Royal College of Psychiatrists
Faculty of General Adult Psychiatry
Annual Conference

15-16 October 2020

Conference Booklet

Contents	Page

General Information

Accreditation

This conference is eligible for up to 6 CPD hours, subject to peer group approval.

Certificates

Certificates of attendance will be emailed to delegates after the conference.

Feedback

A detailed online feedback form can be found by visiting
https://www.surveymonkey.co.uk/r/7CCW6ZS

All comments received remain confidential and are viewed in an effort to improve future meetings.

Social Media

If you wish to tweet about the conference use @rcpsychGAP #gapsych2020

Posters

Poster viewing is available throughout the conference using the following links

Quality Improvement posters
Research & case reports posters
Education and Training posters
Service Evaluation and Audit posters

Conference Resources

Please see the following link to access the conference resources webpage.

Presentation abstracts and biographies

(Listed by programme order)

Abstracts and biographies not included here were not available at the time of going to print.

Thursday 15 October

Introduction and Welcome from the Faculty Chair

Dr Billy Boland

Dr Billy Boland is a Consultant Psychiatrist in community psychiatry and Deputy Medical Director at Hertfordshire Partnership University NHS Foundation Trust. He is the current Chair of the General Adult Faculty at the Royal College of Psychiatrists.

Plenary 1: Domestic violence and abuse and mental health during the Covid pandemic and beyond: implications for general adult psychiatrists

Professor Louise Howard

There has been increasing concern that the Covid pandemic has been associated with an increase in domestic violence and abuse. As mental health service users are at high risk of experiencing domestic violence and abuse (and less commonly but still with an increased risk, of perpetration of domestic abuse) psychiatrists need to know about domestic abuse, how the pandemic has impacted on this form of abuse and how to safely identify and respond to it. Recent research and guidance will be presented and an update on the domestic violence and abuse bill currently going through Parliament will also be discussed.

Louise Howard is a Professor of Women's Mental Health and Honorary Consultant Psychiatrist at the South London and Maudsley NHS Foundation Trust. She leads research programmes on violence against women, perinatal mental health and gender difference in mental health. She received funding from MRC, NIHR, Charitable Foundation Trusts and co-leads the UKRI Mental Health Network on Violence, Abuse and Mental Health (www.vamhn.co.uk). She is an NIHR Senior Investigator.

Symposium 1: Open dialogue as an example of co-production

Open Dialogue is a highly person-centered, systemic approach to acute mental health care, in which all staff are trained to work, not just with the patient, but with his/her whole network. This is done in a collaborative way, where every family member, friend or

significant other is seen as a true partner in the recovery process. The relationship between clinicians and the network is thus at the center of the care provided, requiring focus on continuity of care as well as a therapeutic approach to meetings that ensure every voice is heard and the network is given a sense of maximum agency and power over their own care and decisions.

The session will start with testimony from a service user about her experience of receiving Open Dialogue, followed by a discussion and Q&As with her family members about their own experiences too.

There is currently a major national trial going on evaluating Open Dialogue across the NHS and so, at the end, we will also hear about co-production in a research setting; how it is designed and cultivated at all stages of the evaluation process.

Professor Russell Razzaque is a consultant psychiatrist in north east London and also Director of Research at his NHS Trust, as well as a Visiting Professor at London South Bank University. He is an Open Dialogue trainer and coordinates the NHS's Open Dialogue training as well as the national ODDESSI trial, led by UCL and Kings College, London.

Russell is also an elected member of the General Adult Faculty Executive as well as the Council of the Royal College.

PPI Café Pilot Project - Co-production in Action
Dr Sam Robertson

Dr Sam Robertson is Lead Service User and Carer Involvement and Lead AIR (Approaches to Involvement and Recovery) Research Theme at Sussex Partnership NHS Trust.

Plenary 2: Responding to COVID-19 in mental health rehabilitation services
Professor Helen Killaspy

Helen Killaspy is Professor and Honorary Consultant in Rehabilitation Psychiatry. Her research focuses on services and interventions for people with complex mental health problems.
She is Chief Investigator for a national programme of research funded for five years (2012-2017) through a National Institute of Health Research Programme Grant for Applied Research - the Quality and Effectiveness of Supported Tenancies (QuEST) project. The programme is investigating the quality and outcomes associated with specialist supported

accommodation for people with mental health problems across England. It complements her previous NIHR Programme Grant (2009-2015) that investigated quality and outcomes for users of inpatient mental health rehabilitation services, the Rehabilitation Effectiveness for Activities for Life (REAL) project.

