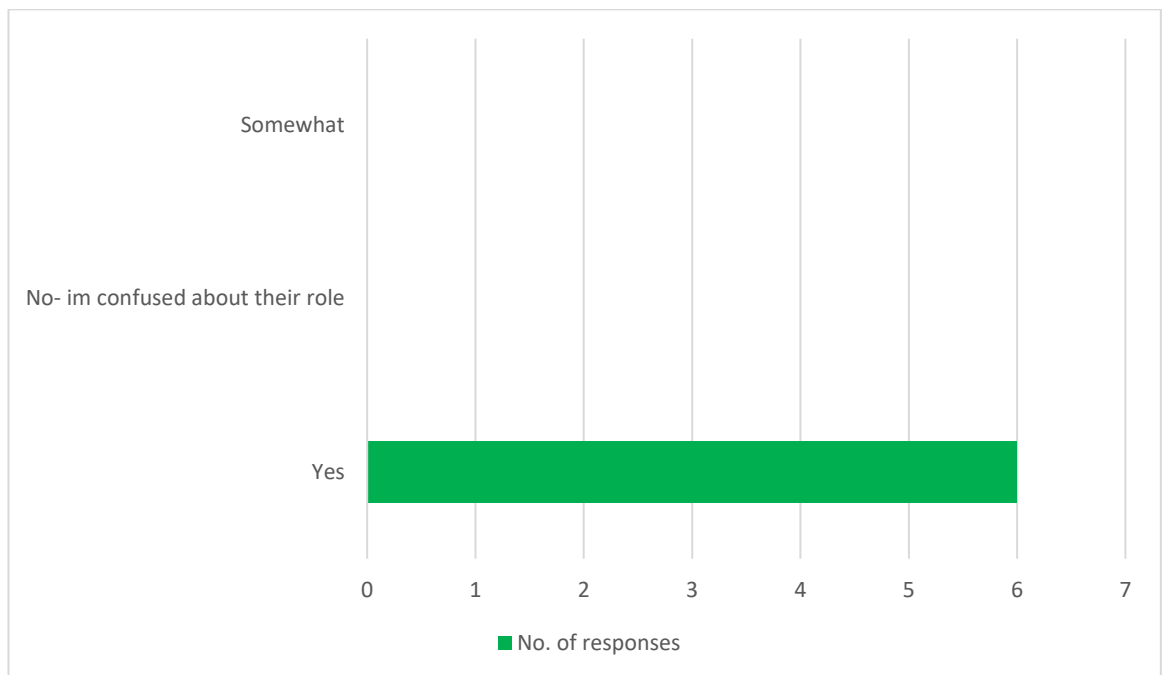
What is your opinion of the incorporation of the clinical psychology service into the broader Orthognathics service at RLH/Whipps X?



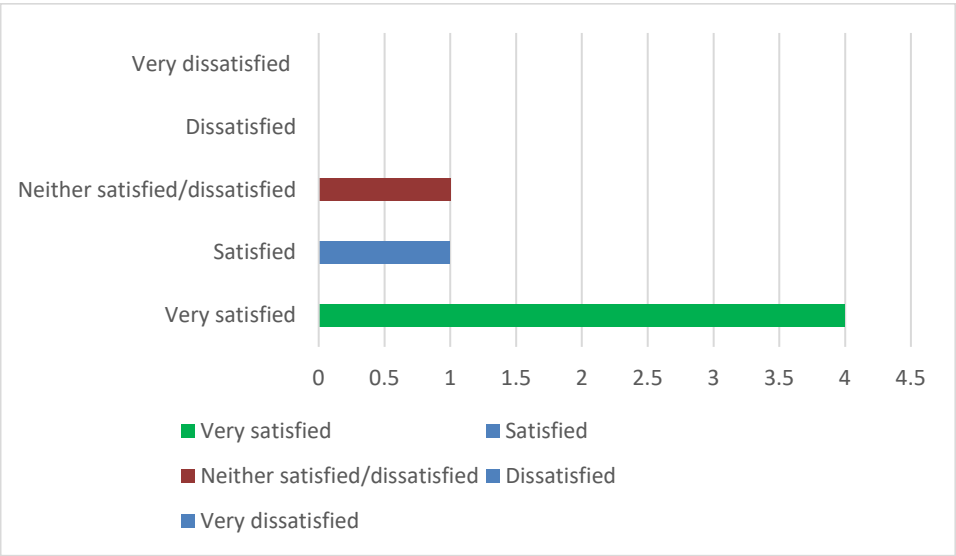
Comments:

It has been a very positive development providing comprehensive care to all of our patients needs, both physical and mental, whilst they are assessed and undergoing complex treatment.

I understand the Psychologists role in the MDT and what they provide for patients in the Orthognathics Service?



How satisfied are you with the straightforwardness of the Psychology referral process?

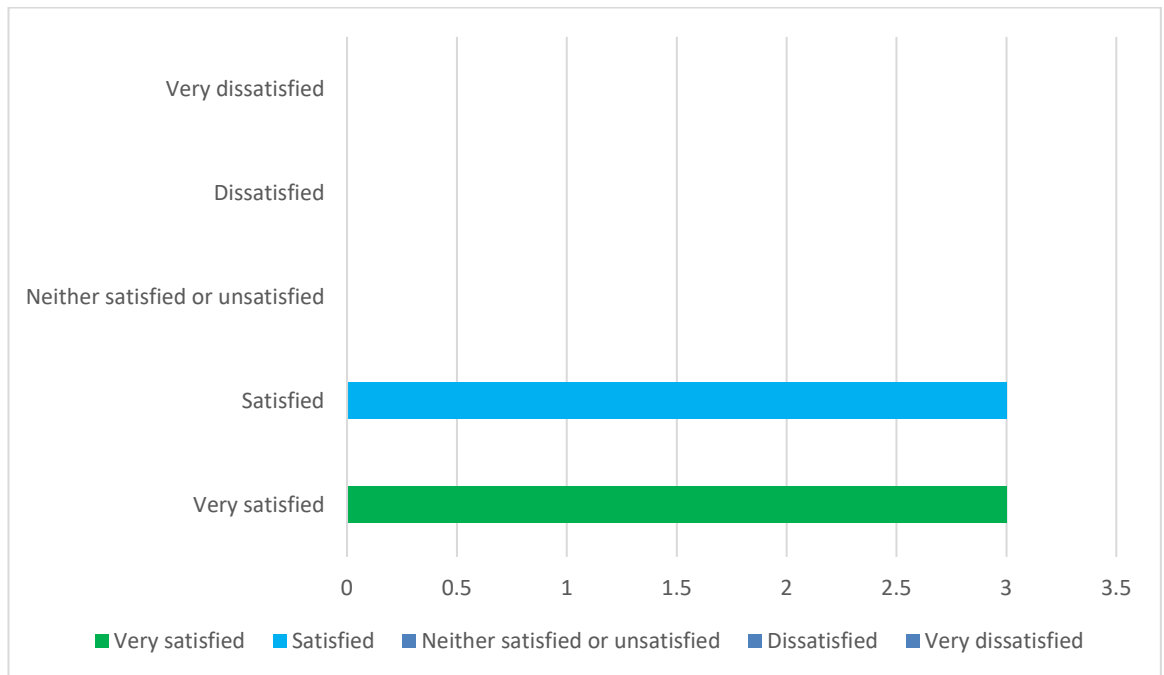


Comments:

- Unsure of the process of referral

How satisfied are you with the responsiveness of our service to your needs?

Level 2 supervision groups for attenders

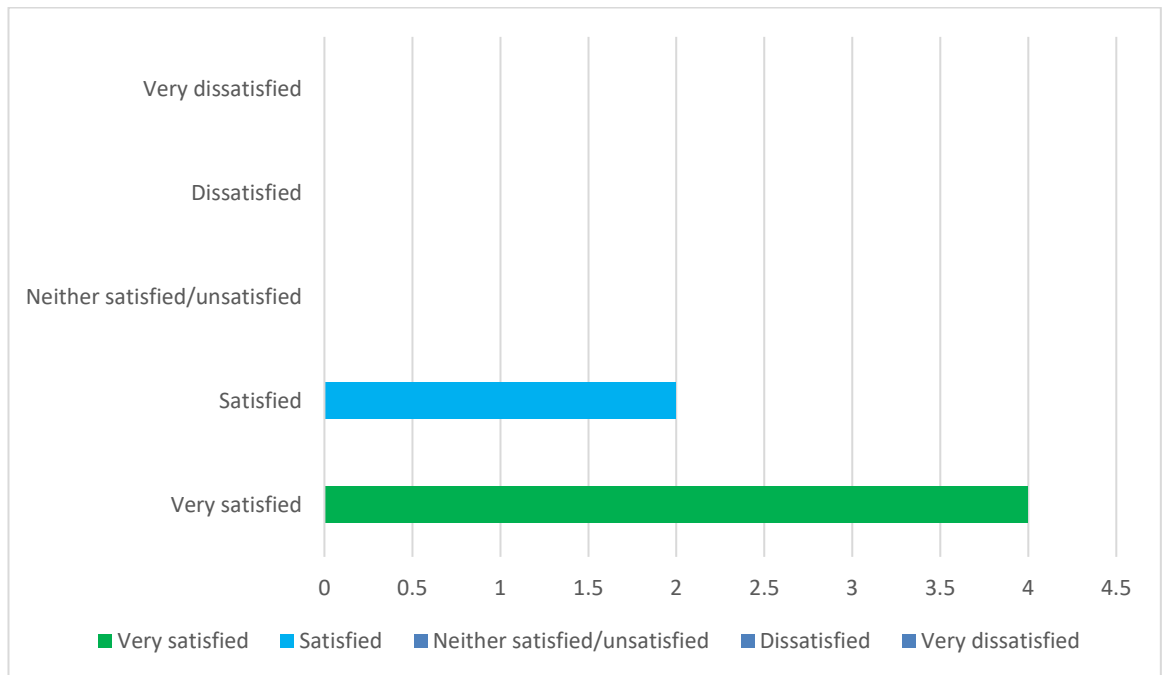


Comments:

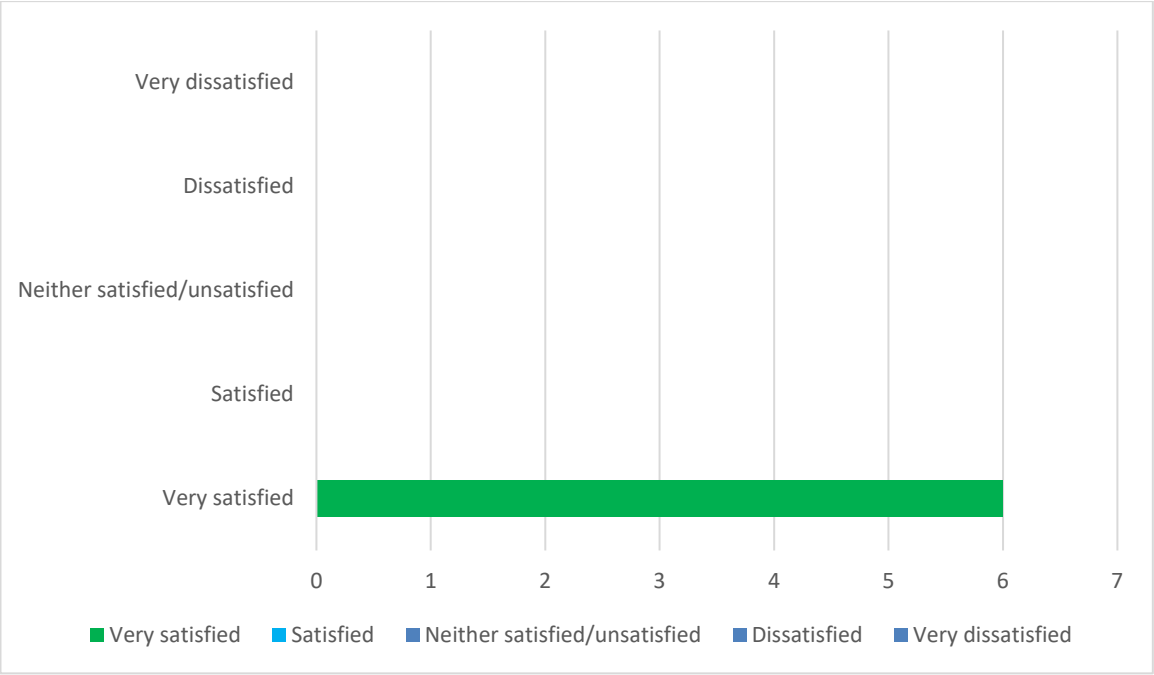
- All the team are extremely caring and responsive

How satisfied are you with the responsiveness of our service to your patients' needs?