Professor Killaspy is an active teacher involved in supporting the education of students and mental health professionals at all levels of training and Continuing Professional Development

She teaches undergraduate medical students through formal lectures and clinical attachments. She is co-lead for the 'Mental Health Care; Evaluation and Policy' module of the Division of Psychiatry's MSc courses in Mental Health Sciences Research and Clinical Mental Health Sciences. She supervise PhD students within the Division of Psychiatry and has examined PhD students at Universities across London, the UK and abroad.

Friday 16 October

Symposium 2 - Racism, inequality and Covid-19 – the impact on BAME mental health

The wheels of race equality within organisations-they are a-turning
Dr Ananta Dave

My talk will discuss the need for inclusive, decisive and compassionate leadership and a robust organizational approach to addressing racial inequalities. Covid-19 has brought devastation and despair but also an opportunity to set things right. I will also be talking about my work as Chair of the Task and Finish Group at RCPsych which produced guidance around risk assessments, policy and recommendations to address the disproportionate impact of Covid-19 on BAME staff.

Dr Ananta Dave is Medical Director and Consultant Child & Adolescent Psychiatrist at Lincolnshire Partnership NHS Foundation Trust (LPFT). She is a Fellow of the Royal College of Psychiatrists and also holds a Master's degree in Medical Ethics and Law.

She was awarded one of the national Churchill Fellowships this year funded to conduct research in the United States on the topic of preventing doctors' suicides.

She is passionate about helping develop a leadership culture which promotes wellbeing of the workforce, and is actively involved in developing, mentoring and support services for doctors.

Dr Dave is President of the British Indian Psychiatric Association (BIPA) and in that role is keen to promote diversity in leadership, especially encouraging more women to take up leadership roles.

BAME patients and carers needs matter
Karen Persaud

The presentation gives an insight into the journey, emotional experiences and needs of patients and carers going through psychiatric services with particular reference to BAME communities.

Karen Persaud is a carer representative and campaigner for Mental Health patients and service users. Karen's involvement grew from a desire to influence change and ensure that the transformation of services had the needs of patients, service users and carers at its core. Karen is passionate and committed to evolving Mental Health Services provision with a specific focus on addressing gaps in provision for people from BAME background, SMI and carers. Karen's specific interests include; developing early intervention provision, social integration models, improved quality and choice of extended psychological therapies, wellbeing and quality of life, and the value of trauma informed approaches as relevant to the over-representation of young black males in the MH system. Karen's involvement as a carer adviser started with joining The Royal College of Psychiatrists in 2017 and has grown to include working on the Mental Health Act Review, NCCMH Framework for Community Mental Health, NIHR Mental Health PRU (published research on BJPsych and EClinical), NHS England Adult Mental Health Steering Group, Rethink and with the SWLStG and Oxleas NHS Trusts.

A perfect storm: A Pandemic Meets Structural Inequalities
Dr Rajesh Mohan

Dr Rajesh Mohan is a Consultant Psychiatrist at South London and Maudsley NHS Trust. He is also the Faculty Chair, Rehabilitation and Social Psychiatry. Dr Mohan is also the RCPsych Presidential Lead for Race Equality.

Symposium 3: Symposium 3: The Mental Wellbeing & Health of Doctors
Chair: Dr Adrian James

Dr Adrian J B James FRCPsych was elected President in 2020. He holds this role until 2023 and leads the RCPsych on behalf of its members and associates.

Adrian is Consultant Forensic Psychiatrist at Langdon Hospital in Dawlish, Devon. He is a former Medical Director of Devon Partnership NHS Trust and Founding Chair of the School of Psychiatry at the Peninsular Deanery (2006-2008).

He was the elected Chair of the South West Division of the Royal College of Psychiatrists (2007-2011) and sat on the College Council in this capacity. In 2010 he was appointed Chair of the Westminster Parliamentary Liaison Committee of the Royal College of Psychiatrists (attending the three main Party Conferences 2011-14 in this capacity).

He was Clinical Director for Mental Health, Dementia and Neurology, working for NHS England South West (2013-2015, interim from 2012-13). He has also acted as a Reviewer and Clinical Expert for the Healthcare Commission and its successor organisation the Care Quality Commission (CQC).

He has chaired expert review groups on Integrated Care Systems, Cannabis, Prevent and Learning from Deaths. In addition, he set up the Quality Improvement (QI) Committee and Workforce Wellbeing Committee at the College.

His priorities as President are:
1. Establishing a pathway to parity for mental health services
2. Equality and diversity
3. Sustainability
4. Workforce Wellbeing

Adrian is a keen cyclist.

PTSD in healthcare practitioners in relation to COVID-19
Professor Neil Greenberg

I will speak about the potential mental health impact of COVID on healthcare staff and evidence based ways of supporting them. This will include information about moral injury, PTSD, and the prevention of traumatic stress difficulties in organisational settings.

Professor Neil Greenberg is a consultant academic, occupational and forensic psychiatrist based at King's College London. Neil served in the United Kingdom Armed Forces for more than 23 years and has deployed, as a psychiatrist and researcher, to a number of hostile environments including Afghanistan and Iraq. At King's Neil leads on a number of military mental health projects and is a principal investigator within a nationally funded Health Protection Research unit. He also chairs the Royal College of Psychiatrists (RCP) Special Interest Group in Occupational Psychiatry. Neil has published more than 250 scientific papers and book chapters and has been the Secretary of the European Society for Traumatic Stress Studies, the President of the UK Psychological Trauma Society and Specialist Advisor to the House of Commons Defence Select Committee. During the COVID19 pandemic, Neil has worked closely with NHSEI, PHE and has published widely on psychological support for healthcare, and other key workers.

The Wellbeing Committee's Top Priorities

Dr. Mihaela Bucur

Dr Mihaela Bucur is the Royal College of Psychiatrists, Associate Registrar for Wellbeing and Retention Dr Mihaela Bucur is a Consultant Psychiatrist specialised in General Adult Psychiatry working at Linwood ATC, Sussex Partnership NHS Foundation Trust. She is The Associate Registrar for Wellbeing and Retention and Chair of the Wellbeing Committee at the Royal College of Psychiatrists. Workforce wellbeing, prevention of mental disorders and cultural psychiatry are Mihaela's main areas of focus, in addition to a longstanding interest in medical education. As a Honorary Senior Clinical Lecturer, she is leading a Postgraduate Module at the PGCert Psychiatry Course, Brighton and Sussex Medical School.

The Doctors' Mental Health Programme

Dr Nick Stafford, Black Country Healthcare NHS FT

In this talk I describe the need for a well-designed evidence-based internet psychoeducation programme to help support doctors and other healthcare practitioners with pre-existing mental disorders or a history of work related stress. Staying mentally well at work can be challenging, in particular when working in a complex healthcare setting such as the NHS. As well as understanding and managing your own mental disorder, there is the additional challenge of recognizing the various impacts and stresses that working as a doctor in healthcare brings, such as: your job plan; how work-related stress and burnout affect you; your work relationships; your manager and your relationship with them; the culture of your organization; your lifestyle and well-being; understanding your resilience as an individual and that of your organization; family and social support; and the wellbeing

and psychological safety of your Trust. Such a psychoeducation programme is currently under concept and design at the Royal College of Psychiatrists and this is introduced here.

Dr. Nick Stafford is a consultant general adult psychiatrist in the Midlands. He has an interest in the mental health of healthcare workers. He has established mood disorders services across the Midlands, including psychoeducation groups and a mood disorders tertiary service. He has published on these in peer-reviewed journals. He has an interest in the public understanding of psychiatry, having written and co-written books, had a long standing column in Mental Health Today magazine and edited books in the popular Dummies series. As a member of the Medical Journalists Association he supports journalists in the technical side of their writing. He is an executive member of the Workforce Wellbeing Committee for this project, the General Adult Psychiatry Faculty and is developing an educational service for faith leaders for the Spirituality SIG. He has sat on the Board of two mental health charities, including currently national Mind.

Poster exhibition

(alphabetically by surname)

Quality Improvement

1. Audit on overnight presentations in Mental Health Liaison Team, Lister Hospital, Stevenage

Dr Meda Apetroae, ST4, HPFT, Dr Arvind Hunjan- MHLT Consultant Psychiatrist, HPFT; Dr Champa Balalle, MHLT Consultant Psychiatrist, HPFT; Matthew Clarke- CGL worker, Lister Hospital, Stevenage

Background

Between 9 pm and 9 am, the referrals to mental health liaison team done by A&E Lister Hospital, Stevenage, consist mostly of people with drug and alcohol problems. These patients are a high risk group and they are referred to the mental health liaison team as we don't have a 24 hour Drugs and alcohol (CGL) service.

Aims and hypothesis

The aim of this project is to show how many of the cases that are referred to Mental Health Liaison Team by A&E overnight are related to drugs and alcohol misuse and what can we do to improve our services to help support these people, but also help prevent strain on mental health services.