Level 2 supervision groups for attenders



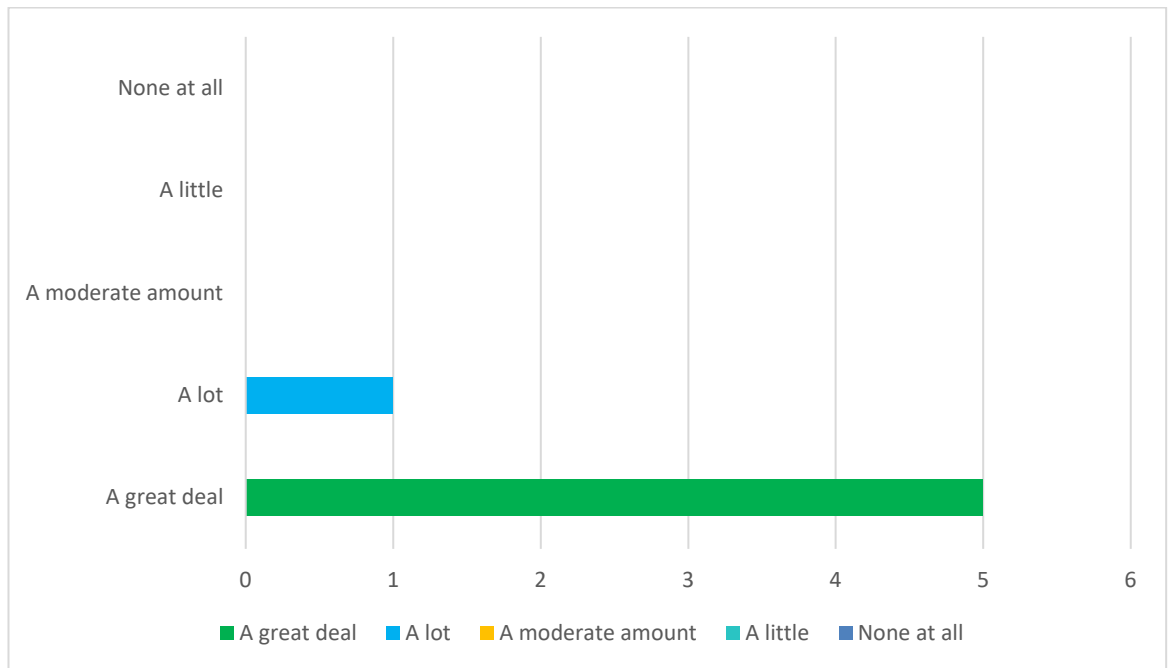
How satisfied are you with our ability to work with other professionals in an MDT?



Please rate the extent to which involvement with our team has helped you deal more effectively with patients?

100%- rated "A great deal"

Level 2 supervision groups for attenders

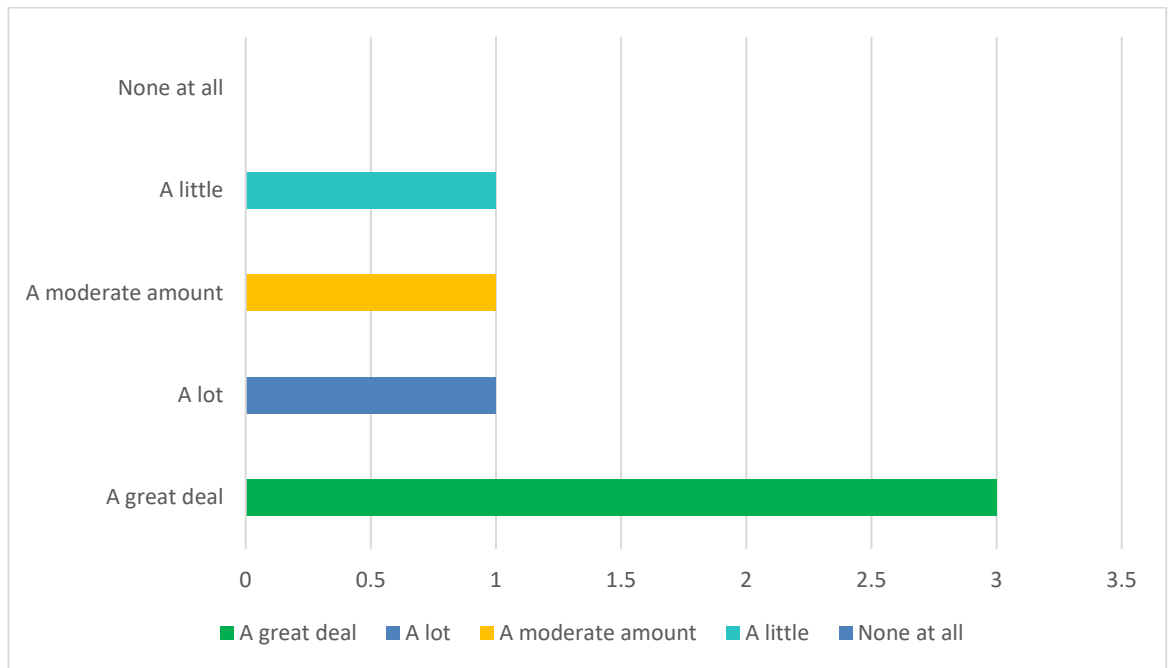


Comments:

- I feel we are now properly assessing the patients in all aspects and I welcome the input from the team.

How well informed do you feel about the nature of the service and the support it provides?

Level 2 supervision groups for attenders

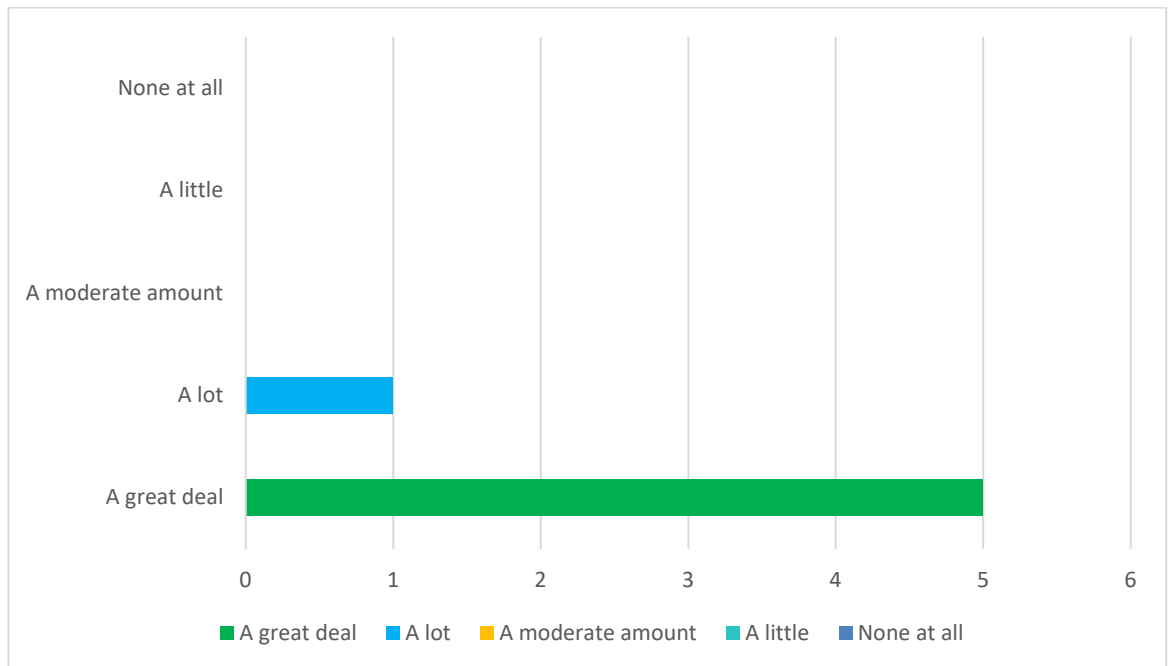


Comments:

- Charlottes presentation at the recent audit meeting and orthognathic course as excellent
- Until recently

How comfortable do you feel discussing patient referrals with a member of our team?

Level 2 supervision groups for attenders



Other Comments

- Thank you for all you do and the valuable service you provide for us
 - A good service and fantastic addition to the Orthognathics team
- Extremely helpful and valuable part of the service that we could not do without. It means we are really able to provide a gold standard level of care to our p

Public Works 33: Audit results and graphs patient satisfaction OPS 2020

Our aim: To support patients in their orthognathic journey and to improve surgical and psychosocial outcomes.

5X5 Audit results :

May 2019- Jan 2020

Kingsley, M, Priestley C, Hassan S and Kapoor, J

N=58 surveys collected

100%- Patients

1.How likely are you to recommend this service to friends and family if they needed similar care or treatment ?

N=57

Extremely likely: 26 (45%)

Likely: 20 (35%)

Neither: 4 (7%)

Unlikely: 1 (2%)

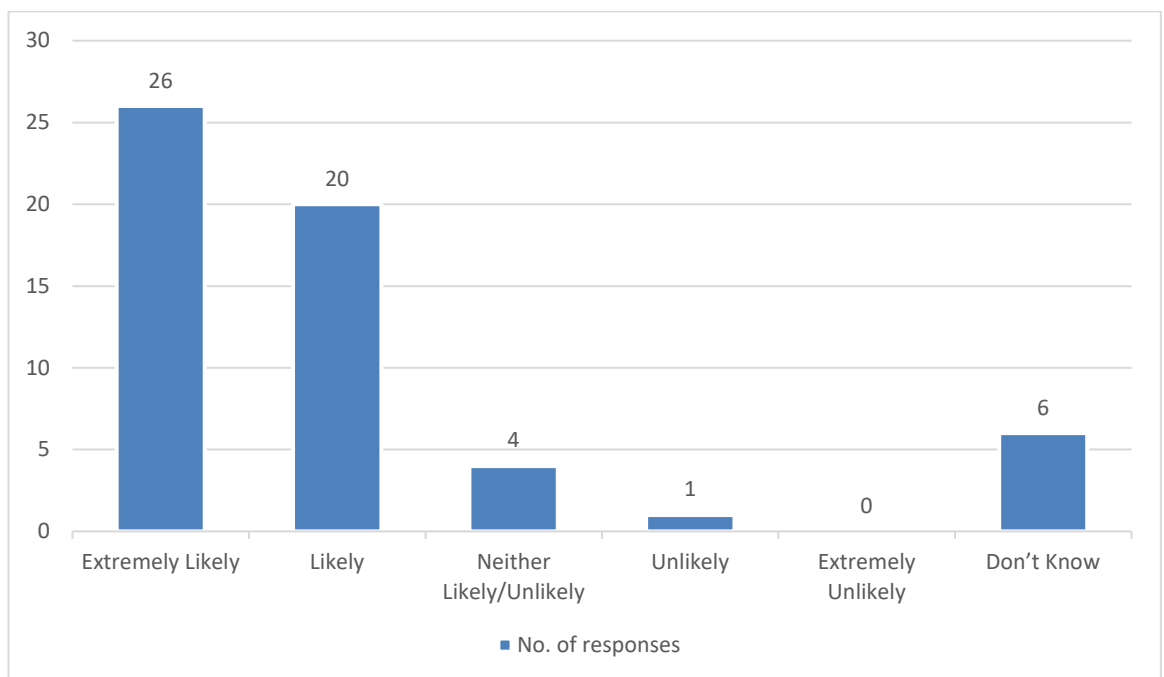
Extremely unlikely: 0 (0%)

Don't know: 6 (11%)

Level 2 supervision groups for attenders

*comments for those responding: Neither; Don't know- could be due to unsure how to rate the satisfaction they have with OPS because it was their first time being introduced to us.

*Unlikely- was chosen by 1 patient. They were of the impression this feedback was for Orthognathic team in general- not OPS.