Methods:

1. Sample: patients who presented to A&E Lister Hospital, Stevenage, Hertfordshire between 9 pm and 9 AM in the period 1st of April 2019 - 31st of May 2019
2. Project Tool: An audit tool was created
3. Method of data collection: Using Mental Health Liaison Team and CGL monthly databases and PARIS

Results

1. The number of presentations out of hours was 165
2. Out of all presentations, 15% of females and 67% of males had drugs involvement and 30% of females and 45% of males had alcohol involvement
3. 10% of the patients who presented to A&E that had drugs and alcohol involvement were already known to CGL and for 22% of patients a referral to CGL was discussed and 12% accepted the referral

4. 16% of presentations had contact with CGL within one month of the initial presentation to A&E. 8% of presentations had ongoing contact with CGL

Conclusions

1. Read only access to CGL patient records system for the mental health liaison team staff is needed prior to assessment in A&E
2. We recommend that CGL offers a 24/7 service in A&E

2. What should a psychiatry new patient clerking include? (A closed-loop quality improvement project)

Dr Dina Bastola, FY2, Kent and Medway NHS Trust (Lead author); Dr Michael Odunyemi, FY1, Kent and Medway NHS Trust; Dr Samantha Haines, FY1, Kent and Medway NHS Trust

Aims and hypothesis

Clerking a new patient in is part of the job role as a junior doctor in psychiatry. Although mental state exam is taught in medical schools, a thorough psychiatry clerking is not part of the curriculum. The aim of this closed-loop quality improvement project was to recognise the important information needed in a new patient clerking who has been admitted in an acute psychiatry unit. A new patient clerking proforma was created and sent to junior doctors after collecting data from the first study that included various subheadings and also the plan that needs to be carried out within 24 hours of a new patient being admitted in an acute psychiatry unit.

Background

Starting a new job in an acute psychiatry unit can be daunting to junior doctors. A survey done amongst new junior doctors found that most doctors were not sure of what needs to be included in a new patient clerking..

Methods

Data was collected from January to May 2020 for the first study and included 45 patients. Second study was carried out from May to August 2020 and included 17 patients. Data on various subheadings were collected including: Presenting complaint, history of presenting complaint, past psychiatry history, past medical history, psychiatry medications, other medications, allergies, family history, forensic history, physical examination, social history, mental state exam, risk and plan (which included blood form, ECG, VTE and drug chart to be written).

Results

Results from the first study showed that only 40% of the doctors asked patients about their allergies, 15% asked about forensic history, 66% performed a physical examination and 80% implemented the plan. New patient clerking proforma was then sent to all junior doctors on the rota and data was then collected. In the second study, there was a significant improvement; 88% asked about allergies, 29% asked about forensic history, 88% performed a physical examination and 94% implemented the plan within the first 24 hours.

Conclusion

New patient clerking proforma definitely helps junior doctors to include various important information as shown by results of this study and eases anxiety related to starting a new job and doing on-calls in an acute psychiatry unit. However, bigger data is required to analyse this further. Due to covid-19, there have been fewer admissions in the acute psychiatry unit which is reflected on the reduced number of patients in second study..

3. Collaborative Therapeutic Interventions during challenging times

Dr Kunal Choudhary, Consultant Psychiatrist, Cygnet Hospitals Woking; Ms Zelmarie DeVisser, Occupational Therapist, Cygnet Hospitals Woking; Ms Lucy Miller, Psychology Assistant, Cygnet Hospitals Woking

Aims and hypothesis

Aims and Hypothesis By combining the Occupational Therapy and Psychology group interventions we would expect to see a similar attendance rate combined in comparison if the groups were being run separately during the pandemic.

Background

There were significant disruptions in services delivered by healthcare professionals during the covid-19 crisis which posed a challenge for our female patients in the high dependency rehabilitation unit. This was in part due to the strict, but necessary social distancing measures advised by government guidelines. The therapeutic interventions offered on the ward are an integral part of the recovery pathway, and in the midst of the crisis, our professionals were able to think creatively and offer joint therapeutic interventions between Psychology and Occupational Therapy services, with the aim of continuing care delivery for our service users and maintaining their general well-being during such unprecedented times

Methods

We developed two specific trial groups.

1. Music and Emotional Regulation
2. Sensory and Anxiety Management Discrete groups run by each of the disciplines were reviewed, and those with common overlap were grouped together to run as a single joint working group whilst allowing each discipline to ensure their goals and outcome measures for the patients were still being fulfilled. Each group was scheduled over an 8 week trial period, open to all patients from the female High Dependency unit, with the intention of reviewing attendance rates during the period.

Results

1. Music and Emotional Regulation There was a 59% increase in attendance rates in comparison to the sum of the average attendance rate of service users in each group run separately

2. Sensory and Anxiety Management There was a 31% increase in attendance rate in comparison to the sum of the average attendance rate of service users in each group run separately.

Conclusion

1. Combining the therapeutic groups led to an unexpected increase in attendance rates during the pandemic.
2. This unexpected increase created challenges which were overcome by finding a larger capacity venue in order to ensure social distancing was being exercised.
3. The service users have responded positively to the collaborative interventions offered.

Next Steps:

1. We would aim to continue running the combined therapeutic interventions and monitor attendance rates, satisfaction surveys and relevant outcome measures as restrictions ease
2. Ongoing local restrictions are being utilised in light of rising R rates and concerns of a future surge in covid-19 cases, particularly as people are being encouraged to go back to work, schools re-opening and winter approaching. Collaborative methods of working may help services prepare in advance of any future unforeseen events, with the aim of causing minimal disruption of clinical service delivery

4. Are the staff in Heddfan Psychiatric Unit, Wrexham Maelor Hospital, are adhering to the Personal Protective Equipment (PPE) guidance as per Public Health Education, England? A QIP

Dr Asha Devi Dhandapani, CT3, BCUHB NHS Trust; Dr.Sathyan Soundararajan, CT3, BCUHB, NHS Trust; Dr Rajvender Sambhi, Consultant Psychiatrist, BCUHB, NHS Trust

Aims and hypothesis

1. To ensure that the PPE guidance is strictly adhered to
2. To ensure that patient care is not compromised
3. To help us in areas of need in order to teach the staff regarding the techniques of PPE and thus patient and staff safety and care.

Background

Novel coronavirus 2019 was first described in December 2019 in Wuhan in China. Since those initial few cases, it has rapidly proliferated to a global pandemic, putting an inordinate amount of strain on healthcare systems around the world. The aim of this audit is to assess whether healthcare staff are correctly donning and doffing PPE

Methods

None of the staff were aware of this Audit and this is entirely random observation Data collection was done by Junior doctor. This is a prospective audit. A table was created, with the key relating to the techniques as per guidance for PPE, which related to the standards listed in PHE guidelines

Results

We observed 50 members in total. Out of this 50, 37 of them washed their hands prior to donning. 32 of them wore the apron, mask and gloves appropriately while donning PPE, which is 64 % whilst 36% did not wear them appropriately and about 10-14% did not wear PPE at all. In regard to doffing technique, overall utilising of hand gel was least performed in between the techniques. A mere 7 out of 50 alone used hand gel. I had noticed that the staff nurses, health care support workers and Helpers were not able to recollect the PHE guidelines. There are no posters available in the clinics and outside in the communal area, which could re-inforce the staff regarding the PHE guidance. I personally felt that we need further training of the staff in Heddfan in this regard. Whilst 68% of them removed the gloves first, just over 50 % of them removed the apron and mask correctly in an order as per guidelines. Final hand washing was achieved by 94% of them.

Conclusion

Overall the donning and doffing of PPE was not being followed and adhered to according to the standards from PHE. Hence the recommendations were made to train staff and re-arrange areas for PPE use. The PDS is being done now this week

5. A Quality Improvement Project on Improving Risk Assessment of Domestic Violence and Abuse at Southwark Perinatal Service

Dr Christina Huggins, CT3, South London and Maudsley NHS Foundation Trust

Aims and hypothesis

A Quality Improvement Project on Improving Risk Assessment of Domestic Violence and Abuse at Southwark Perinatal Service

Background

Southwark Perinatal Service provides specialist mental health care to a caseload of around 75 women in Southwark who are pregnant or up to one year post-partum and experiencing moderate to severe mental illness. 1 in 4 patients in contact with mental health services are likely to be current or recent victims of DVA and perinatal patients are especially vulnerable. During the COVID-19 epidemic, there has been a reported increase in DVA nationally and there was a serious incident of DVA within our service during lockdown. NICE guidance states that the assessment of a suspected mental health problem in pregnancy and the postnatal period should include risk assessment of DVA, but this is not always clearly documented.

Methods

Risk Assessment Tools for 29 initial assessments conducted by clinicians at Southwark Perinatal Service over two defined six week intervals between 23/03/2020 and 24/07/2020 were screened for evidence of documentation of the absence or presence of recent or current DVA and, if present, a specific plan regarding DVA. The interventions were implemented prior to the second round of data collection and included a training session and summary sheet of this training. Online surveys prior to and following the interventions assessed for improvement in clinicians' confidence in their assessment of DVA.

Results

Following the interventions, clinicians' confidence in carrying out a risk assessment of DVA improved from 3 to 3.25 out of 5, where a score of 1 indicates "not at all confident" and 5 indicates "extremely confident".

Of the 14 initial assessments completed pre-intervention, 11 had a Risk Assessment Tool completed, seven of which (63.6%) included documentation on the presence or absence of DVA. Two of the four identified DVA cases had specific plans documented. Post-

intervention, this worsened to seven out of 13 (53.8%) Risk Assessment Tools including documentation on DVA. Neither of the two identified DVA cases had plans documented.

Conclusion

Whilst clinicians reported improved confidence in risk assessing DVA post-interventions, this was not reflected on review of documentation. High staff turnover and small sample sizes were noted. Further training on DVA will be delivered on a regular basis and outcomes reassessed.