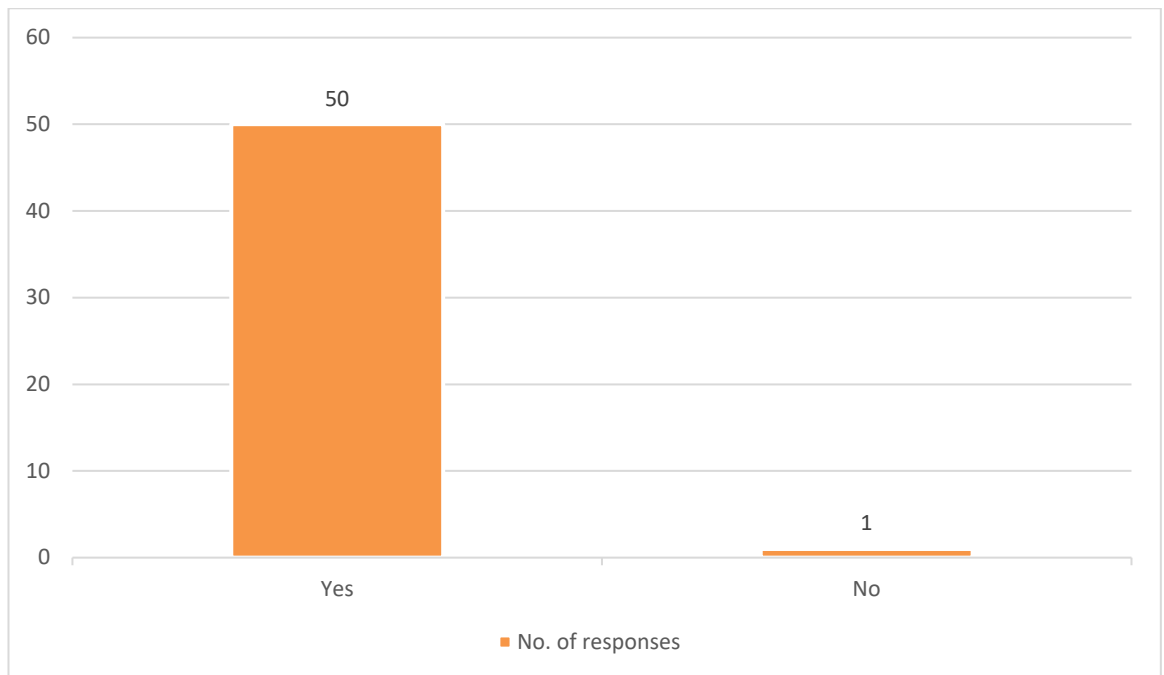


2. Did you find it easy to get care, treatment or support from this service?

N= 51

Yes: 50 (98%)

No: 1 (2%)



Question 2- Qualitative comments:

- "I've not used this service"
- "Initially not but a lot as done to ensure I could so I really appreciate that"
- "I did not request this care therefore cannot really comment on how easy it was to access"
- "Very approachable service"
- "Not sure about treatment therefore not experienced in visiting this service"

- “Everyone was friendly and approachable”
- “Straight forward easy access when needed”
- “Kind- good for those that need it”
- “The person really nice he tried to help in any way he can”
- “It is good to have a one on one chat on how I am feeling and how important the process may be”
- “The service is open to helping us”
- “Saw me and was super friendly and made me feel at ease”
- “Extremely helpful”
- “Contacted very quickly and offered an appointment”
- “Received very useful information”
- “Psychologist attended joint clinic and support followed from there”
- “In the past no- but now, yes”
- “I am looking forward to seeing how my journey goes”
- “Yes- has been readily available to me- as and when required. Regular appointments”

3.Did Staff introduce themselves to you when you met?

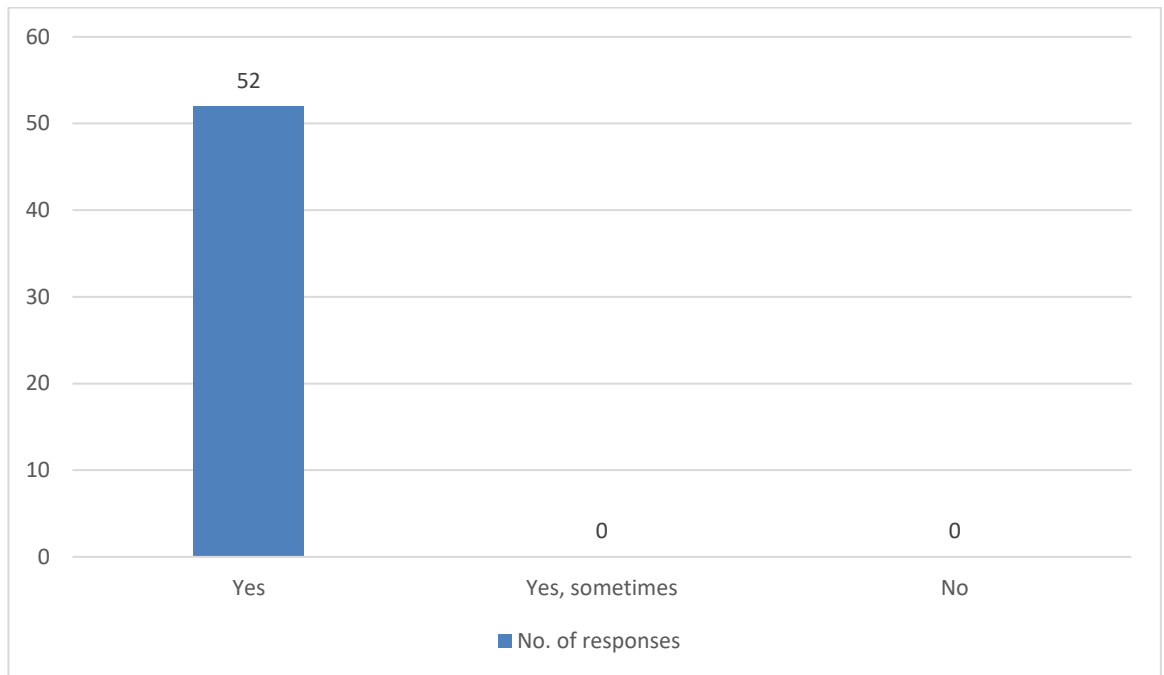
N= 52

Yes: 52 (100%)

Yes, sometimes: 0

No: 0

Level 2 supervision groups for attenders



Question 3: Qualitative comments

- “Very friendly”
- “Very welcoming and smiley”
- “Very nice and welcoming”
- “Staff are extremely friendly”
- “Always”
- “Very friendly”
- “Friendly and approachable”
- “Very friendly and welcoming”
- “I was introduced to Charlotte at the first meeting/appt”

4. Did you feel you have been involved in your care as much as you would have liked?

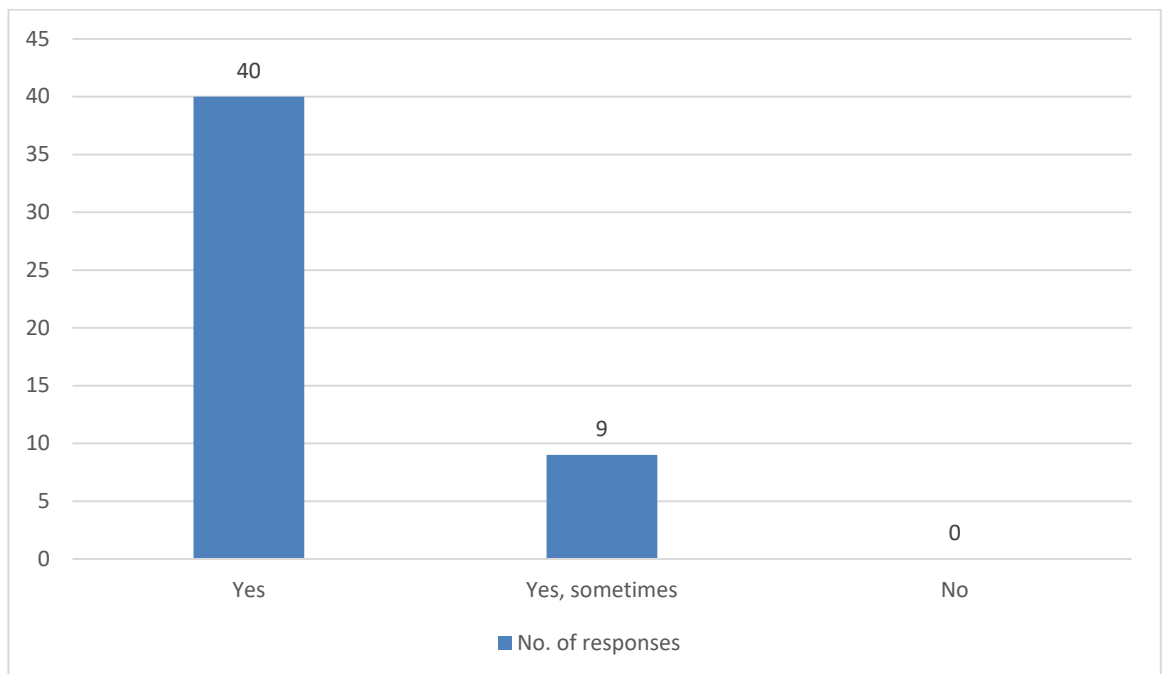
Level 2 supervision groups for attenders

N=49

Yes:40 (82%)

Yes,sometimes:9 (18%)

No: 0



Question 4: Qualitative comments:

- “Constantly asked me if I had any questions”
- “Yes, personally at the moment I don’t think I need it”
- “The psychology person who I saw was the only one who seemed to do anything”
- “Everyone I saw made sure I understood what was happening”
- “Extremely polite”
- “yes we discussed types of therapy that might be useful and will suit me”
- “Better than expected”
- “very useful to speak to non-medical team member and express my concerns in a less intimidating setting”
- “very much”

- “I feel as if sometimes I’m left in the dark about how long until treatment can begin”

5. Did the service meet your expectations

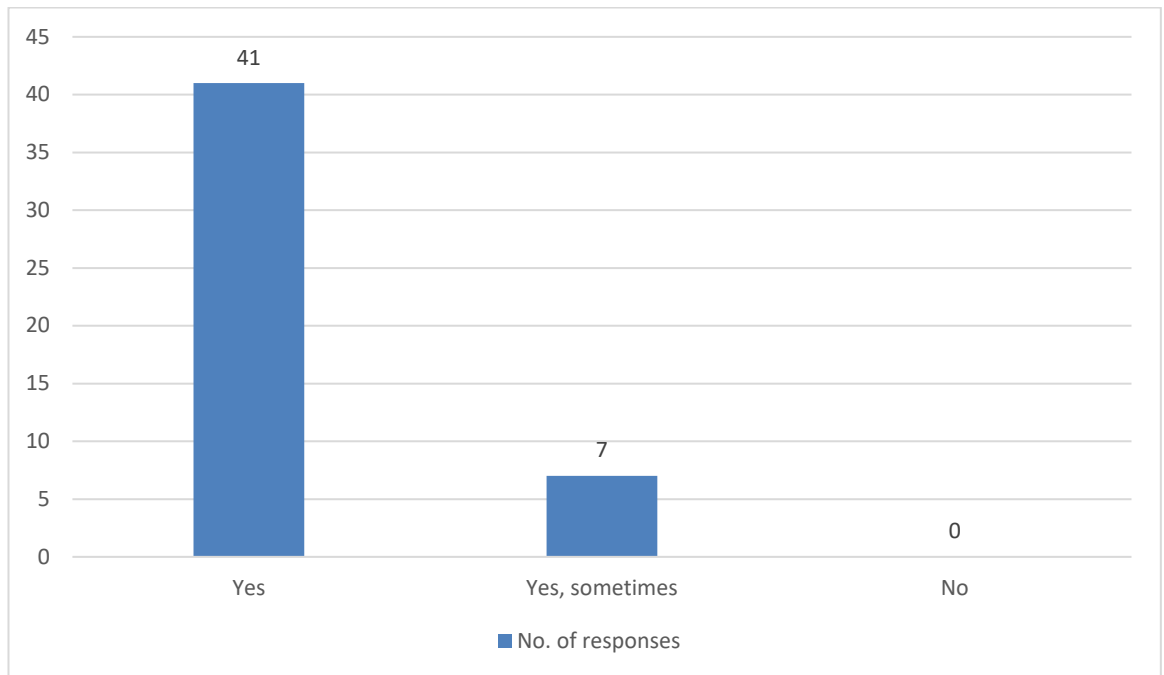
N=48

Yes: 41 (85%)

Yes, sometimes: 7 (15%)

No: 0

Level 2 supervision groups for attenders



Question 5: Qualitative comments:

- “ Only recently engaged therefore no expectations”
- “Explained everything”
- “I guess? Nice to have”
- “Didn’t know what to expect but was pleasantly surprised”
- ‘Brilliant service- has helped me so much”
- “Thoroughly exceeded my expectations”
- “This service has been needed for years, its madness it’s a new service really”
- “The service has exceeded my expectations in terms of frequency of visits and improvements I have seen since starting with Charlotte”

6. Do you have any further comments

- “They provided support and made it more of a comfortable situation”
- “Questionnaire about dissatisfaction with appearance is unclear. Questions on how do you feel are ambiguous”
- “Very polite! Give option if patient wants it or not”
- “Just would like to know when my treatment would be started”
- “I hope this helps my confidence and self-esteem”
- “Meeting made me feel more sure of my decision”
- “I think the psychology service offered has been extremely beneficial to me in regards to scoping out my potential treatment and managing key expectations. It has been a vital part of my overall treatment”