6. Reducing long acting injectable antipsychotics (LAIs) frequency in response to COVID-19: a community mental health team's approach

Dr Amrita Joottun, CT3, West London NHS Trust Dr Clare Smith, Consultant Psychiatrist, CNWL NHS Foundation Trust

Aims and hypothesis

The aim of this Quality Improvement Project is to reduce the number of face-to-face contacts in the depot clinic at the South Kensington and Chelsea Community Mental Health Team (SK&C CMHT) by 25% over a period of 3 months by reducing the frequency of LAIs where it is clinically indicated. The rationale is that this will lead to a decrease in the risk of SARS-CoV-2 transmission at the CMHT.

Background

Despite the push to minimise close contacts with patients during the pandemic, there has been little guidance on how to determine the clinical suitability of patients for reducing their LAIs frequency.

Methods

A criteria was devised to assess the clinical indication for the intervention: 1. Stable mental state 2. Absence of side effects on the current dose of LAIs 3. Absence of breakthrough symptoms 4. Good engagement with the depot clinic 5. Maximum injection dose not reached 6. Patient consent Patients who were on 2-weekly and 3-weekly injections were identified, and their notes were systematically reviewed using these criteria. Feedback was also obtained from their care-coordinators and the clinic nurses. The patients were consented and their LAIs were switched to a higher injection dose and lower frequency, keeping the overall dose unchanged. Going forward, these patients will be monitored for relapse indicators, side effects and breakthrough symptoms. The number of clinic attendances before and after the intervention was calculated for a period of 3 months for these patients.

Results

There was a total of 85 patients on LAIs at the CMHT. 35 of them were identified to be on 2-weekly and 3-weekly depot injections. 11 patients met the criteria and were switched to a lower frequency of injections. Over the next 3 months, it is projected that these patients would now have a reduction of 30 (42%) close contacts in the depot clinic. As the injections will now be administered less frequently, the cost savings over this period are expected to be £297.21.

Conclusion

Using the robust criteria that was established during this project, this intervention is replicable in depot clinics based in other community teams in an attempt to minimise close contacts. There is also scope for the frequency of monthly Paliperidone injections to be further reduced to 3-monthly.

7. Containing Covid: Quality Improvement Project on Establishing a COVID-19 Isolation Ward in a Psychiatric Inpatient Unit.

Dr Melanie Knowles, ST6, C&I NHS Trust; Dr Dominic Aubrey-Jones, CT2, C&I NHS Trust; Dr Janet Obeney-Williams, Consultant Psychiatrist, C&I NHS Trust; Dr Senem Tugrul, Consultant Psychiatrist, C&I NHS Trust

Aims and hypothesis

To use the Quality Improvement (QI) Model to establish a safe, effective isolation and treatment ward for adult psychiatric inpatients with suspected or confirmed COVD-19.

Background

On March 11th, 2020, the novel coronavirus (COVID-19) outbreak was declared a global pandemic. Amid other measures taken by our trust's senior management team, a decision was made on 18th March 2020 to convert the trust's acute admissions (triage) ward into a ward dedicated to suspected or confirmed COVID-19 patients. The goals were to isolate patients, contain the outbreak within the hospital, and focus on high quality medical management of patients who became acutely physically unwell.

Methods

We used the QI model to instigate and review multiple rapid changes in the ward's daily structure, nursing and medical practice to accommodate the change in function to a COVID-19 Isolation Ward. Using recurrent PDSA cycles we were able to assess the outcomes to these changes qualitatively using feedback from both staff and patients. Examples include enhancing the frequency of medical and psychiatric reviews for all patients, increasing the frequency of physical observations and conducting staff training on oxygen management.

Results

Overall the structural and clinical changes to the ward were met with positive feedback from staff and service users. Comments or suggestions for further improvement informed further PDSA cycles, which were again initiated in a flexible manner as part of our day-to-day practice on the ward. Patient outcomes were also positive although the data used to drive the QI project was largely qualitative in nature.

Conclusion

Our project demonstrates that the Quality Improvement Model can be used flexibly and does not necessarily need to be driven by quantitative data. We instigated multiple

changes across a broad range of different areas (clinical, structural, patient-focussed and staff-focussed) and were able to further adjust these changes based on ongoing feedback. Some of the changes made during this period will be carried forwards as the ward resumes its usual role as an acute assessment ward.