5x5 Demographic Information

7. Gender

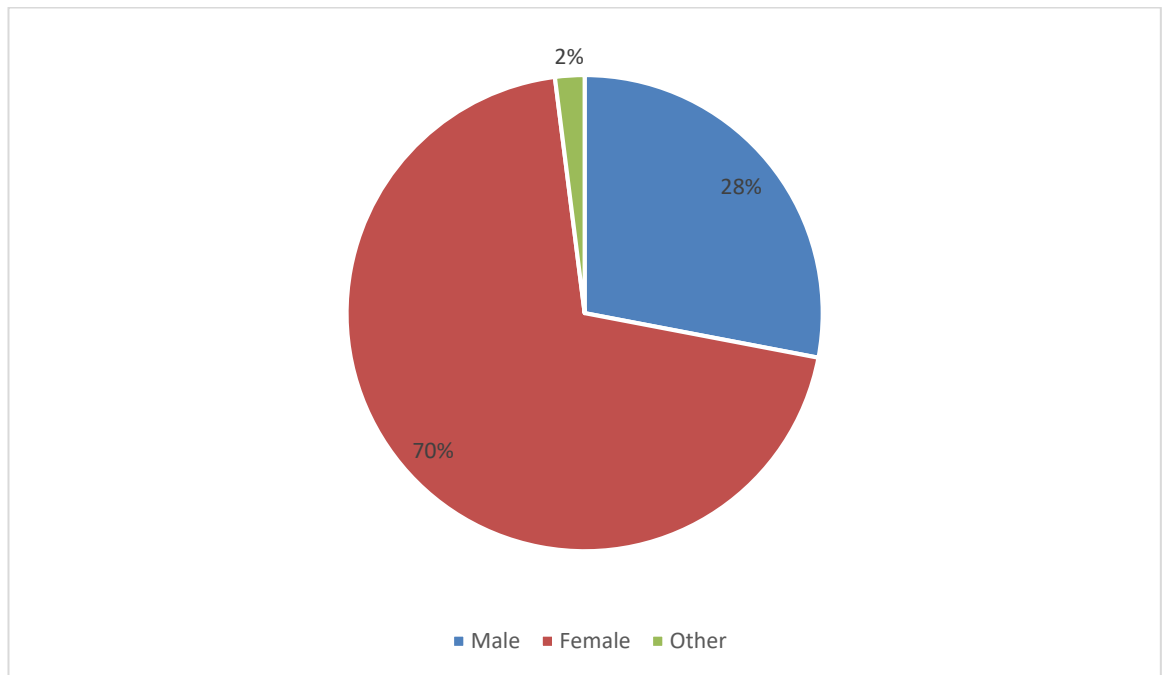
N= 52

Male: 15 (28%)

Female: 36(70%)

Other: 1 (2%)

Level 2 supervision groups for attenders



8. Age group

N= 52

Under 18: 14 (27%)

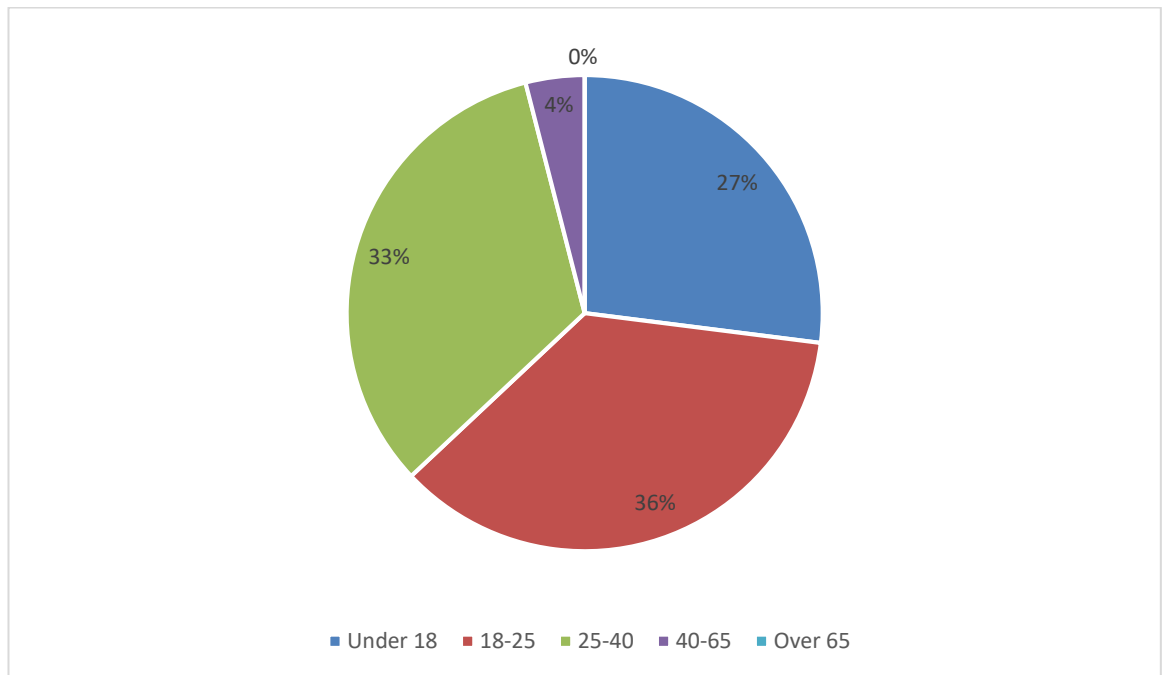
18-25: 19 (36%)

25-40: 17 (33%)

40-65: 2 (4%)

Over 65: 0

Level 2 supervision groups for attenders



9. Ethnicity

N=52

White British: 18 (35%)

White other: 4 (8%)

Pakistani: 5 (10%)

Level 2 supervision groups for attenders

African: 5 (10%)

Bangladeshi: 8 (15%)

Indian: 1 (2%)

Rather not say: 1 (2%)

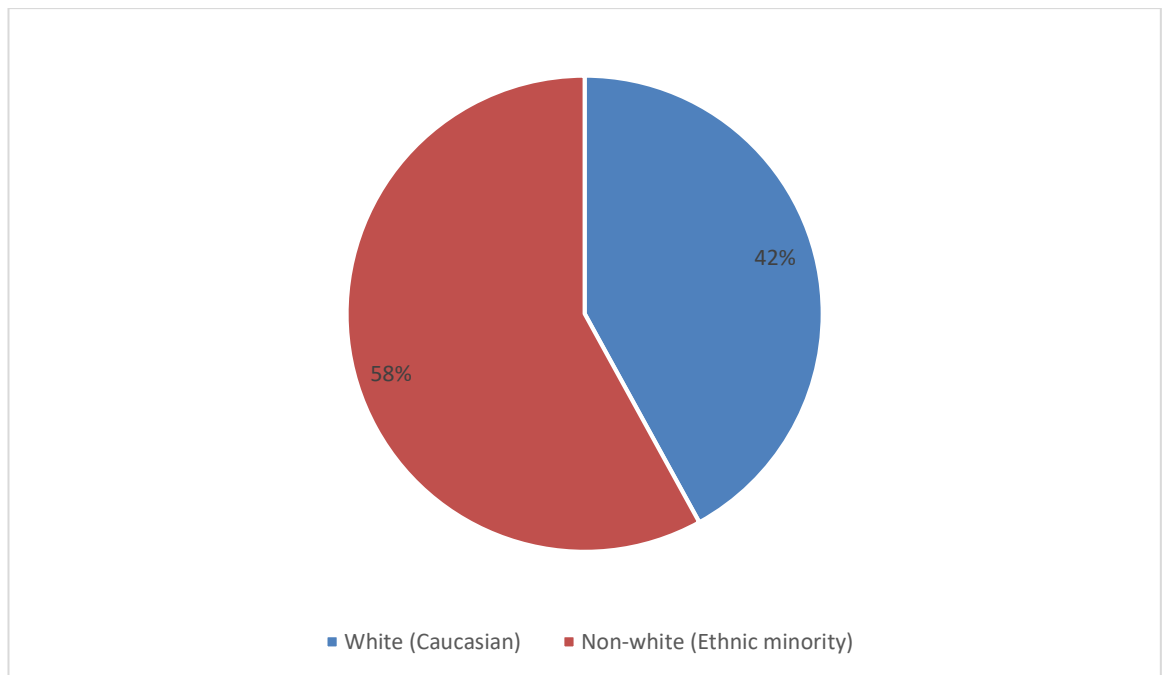
Asian Mixed: 2 (4%)

Black Mixed: 1 (4%)

Other: 5 (10%)

White: 22 (42%)

Non-White (Ethnic Minority): 30 (58%)