8. Quality Improvement Project: Improving Awareness and Liaison Between GP Practices and Mental Health Services in Barnet, Enfield and Haringey NHS Trust

Dr Laura Korb, Consultant Psychiatrist, BEH NHS Trust; Dr Ambrose Viall, ST6, BEH NHS Trust; Dr Melanie Knowles, ST6, C&I NHS Trust; Dr Daniel Hughes, ST6, BEH NHS Trust; Dr Adam Clare, ST5, BEH NHS Trust; Dr Timothy Evans, ST6, C&I NHS Trust; Dr Maja Elia, Consultant, BEH NHS Trust

Aims and hypothesis

Aims: To improve the working relationship between Barnet, Enfield and Haringey Mental Health Trust and local GPs. Hypothesis: Hypothesis Local GPs will not at baseline have a good understanding of the support available and the referral processes across the trust

Background

Barnet, Enfield and Haringey is a large mental health trust serving a population of around one million people. The RCGP estimates that a quarter of all people will experience a mental health problem in a year, with the majority being managed by their GP. It is therefore important for mental health trusts to have excellent working relationships with local GPs in order to provide service users with high quality care

Methods

A pair of Higher Trainees from each borough prepared presentations outlining its services, referral pathways and ways to access advice and support. A pre- and post-session questionnaire with a 5-point Likert scale was devised to measure changes in understanding of and relations with the BEH services. Qualitative data were gathered on the difficulties GPs encounter in liaison their local mental health services.

Results

35 GPs engaged in the sessions from several practices across the three boroughs. There was a 20% increase in understanding of service structures, referral pathways and knowledge of how to access advice and support in both urgent and non-urgent settings following the sessions. There was a 20% increase in perception of the relationship with mental health services in BEH. 86% of GPs agreed or strongly agreed that the sessions were useful. Written feedback indicated the sessions were well received. Themes arising in discussion during sessions included frustration at poor written communication, difficulties in referrals to the Crisis Team, finding Link Workers to be a barrier to accessing secondary care, and practical difficulties or delays with the daily consultant advice line.

Conclusion

Meeting with GPs, sharing information about services and listening to their concerns led to a demonstrable improvement in feedback from GP practices about their relationship to mental health services. Wider issues around written communication, access to crisis support/consultant advice and barriers to referrals will be fed back to service leads.

9. Improving the transfer of physically deteriorating patients between the Mental Health Unit and the Acute Hospital

Dr Ishbel Macfarlane, LAT4 in Forensic Psychiatry, Rowanbank Clinic, NHS Greater Glasgow and Clyde

Aims and hypothesis

This quality improvement project set out to improve the transfer of physically unwell patients between the Mental Health Unit (MHU) and Acute Hospital (AH) at Forth Valley Royal Hospital (FVRH). The project aimed to decrease the time taken for patient transfer and improve consistency of patient handover during the transfer process.

Background

FVRH is a large district general hospital containing all acute medical, surgical and psychiatric wards for NHS Forth Valley. The MHU has a limited capacity to monitor and manage physically unwell patients and therefore patients are regularly transferred to the AH. Staff in both the AH and MHU reported failures in communication during the transfer process. An initial service evaluation demonstrated that Medical Transfer Forms, created for the purpose of patient handover during transfer, were not consistently utilised. In addition there were regularly delays in the transfer of patients to the AH.

Methods

Data was collected prospectively from patient notes, in three cycles, over the period 7 December 2017 – 28 July 2019. Data was collected on the time taken for patients to be transferred from the MHU to the AH and on the completion of Medical Transfer Forms. Over this period several tests of change were implemented. A new policy was introduced stipulating a one-hour transfer time from the MHU to the AH. Interventions also focussed on increasing awareness and availability of Medical Transfer Forms.

Results

During the three cycles there were 51 transfers from the MHU to the AH and 34 return transfers. Median time for patient transfer from the MHU to the AH reduced from 3hours 10minutes to 1hour 45minutes. There was an increase in the completion of Medical Transfer Forms from 31% to 79% for patients transferred from the MHU to the AH. For patients returning from the AH the completion rate of Medical Transfer Forms increased from 55% to 100%. Telephone discussion between medical staff in the AH and MHU prior to return transfer reduced from 61% of patient transfers to 57%.

Conclusion

Overall, there was an improvement in the safety of transfers between the MHU and AH. Further interventions could be aimed at medical staff in the AH and psychiatric nursing staff; two groups that are vital in the safe transfer of patients. Further changes also need to be made to encourage psychiatric junior doctors to follow the escalation policy for patients not transferred to the AH within 1hour.

10. Are new referrals to EIS assessed quickly enough? – a quality improvement project

Dr Sachin Modi, FY2, BEH Mental Health Trust; Dr Latha Weston, Consultant Psychiatrist, BEH Mental Health Trust

Aims and hypothesis

To determine if new referrals to our local Early Intervention in Psychosis Service (EIS) were seen for initial assessments and medical reviews in a timely manner.

Background

For patients with first episode psychosis, getting access to appropriate care efficiently is essential for optimising the long term prognosis. As per NHS England/NICE standards, 60% of referrals to EIS should have an initial assessment, acceptance onto the caseload and allocation of a care coordinator within 2 weeks of the initial referral date to ensure this. There is however no national advice on how quickly patients should be seen for a medical review. Our aims were therefore to determine how long it was taking to arrange medical reviews and subsequently implement a suitable temporal policy, and also assess if the standard for initial assessments is being met.