10. Disabilities reported

N= 15

Visual impairment: 2

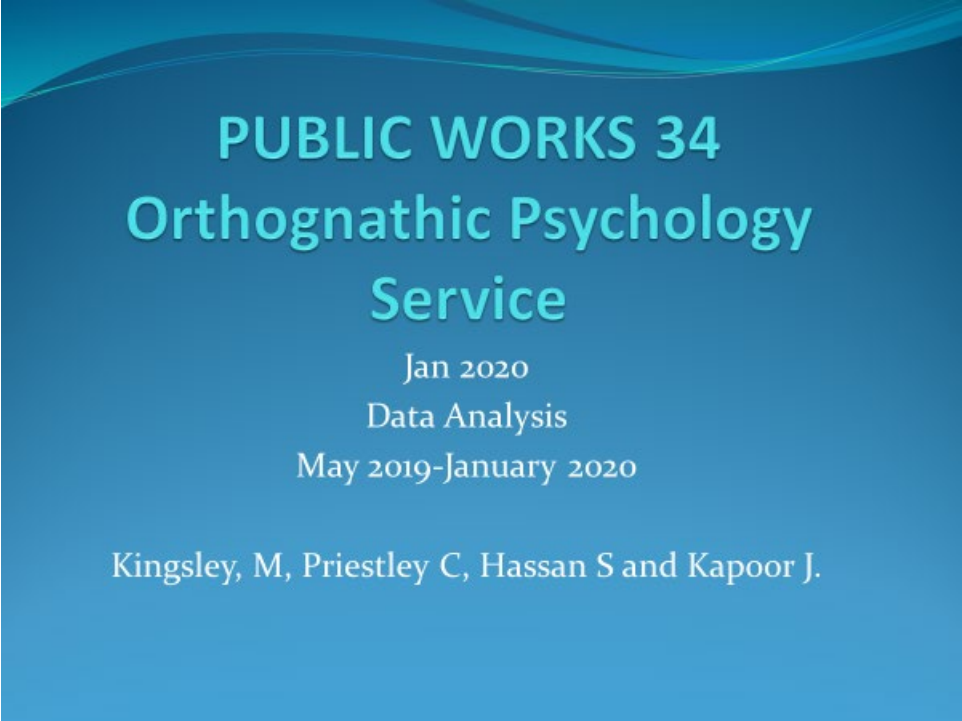
Mental Health: 7

Learning Disability: 1

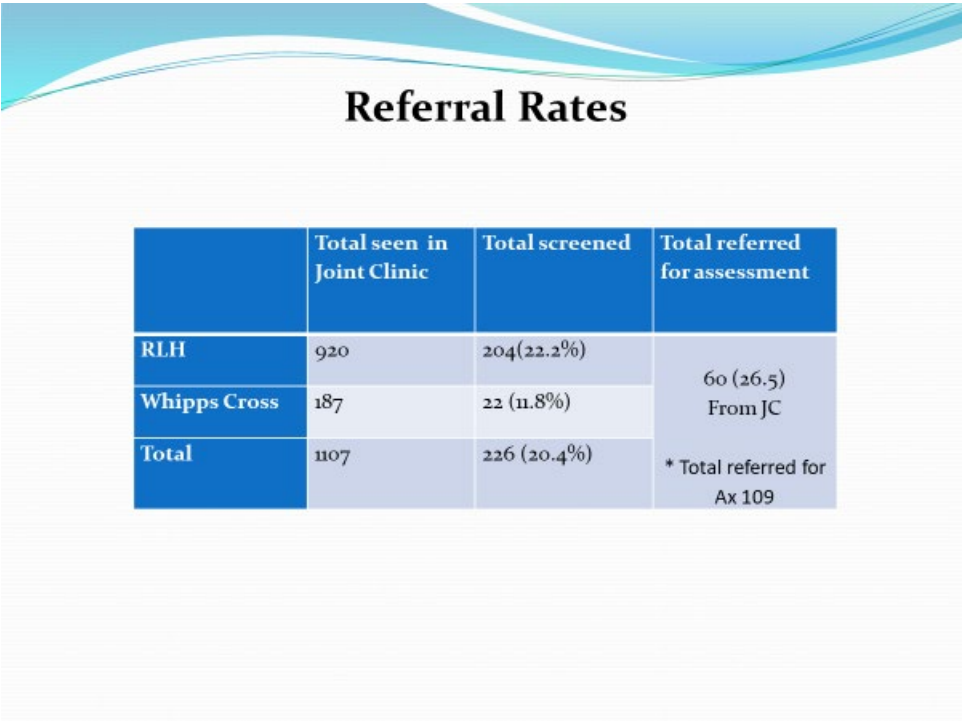
Hearing impairment:1

Other: 4

Public Works 24: Presentation of OPS Impact 2020

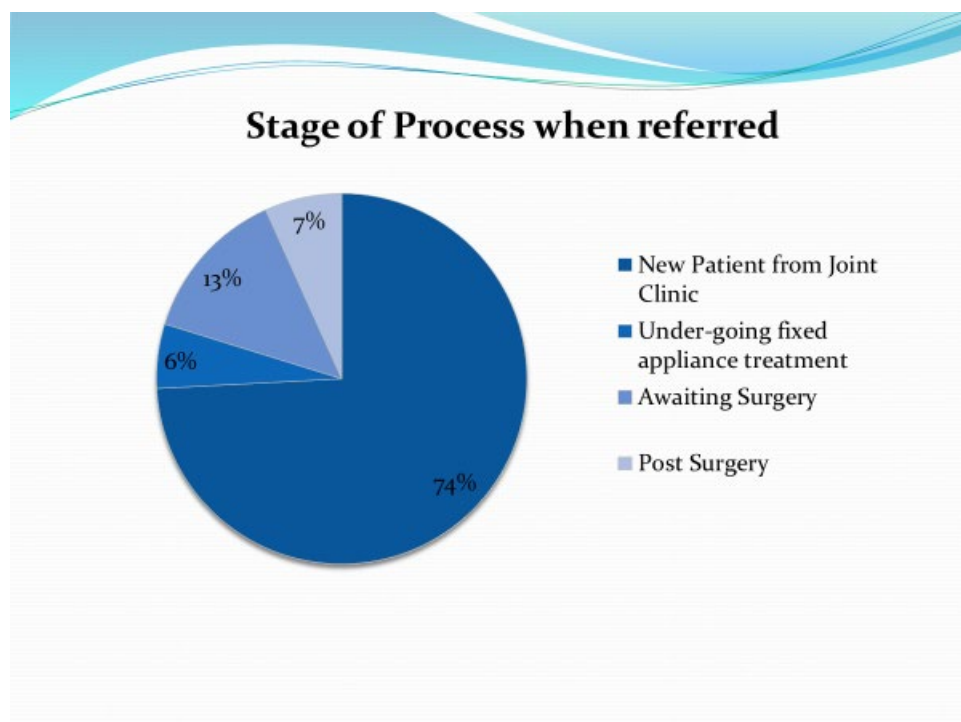
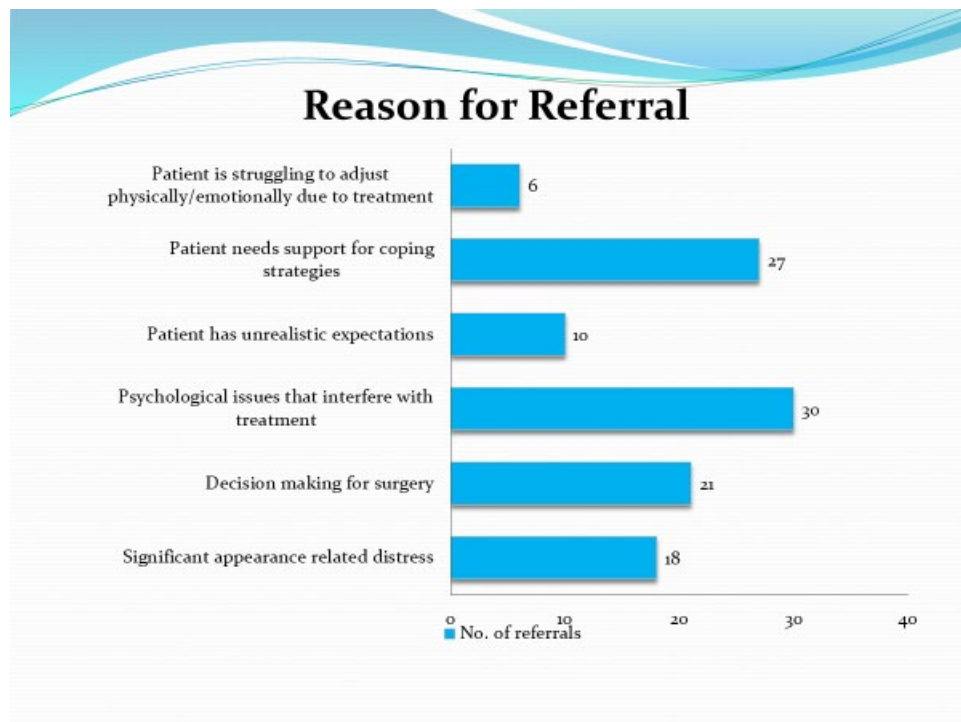


PUBLIC WORKS 34
Orthognathic Psychology
Service
Jan 2020
Data Analysis
May 2019-January 2020
Kingsley, M, Priestley C, Hassan S and Kapoor J.



Referral Rates

	Total seen in Joint Clinic	Total screened	Total referred for assessment
RLH	920	204 (22.2%)	60 (26.5) From JC
Whipps Cross	187	22 (11.8%)	
Total	1107	226 (20.4%)	* Total referred for Ax 109



Level 2 supervision groups for attenders

No. offered first appt	No. who attended first appt	No. of people who completed assessments
83	71	58

Seen more than once	Average No. sessions offered
57	4 (3.95)

Wait list:

Length between accepted referral and first apt offered: **Up to 5 weeks. 41.66 days (9 days-176 days)**

Reasons for delays:

**some patients were kept on waitlist until they wanted a first apt – could be half a year, may have wanted treatment nearer to surgery, or after.*

**some patients needed to wait longer for interpreter to be available*

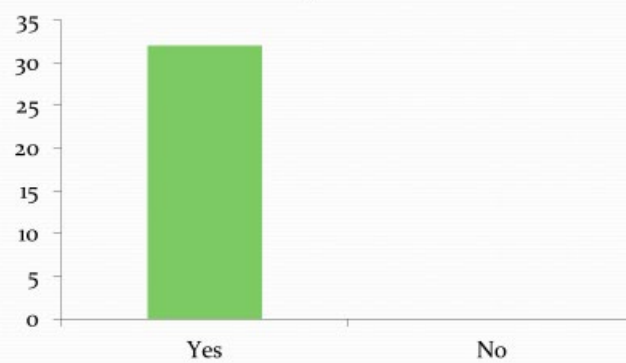
**some dates are first referrals but closed and then re-referred nearer to apt date- data may not be fully accurate in these instances.*

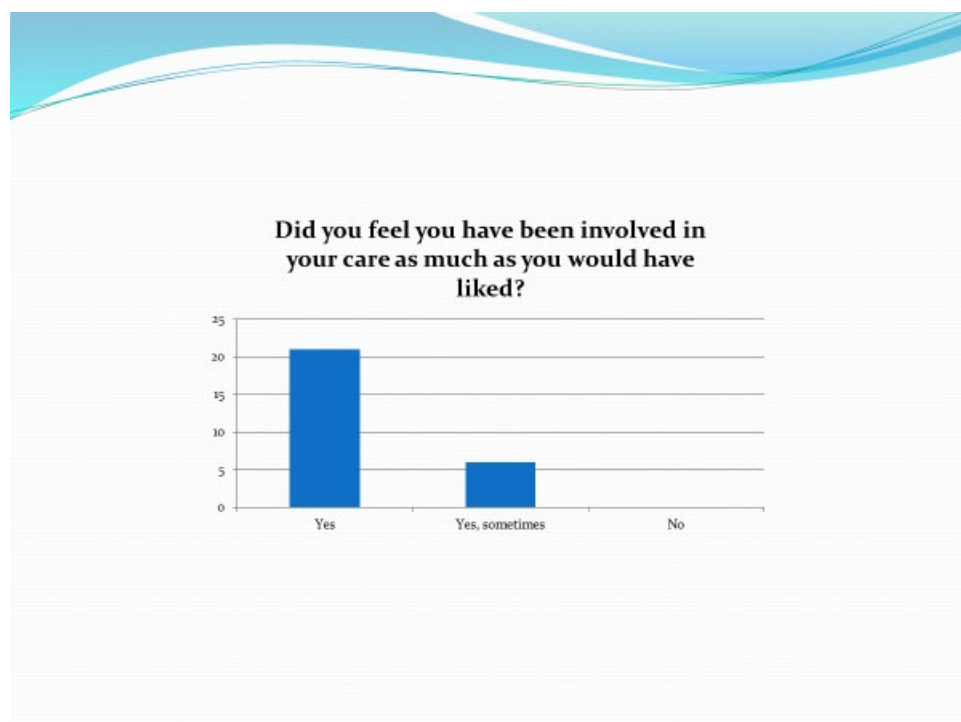
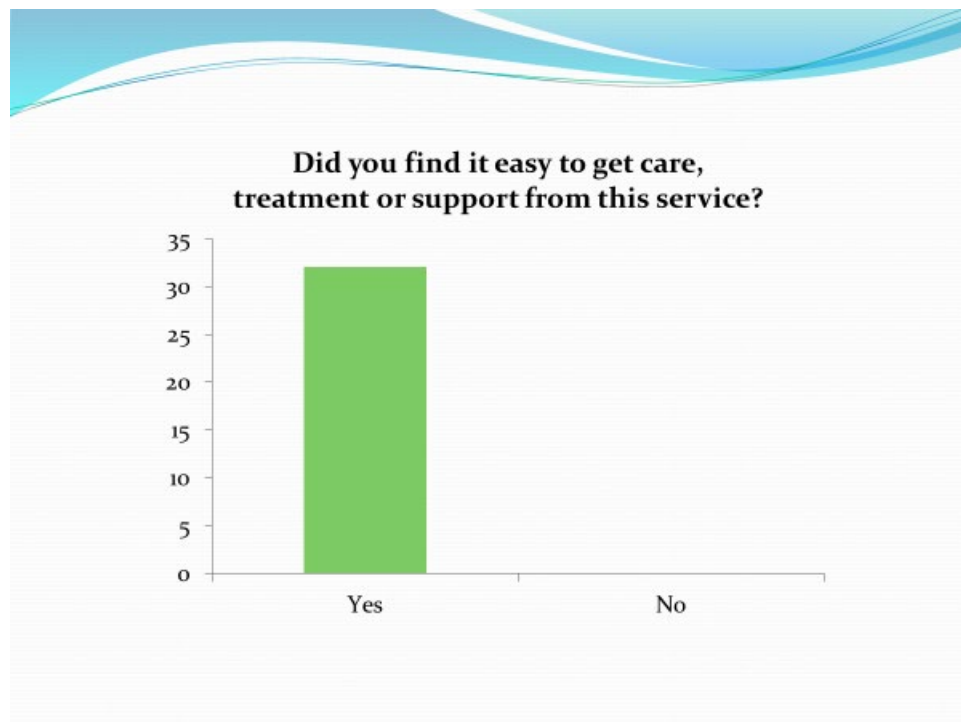
**some patient located out of borough therefore could not commit to earlier appts i.e. Bristol/Manchester*

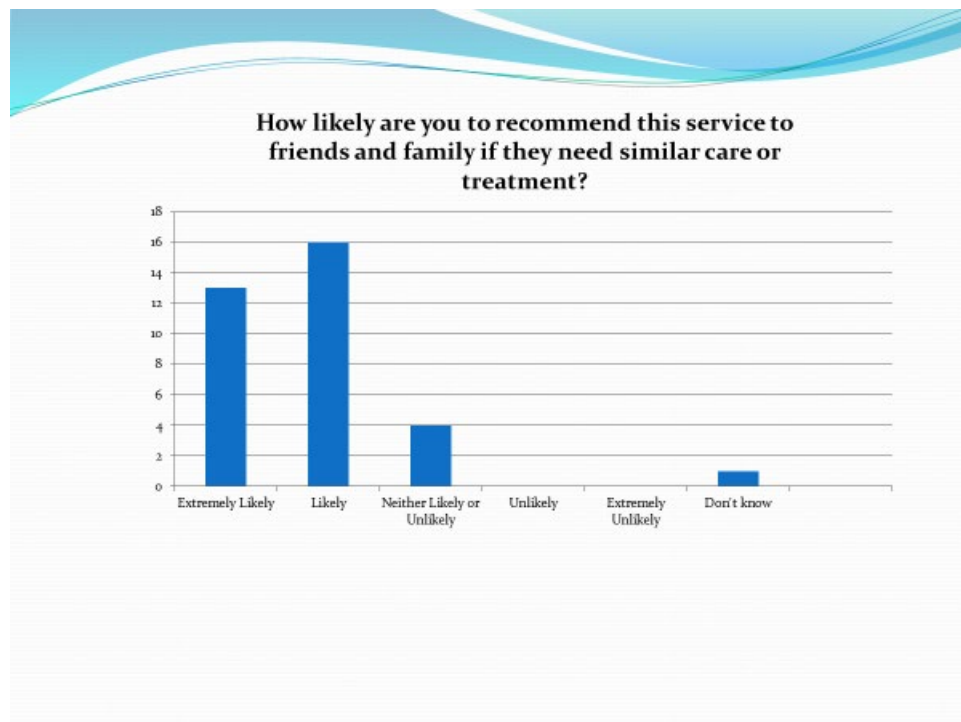
**Clinician left service/ Clinician on A/L*

Friends and Family Test

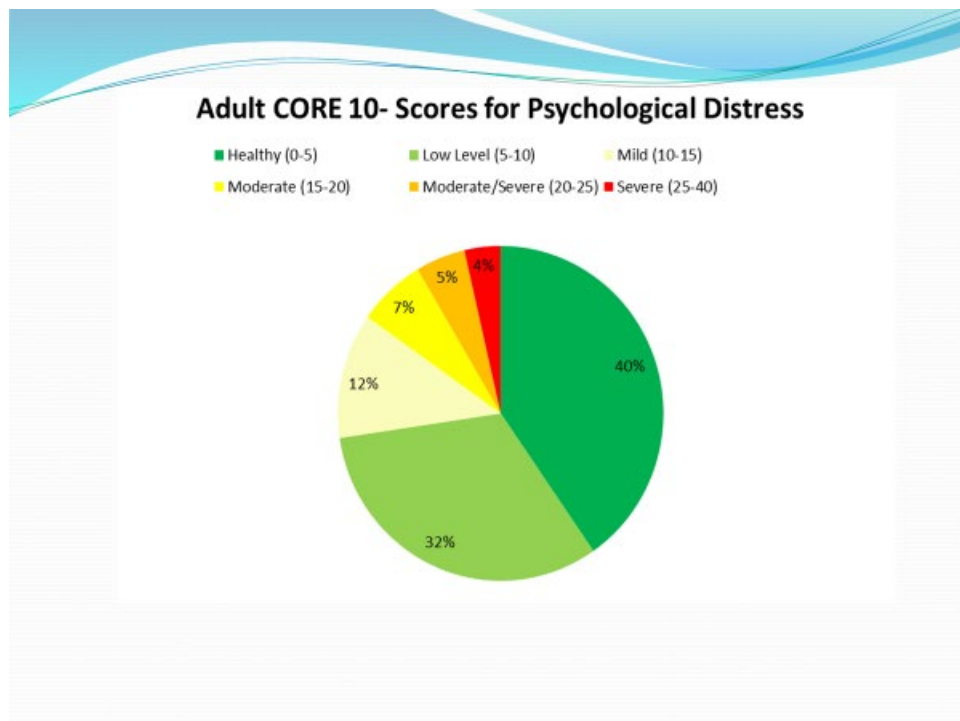
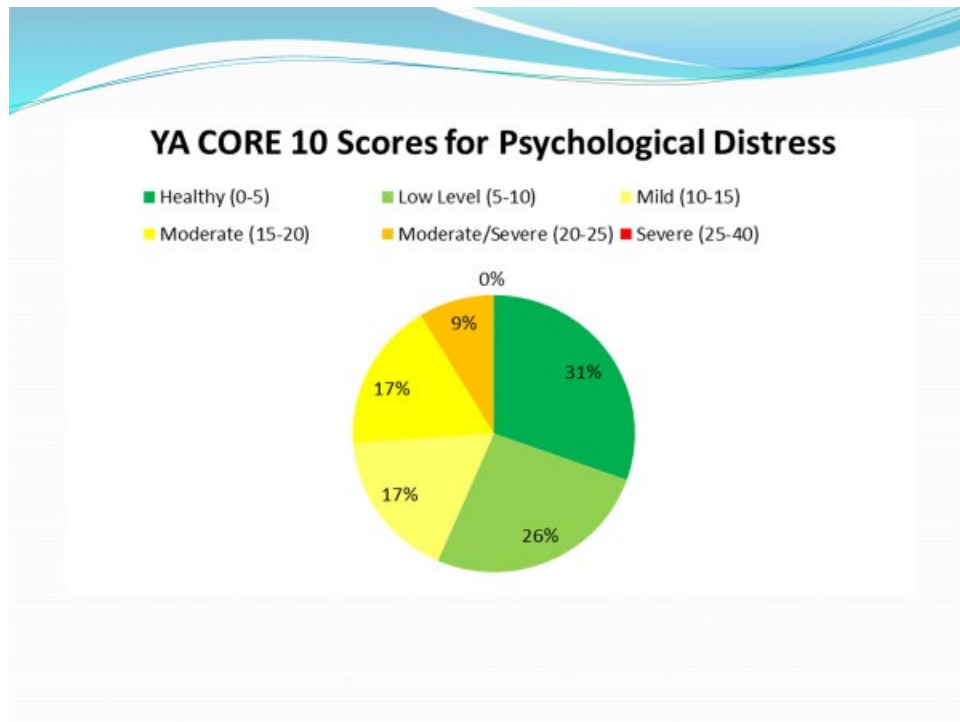
**Did staff introduce themselves to you
when you met?**







Outcome Measures

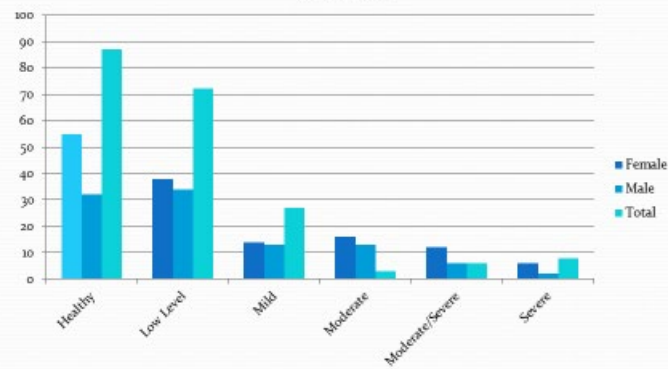


Level 2 supervision groups for attenders

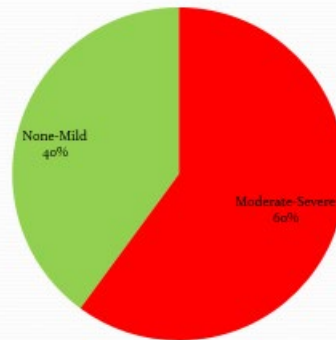
Breakdown of Adult CORE 10 scores

Score range	N (M;SD)	Average Age	Female (M;SD)	Male (M;SD)
0-5 Healthy	87 (2.5; 1.8)	23.2	55 (2.6; 2.5)	32 (2.8;1.8)
5-10 Low Level	72 (7.1;1.6)	23.0 (8.7)	38(7.1; 1.6)	34 (7.1; 1.6)
10-15 Mild	27 (12.1; 1.8)	22.0 (9.2)	14 (12.6; 1.9)	13 (11.6; 1.6)
15-20 Moderate	16 (17; 1.9)	24.1 (6.8)	13 (17; 1.8)	3 (17; 2.6)
20-25 Moderate/severe	12 (22; 1.9)	23.8 (5.8)	6 (22;2.1)	6 (22.1;1.8)
25-40 Severe	8 (29.5; 4.3)	19.1 (2.9)	6 (30; 4.7)	2 (28; 4.2)
Total	222 (7.9; 7.8)	23.2	132 (8.1; 7.8)	90 (7.9; 6.4)

CORE 10: Gender and degree of Psychological distress



DAS24: Appearance related distress N=233



Future Developments

- Service model and alternative approaches
- Providing feedback/Information sharing
- Reflective practice
- Service user groups
- NHSE MDT feedback

Service model

- Current model – Psychologist attending all clinics and routinely screening new patients and picking up any existing patients. Additional referrals from MDT members
- New patient clinic – patients attend “education session” by surgeon, orthodontist and psychologist – new patients screen
- Only patients with concerns referred

Psychology Feedback

- Current model – Assessment reports, end of therapy letters, verbal feedback at JC
- Length of reports, where/how psychology information is recorded – thoughts?
- Regular feedback sessions/handover?
- Patients who DNA'd don't engage with psychology – ensuring they don't get lost – could we improve this process?

Reflective Practice

- Can offer regular reflective practice sessions –
 - Space to think about the work we do
 - Acknowledgement of the emotional aspects of work
 - Understand group/team dynamics
- Complex case discussions
- Can be used to illuminate best practice
- Review a particular incident
- Develop psychological skills – e.g. mindfulness

NHSE Feedback

- Sending out questionnaire to gain feedback from MDT to present with data for NHSE
- Plan to send out on survey monkey



Service User Groups

- General support group for those undergoing, considering and completed treatment – monthly/6 weekly group, drop in and focused topics each session
- Focus group initially to generate ideas – e.g. preparing for surgery, coping with treatment, managing social media, body image
- Skills based – mindfulness, CBT skills, distress tolerance

Public Works 35: Dental and Oral Trauma Staff Support Video Link



[Staff Support video.mp4](#)

[Open](#)

Public Works 36: Dentistry staff psychological support referral form

STAFF REFERRAL FORM

**DENTAL AND ORAL TRAUMA PSYCHOLOGY SERVICE
STAFF SUPPORT**

During challenging and uncertain times, there can be limited time to make sense of the impact on staff well being. The Dental Psychology Service (DPS) is offering confidential appointments to any staff members who feel they may benefit from a space to talk about their experiences and/or additional support to help them cope more effectively during this difficult time.

Please note:

- Any contact between yourself and our service will be kept confidential.
- Confidentiality will be upheld unless there are concerns for the safety of yourself or others; if this were the case we would aim to discuss this with you first.
- Your details will not be added to our clinical systems although risk information will need to be shared.
- Your contact details will be destroyed after 12months.

If you wish to have a brief discussion about what the service is able to provide, or would like to refer yourself for an appointment, please complete the form below and email to the secure email address: nem-tr.orthognathicpsychology@nhs.net

Contact Information

Please complete as much information as possible.

Name:
DOB:
Occupation:
Area of work: (Include previous and where you have been re-deployed)
Address :
Contact number:
Email:
Best time to contact:
GP Details:
Next Of Kin Details:

295 /

Contact Number:

Relationship to you:

Please give a brief description of what you would wish to discuss:

What is your preference for contact:

Phone Call ☐

Video-Call ☐

Yours sincerely

Marc Kingsley
Dental and Oral Trauma Psychology Service Clinical Lead

Dr. Vanessa Jones
Consultant Clinical Psychologist/ Lead for A-DOTS

Dr. Kirsty Collins
Clinical Psychologist (OPS).

Chair: Joe Fielder

Chief Executive: Professor Oliver Shanley OBE



Public Works 37: Psychological support for palliative care staff in community settings: the role of Level 2 adapted clinical discussion groups

Marc. J. Kingsley^a, Ruimin Ma^b and Feryad. A. Hussain^c

- a. North East London (NELFT) NHS Foundation Trust. The West Wing, CEME Centre, Marsh Way, Rainham, RM13 8GQ, United Kingdom
- b. Institute of Psychiatry, Psychology and Neuroscience (IoPPN), King's College, De Crespigny Park, London, BOX SE5 8AF, United Kingdom
- c. Black County Foundation Trust, Delta House, Delta Point, Greets Green Road, West Bromwich, West Midlands, B70 9PL

08 February 2021

ABBREVIATIONS:

CDG'S: CLINICAL DISCUSSION GROUPS

EOL: END OF LIFE

LCA: LONDON CANCER ALLIANCE

NELFT: NORTH EAST LONDON NHS FOUNDATION TRUST

NCPC: NATIONAL COUNCIL OF PALLIATIVE CARE

NHS: NATIONAL HEALTH SERVICE

NICE: NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE

PHE: PUBLIC HEALTH ENGLAND

Public Works 38: RCN Lecture 2019

End of Life Care Facilitators

Meeting Title	London Region EOL Care Facilitators Forum	Date	23.1.2019
Time	10.00 -4pm	Venue	RCN Building 20 Cavendish Square
Chairperson	Amanda Young		

The Purpose of the forum is to inform everyone of regional activity and to share ideas, laying the foundations for future meetings and sharing research.

Time	Agenda No.	Item Description	Item Presenter
10.00	1	introductions	Amanda Young
10.00-11.30	2	Liver programme	Virginia Campbell St Lukes Hospice
11.30-13.00	3	The experience of change in EOL in Lebanon (technology allowing)	Hera Tashjian
13.00		lunch	
13.30		Suicide in palliative care	Marc Kingsley
		Tea	
		Round up and next years programme	Amanda Young
16.00		Finish	

Public Works 39: Redbridge EOL Conference 2018

Redbridge End of Life Conference

Tuesday 4th December 2018

City Gates Church, 25-29 Clements Rd, Ilford IG1 1BH

9am - 9.15am	Delegates arrive for registration and coffee, and brief opening by Chair Giovanna Poulter - professional lead for end of life care for NELFT
9.15am - 9.25am	Welcome and introduction to the day Joe Fielder (Trust Chair, NELFT and Chair, BHRUT) Pam Court (CEO, Saint Francis Hospice)
9.25am - 9.45am	National Macmillan Strategy - incorporating the End of Life Care focus Phil Hall (Macmillan Services Project Manager, London)
9.45am - 10.05am	Suicide in Palliative and End of Life Care Marc Kingsley (Consultant Clinical Psychologist, NELFT)
10.05am - 10.25am	Saint Francis Hospice/The Margaret Centre- Service Overview Dr Corinna Midgley (Consultant Palliative Care, Saint Francis Hospice) Dr Elisabeth Bjorndal (Consultant Palliative Medicine, The Margaret Centre)
10.25am - 10.45am	Frailty at end of life Geraldine Rodgers (Associate Director of Nursing for Clinical Effectiveness)
10.45am - 11am	Questions and Answers
11am - 11.20am	Break for tea and coffee
11.20am - 11.40am	Internal Cardioverter Defibrillator at End of Life Suzanne Squirrell (BHRUT)
11.40am - 12.05pm	Culturally sensitive palliative and end of life care for gender and sexual minorities Claude Chidiac (Senior Lecturer, Saint Francis Hospice)
12.05pm - 12.25pm	Redbridge Macmillan specialist palliative team: A case study in Multi-Disciplinary Team working Dorothy Pearlman (End of Life Care), Lesley Grainger (Social Worker) and Kathy Wisbey (Occupational Therapist)
12.25pm - 12.45pm	DNACPR Bridget Moss (Head of Education, Saint Francis Hospice)
12.45pm - 1pm	Questions and Answers
1pm - 1.30pm	Lunch
1.30pm - 2pm	Young person's story through transition Lucy Watts (MBE)
2pm - 2.20pm	Partnership working to deliver choice at the end of life Mike Palfreman (CEO) and Eileen White (Care Director) Haven House Children's Hospice
2.20pm - 2.40pm	Advance care planning - thinking ahead Diane Drain (Practice Development Nurse Lecturer, Saint Francis Hospice)
2.40pm - 3pm	Break for tea and coffee
3pm - 3.20pm	BHRUT enhancing cross-boundary communication Heather Wright (Macmillan Palliative Care Team Leader at BHRUT)
3.20pm - 3.40pm	What's best for Lily? End of life care education Ms. JJ Nadicksbernd (UCL Partners)
3.40pm - 4pm	Palliative and End of Life Care at the London Ambulance Service (LAS) Diane Lavery
4pm - 4.15pm	Questions and Answers
4.15pm - 4.30pm	Closing comments and reflections

Public Works 40: Havering EOL Conference

PUBLIC WORKS 40

Havering End of Life Conference

9.00am - 9.30am	Delegates arrive for registration and coffee Charing - Karen Shepherd (Havering Integrated Community Services Manager, NELFT)
9.30am - 9.40am	Welcome and Introduction to the Day Joe Fielder (Trust Chair, NELFT and Chair, BHRUT) Pam Court (CEO, Saint Francis Hospice)
9.40am - 9.55am	NELFT (Havering) End of Life Strategy Diane Searle (Director of Nursing, Patient Safety, NELFT)
9.55am - 10.15am	National Macmillan Strategy – Incorporating the End of Life Care focus Phil Hall (Macmillan Services Project Manager, London)
10.15am - 10.55am	Culturally sensitive palliative and end of life care for gender and sexual minorities Claude Chidiac (Senior Lecturer, Saint Francis Hospice)
10.55am - 11.15am	Break for tea and coffee
11.15am - 11.35am	Advance care planning – thinking ahead Diane Drain (Practice Development Nurse Lecturer, Saint Francis Hospice)
11.35am - 11.50am	End of Life Data Dr Andrew Gage (Consultant in Palliative Medicine)
11.50am - 12.15pm	Internal Cardioverter Defibrillator at End of Life Suzanne Squirrell (BHRUT)
12.15pm - 12.30pm	Saint Francis Hospice – Service Overview Dr Mark Howard (Consultant Palliative Care, Saint Francis Hospice)
12.30pm - 12.55pm	Suicide in Palliative and End of Life Care Marc Kingsley (Consultant Clinical Psychologist, NELFT)
12.55pm - 13.15pm	Q & A session Panel: Lesley Burrows (Chair), Diane Searle, Claude Chidiac, Marc Kingsley, Phil Hall, Diane Drain, Dr Mark Howard and Dr Andrew Gage
1.15pm - 2.00pm	Lunch
2.00pm - 2.30pm	Young person's story through transition Lucy Watts (MBE)
2.30pm - 2.50pm	Havering EOL Carers and Carers Support group – Pilot Study Suraj Mehan (Assistant Psychologist) and Tarek Seeraullae (Carers Lead, Havering NELFT)
2.50pm - 3.15pm	PEACE – Trusted Assessor & Red Bag Initiative Heather Wright (Palliative Care Lead, BHRUT) and Tracy Morton (Facilitator, BHRUT)
3.15pm - 3.35pm	Break for tea and coffee
3.35pm - 3.55pm	DNACPR Bridget Moss (Head of Education, Saint Francis Hospice)
3.55pm to 4.15pm	Q & A Panel: Lesley Burrows (Chair), Lucy Watts (MBE), Marc Kingsley, Tarek Seeraullae, Bridget Moss, Heather Wright, Suraj Mehan and Tracy Morton
4.15pm to 4.30pm	Closing - Geraldine Rodgers (Associate Director of Nursing for Clinical Effectiveness)

Public Works 41: NELFT NHS Foundation Trust Blog

NELFTtalks blogs: NELFT NHS FOUNDATION TRUST: SUICIDE RISK IN PALLIATIVE CARE/ END OF LIFE PATIENTS

Link to NELFT blog

<https://www.nelft.nhs.uk/nelft-talks/suicide-risk-in-palliative-care-end-of-life-patients-3228>

Public Works 42: Report of Havering End of Life conference

CHPS staff present at Havering End of Life conference

NELFT joined with [BHRUT](#) and [St. Francis Hospice](#) to organise a Havering End of Life Conference, enabling all health and social care professionals to come together and discuss palliative care in the local community.

This event provided an opportunity to work in partnership and ensure that people with life-limiting illnesses, and for families and friends, receive the care that they need and in their place of choice.

The conference focused on the following six 'Ambitions';

- Each person is seen as an individual
- Each person gets fair access to care
- Maximising comfort and wellbeing
- Care is co-ordinated
- All staff are prepared to care
- Each community is prepared to help

Marc Kingsley, consultant clinical psychologist, Suraj Mehan, assistant psychologist and Tarek Seeraullee, carers lead, Havering presented at the Havering End of Life conference on the important and often underreported area of suicide risk within palliative and end of Life patient groups and Palliative Carers Support. You can access their presentations and hear their views below

[Marc Palliative Care End Of Life Conference \[pptx\] 213KB](#)

[End of Life Conference Presentation - Carer Awareness and Support \[ppt\] 308KB](#)

Posted on 24 Aug 2018 at 04:14 PM

Public Works 43: PDOT Referral Form

CLINICAL HEALTH PSYCHOLOGICAL SERVICES

REFERRAL FORM PAEDIATRIC DENTAL ORAL TRAUMA SERVICES (PDOT)

Have you had a conversation with a DOT-P psychologist about this referral? We encourage conversations about referrals within the dental and psychology team.

PLEASE NOTE :

1. This referral form must be FULLY completed in order to avoid delay in processing
2. *If a patient presents as RISK TO SELF / OTHERS or there are SIGNIFICANT SAFEGUARDING ISSUES, please refer to the mental health or social services in your borough.*
3. To send your email securely, protecting patient identifiable information, please only send from an nhs.net account.

Your referral will be processed more quickly and efficiently if you could please email it, fully completed to:

maria.langridge1@nhs.net

Patient Information -Complete for ALL referrals

Patient Name:		Patient Contact Number:
Disability: ☐ Yes (please detail in the space provided) ☐ No ☐ Prefer not to say		First Language: Preferred language to communicate in: Interpreter required? If yes, please details below:
Address:		RiO Number:
DOB:	NHS No.:	Hospital No:
Ethnicity:	Gender: ☐ Male ☐ Female ☐ Other (please specify below): 303 /	Next of Kin name: Next of Kin contact number: Next of Kin address:

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1. Please tell us about the service user's place of residency. Tick the relevant box, and provide any additional information where possible.

- ☐ With parent/s.
- ☐ With extended family.
- ☐ Under LA care.
- ☐ Other (please specify).

2. Does the service user currently have any other referrals in place? Tick the relevant box, and provide any additional information where possible.

- ☐ Safeguarding/Welfare
- ☐ Acute Medicine
- ☐ Community Team
- ☐ Mental Health/CAMHS
- ☐ Other (please specify)

Patient Status

	Please select 'a' or 'b'
a.	Routine
b.	High Priority – If so, why:

Consent

Is the patient and family aware of referral? ☐ Yes ☐ No	Does the patient and family consent to the referral being made? ☐ Yes ☐ No	Does the parent/carer of the patient consent to the referral being made? ☐ Yes ☐ No
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Referral Information

Where is the patient currently on the paediatric dental pathway?	
a. Dental trauma	c. Oral Medicine
b. Oral-maxillofacial trauma	d. Special Dentistry
e. Appearance Related Distress	f. Other – please specify: _____

Referral Request

Please tell us about the referral request.	This referral request is coming for:
	☐ Assessment
	☐ Joint Working
	☐ Individual Work
	☐ Consultation
	☐ Liaison

Reason for Referral including any relevant Medical Information (*presenting difficulties, duration of problem, impact on daily functioning, impact on mood, current support, history of mental health problems, previous psychological therapy etc*).

What is your/the patient's concern? Please tick the relevant boxes and provide additional information if possible:

- ☐ The service user is presenting with significant appearance related distress.
- ☐ Decision-making for treatment – where the service user is having difficulty in deciding whether to have treatment/surgery, or not.
- ☐ Psychological issues which may interfere with treatment compliance, and which may impact treatment outcomes. For example; phobias of needles or the dentist, anxiety, low mood, chronic pain and trauma. Please detail clearly:

Level 2 supervision groups for attenders

- ☐ The service user/significant others have unrealistic expectations of the treatment and its likely outcomes.
- ☐ The service user needs support to develop coping strategies to manage their treatment/condition management.
- ☐ The service user is struggling to adjust physically and emotionally as a consequence of their oral health, or related treatment.
- ☐ There has been a change in the service user's cognition or personality.
- ☐ The service user is displaying risk behaviours (e.g. behaviours that contribute to unintentional injuries and violence).
- ☐ The service user is displaying signs of substance abuse (e.g. legal and illegal substances).

Please note that this is not an exhaustive list, use the space below to highlight any other areas of difficulty you have identified.

Please provide further detail as to the purpose of referral:

Who else may need to be included in this referral ? (e.g. spouse, family, etc)

Referrer Information (for ALL referrals)

Referrer Name :	
Site :	
Date of Referral (dd/mm/yyyy) :	

To Be Completed by Psychologist:

- Discussed with referrer ☐
- Referral accepted ☐
- Patient contacted ☐
- Details entered onto RIO ☐

Additional information:

Plan:

Any Other Information

Please enter below any other information that may help with the triaging and processing of this referral

Public Works 44: PDOT Referral Criteria

Our aim: To support service users in their treatment journey, and to improve surgical and psychosocial outcomes.



The Paediatric Dental and Oral-maxillofacial Trauma Psychology Service (PDOT) is a service designed to meet the psychological needs of children and young people (CYP) within the Dental and Oral Trauma pathways. If you think someone in your care is, or will be, at risk of experiencing significant psychological distress, we can provide specialist psychological assessment and support.

In particular, we will be working with CYP whose psychological distress may impact on:

- Their ability to undergo oral treatment,
- Those whose psychological distress has been caused or exacerbated by the traumatic event/diagnosis that led to their oral treatment,
- Those who have experienced trauma related to the oral treatment/diagnosis itself,
- Those who are experiencing appearance related distress as a result of their oral health, or related treatment.

REFERRAL CRITERIA

Who can be referred?

Anyone fulfilling the inclusion criteria below, aged up to 16 years old, who are currently under the care of **Barts Health Oral and Maxillofacial Surgery service** can be referred by their consultant surgeon or consultant orthodontist*. We are unable to accept referrals from any other speciality/service at this point.

We welcome referrals for CYP at the beginning of their oral treatment, as well as CYP at other points along the pathway, about whom you have concerns.

We can also meet with service users towards the end of their treatment, who present with difficulties in adjusting to their changed appearance.

Inclusion Criteria

1. Psychological distress* that interferes with upcoming or ongoing dental/oral treatment. This may include difficulties which impact on decision making

regarding their treatment e.g. whether or not to proceed with treatment. For example, where there are concerns about the service users:

- Psychological or cognitive capacity to agree to, or adhere to, a treatment plan.
- Understanding of treatment, or the associated risks and likely outcomes.
- Expectations and likely outcomes of treatment; aesthetic, physical and psychosocial expectations.

*Psychological distress may include: distress related to changed appearance, low mood, anxiety, phobias, self-harm, unrealistic perceptions about their body image, interpersonal difficulties, increased anger/ irritability, changes in sleep pattern and or eating, increased avoidance of social contact.

2. Psychological distress that is caused by:
 - a) The traumatic event or diagnosis leading to presentation at the PDOT clinic.
 - b) A traumatic event related to the treatment itself, e.g. a distressing surgical or ward experience.
 - c) A change in appearance, due to the traumatic event or diagnosis, leading to presentation at the PDOT clinic.
 - d) Significant anxiety/distress in relation to appearance.
 - e) Fear or phobia related to undergoing dental treatment/surgery. For example, needle phobias.
 - f) Interpersonal difficulties as a result of appearance concerns, or as a result of undergoing dental treatment.
 - g) Difficulties around decision-making regarding treatment. E.g. whether to proceed with treatment/surgery or not.
 - h) Chronic or acute pain, caused by oral condition.
3. Where there are concerns about the service user's adherence to treatment plans.
4. Where there are concerns about the service user's, or significant others, expectations of treatment and ultimate outcomes. These outcomes may be aesthetic, functional and/or psychosocial.
5. Clients requiring lifestyle support/intervention in facilitating dental care.
6. Family members, carers or other named individuals who are experiencing significant psychological distress as a result of the traumatic events experienced by the CYP*.

Exclusion Criteria

1. Severe and enduring mental health difficulties (e.g. active psychosis, substance misuse, risk to self and/or others) that are not managed elsewhere and that

impact directly on service user's engagement with the oral treatment pathway or with psychological therapy.

2. Mental health needs or psychological distress that pre-dates oral trauma/diagnosis, and does not directly impact on the planned oral treatment (as outlined in the inclusion criteria).
3. High risk of harm to self or others which is not managed by a secondary mental health care service. If you are concerned about immediate risk to the patient, please refer them to their GP, or to their local A&E.
4. People who do not want to access psychological interventions, or where applicable, have a legal guardian who does not consent to have the provision of psychological input.

**In line with the development of this new service, we will be implementing a phased approach for the referral process. In phase one, we will be accepting referrals from Consultant Surgeons and Consultant Orthodontists in the Barts Health Oral and Maxillofacial Surgery service. In phase two, we will be accepting referral requests from other healthcare practitioners and clinicians within the Barts Health Oral Maxillofacial Surgery service MDT, as well as internally from the dental psychology service. If there are any families who feel they need urgent psychological assessment or input, please do speak to a member of the team who can discuss the referral with you.*

How to Refer:

We are more than happy to discuss any potential referrals. If you are unsure or you would like to discuss a case informally please contact the PDOT team on:

Maria Langridge, Assistant Psychologist:

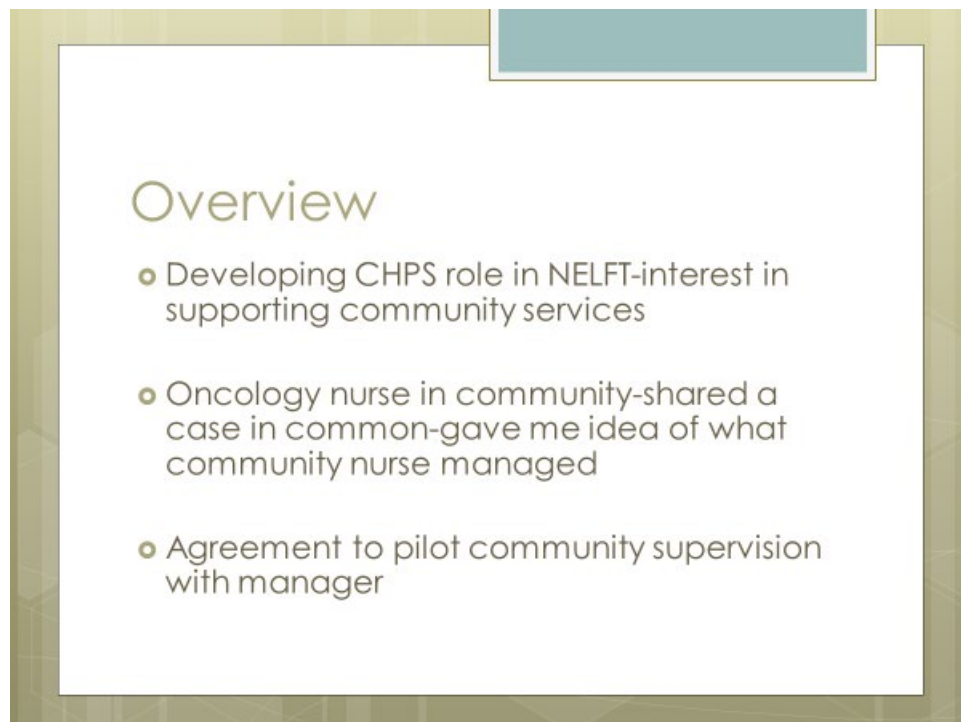
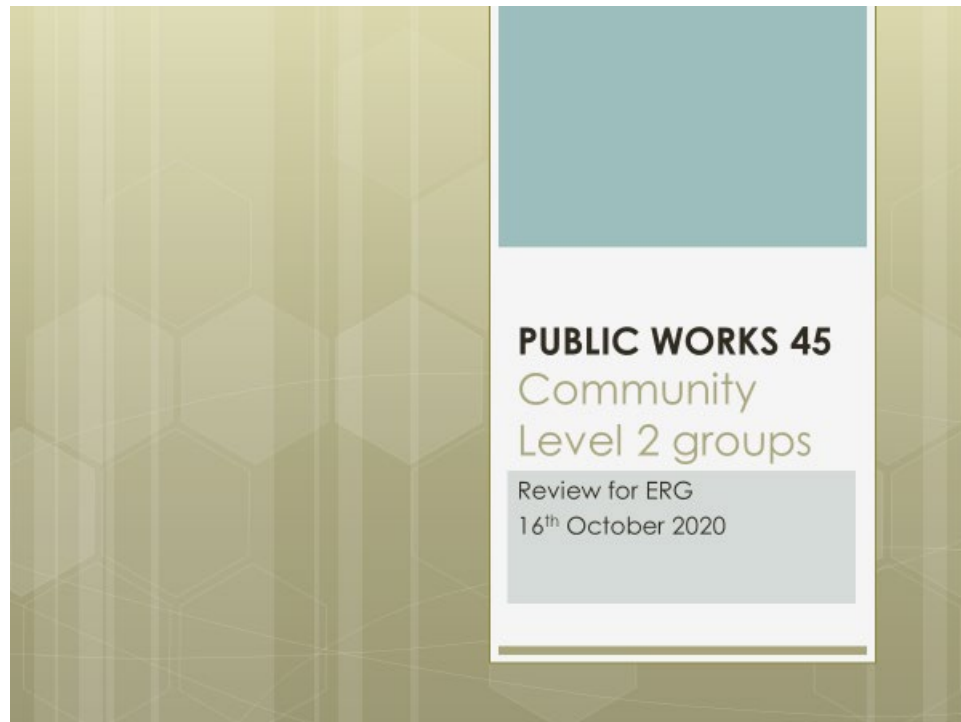
nem-tr.pdotpsychology@nhs.net , 0300 555 1201 ext. 55806

To make a formal referral, please email a completed referral form to:

Dr. Saras Saminathan, Consultant Clinical Psychologist, Service Lead for PDOT &
Dr. Jessica Roberts, Principal Clinical Psychologist:

nem-tr.pdotpsychology@nhs.net

Public Works 25: Community Level 2 presentation to LCA October 2020



Overview

- Decision to pilot group in 3 palliative care community settings (Macmillan based) in 2015
- No extra funding: part of my role as consultant clinical psychologist/WF colleague support me
- Discussion with ERG re using Level 2 model

Why Palliative Care L2 group?

- Palliative and End-of-life (EOL) conditions – become common aspect of community care
- District nurses-the most frequent and regular providers of 'hands-on' palliative care
- High levels of staff turnover in community health settings nationally
- Work-related stress, burnout and compassion fatigue are listed as significant factors related to these resignations .

Setting up Pilot Group

- No specialist clinical supervision for community teams
- Not only Cancer Nurse Specialists but MDT without input on emotional aspects of care
- Staff responded positively to setting up group

AUDIT

- 2019-approached by NELFT Director of Nursing to look at expanding Level 2 model in Palliative Care due to good feedback.
- Decision to undertake a survey of palliative care teams and psych focused supervision
- This was then registered as an Audit

SURVEY RESULTS

- 2 Questionnaires developed & administered through Survey Monkey
- Questionnaires similar, but one for current attendees of pilot level 2 groups; other community PC/EOL clinicians
- Inclusion/Exclusion criteria for study: no access to Level 2 groups in acute settings, regular access to PC/EOL cases.

What did Questionnaires measure?

- Benefits of level 2 clinical discussion: whether improved participants confidence in working with patients in palliative care managing their own emotional wellbeing?
- would recommend level 2 clinical discussion groups to their colleagues?
- Nature of their caseloads and additional support they obtained.

Questionnaires cont

- Second Questionnaire similar but also also questioned whether non –attenders would participate in a Level 2 clinical discussion forum if it became available
- Explanation of Level 2 model provided at front of questionnaire.
- Mixture of fixed responses and open-ended questions-allow for qualitative analysis of themes

Data and Results

- Analyses carried out in Stata, version 14.
- Thematic analysis of open ended questions.
- 11/12 attendees completed survey (91%)
- 27/30 non-attendees completed survey (90%)

Attendee Results

- 90% found that the group had boosted their confidence in working with patients emotional presentations.
- 82% -level 2 groups improved managing their own emotional well-being inside and outside of work.
- Over 90% would recommend the group to colleagues (11/12 respondents).

Thematic Analysis

- **Safe and confidential environment:** talk freely; no judgement
- Provided **containment**, for overwhelming, complex and distressing material –facilitator key to this
- **Emotionally supportive peer environment:** able to learn from others experiences
- **Shared relatedness:** recognise similar rewards, difficulties and challenges-complex/MH cases

Thematic Analysis cont

- **Reduction in feelings of isolation** by being able to share their concerns in a group setting
- **felt truly listened to** and experiences validated by facilitator & group
- improved **confidence**, especially in working with **mental health presentations** compared to when they first started in the group.

Non-Attendee results

- 90% unaware of Level 2 group model
- 86% of the non-attendees disclosed that their own emotional well-being at work was adversely affected
- 50% would like to join Level 2 group if option provided
- 80% noted like to join to help them with patients emotional presentations
- 60% join to obtain support with own emotional well-being as staff

Non-attendees why not attend?

- Work schedules and high caseloads
- Not having sufficient information to commit to a level 2 group
- Small percentage of respondents citing discomfort with the idea of group clinical discussion

Attendees & Non-Attendees

- Significant between-group differences were found in their answers (all $p < .001$)
- Attendees more likely to report own emotional well-being at work was affected by caseload, as well as by not having sufficient formal support.
- Attendees noted more patients presenting with psychological complexity

Discussion

- Results confirm wider literature especially:
- Community clinicians manage complex caseloads (significant co-occurrence of mental health distress) in patients and their families.
- Over 50% of non-attendeers lacked any regular professional support, but rather obtained from peers on an ad-hoc basis.

Discussion Cont

- Lone working patterns of community staff, especially district nurses prevalent
- Concern- without work peer support at work there may be an increased risk of isolation
- Attendeers reported less likely to require peer support outside of sessions compared
- Preference for group rather than individual supervision.