Methods

An audit was performed investigating twenty new accepted referrals to the EIS over December 2019 to April 2020. For each referral, we retrospectively determined whether they had an initial assessment and acceptance onto the caseload within two weeks, and the number of days between referral and medical review.

Results

For initial assessments, 25% of referrals did not meet the standard of 2 weeks (5% non-attendance; 5% admittance to a ward; 15% other reason).

The average number of days between referral and medical review was 40 (mean) and 29 (median). Range was 3 to 106 days.

40% had medical reviews more than 35 days after referral (5% non-attendance; 15% admittance to ward; 20% other reason).

5% were lost to follow up.

Conclusion

These results indicate that we are currently meeting the standard for initial assessments, although month-month analysis showed that February and March failed to meet the standard likely due to the coronavirus pandemic. However, a quarter of medical reviews

took 5 weeks or longer (excluding patients admitted to wards). To improve this, we updated our team policy such that medical reviews take place within a month of referral. Furthermore, due to a lack of standards for referred ward patients, another target was introduced where patients should be seen for a medical review within 3 weeks of discharge from the ward. For local education, we presented this at our weekly team meeting and posters were distributed around the office and via emails. A second audit cycle is taking place, with the results ready for conference presentation.

11. Reducing the Use of Oral Psychotropic PRN Medication in Acute Mental Health Inpatients

Dr Zoe Moore, ST6, Belfast Health and Social Care Trust (lead author); Dr Clare McGrory, F2, Belfast Health and Social Care Trust; Dr Niamh Crossan, F2, Belfast Health and Social Care Trust; Hilary Rea, Mental Health Pharmacist, Belfast Health and Social Care Trust; Stephen Guy, Lead Mental Health Pharmacist, Belfast Health and Social Care Trust; Joanne Mulryan, Deputy Ward Sister, Belfast Health and Social Care Trust; Shannon Hill, Deputy Ward Sister, Belfast Health and Social Care Trust

Aims and hypothesis

The aim of this quality improvement project was: To reduce the use of oral psychotropic PRN medication on Ward 3 AMHIC (Acute Mental Health Inpatient Centre) by 20% by May 2020

Background

The use of psychotropic "PRN" medication in the acute psychiatric inpatient setting has a clear role in relieving acute distress and agitation. There are, however, a number of potential adverse consequences of this medication, particularly with frequent or long-term use. On Ward 3, we noted these issues to include: 1) Over-use and dependence, 2) Side effects, 3) Escalation of aggression. Following the success of our colleagues in the Child and Adolescent Mental Health Inpatient Service, we decided to embark on a project to reduce the use of psychotropic PRN medication on our ward.

Methods

We gathered a small multidisciplinary project team to set about addressing this problem. First, we collected baseline data on the use of oral PRN medication over a 12 week period and brainstormed potential contributory factors to its over-use. We then displayed these visually as a driver diagram, with 3 primary drivers: 1) Safe prescribing, 2) Safe administration, 3) Safety culture. We agreed on the following measures: Outcome: Number of doses of oral psychotropic PRN medication administered per week; Balancing: 1) Violent incidents 2) IM administrations of psychotropic medication; Process: 1) Time taken to complete interventions, 2) Patient and staff satisfaction. Data was then collected weekly from the beginning of February 2020. We selected two key interventions, which were implemented in turn, using Plan-Do-Study- Act methodology, 1) Weekly review of PRN prescribing (commenced 03/02/20); 2) Nursing administration sheet (commenced 24/02/20). We plotted our weekly data on a run chart and held regular meetings to review progress and make necessary amendments.

Results

By the end of May 2020, we had exceeded our initial goal, reducing the weekly median number of doses of oral psychotropic PRN medication administered by over 30%. Our balancing measures of numbers of violent incidents and IM administrations remained unchanged from baseline. We received positive feedback from a staff survey.

Conclusion

We hope to continue this project over the coming months and build on the progress that we have made. Further interventions will include junior doctor education on prescribing of PRN and RT as part of trust induction. We also aim to introduce patient education and feedback in either 1:1 or focus group format

12. Exploring Participants' Views on Virtual PGME

Dr Razan Saeed, CT2; **Dr Megan Parsons**, CT2; Dr Nidhi Gupta, ST6; Dr Kallol Sain, Consultant, Clinical Tutor; Dr Fiona Hynes, Consultant, Director of Medical Education, Birmingham and Solihull Mental Health

Background

Due to the COVID-19 pandemic and introduction of social distancing measures, the weekly postgraduate medical education meeting (PGME) could not be conducted face to face. A 'virtual PGME', delivered via a web-based platform, was introduced in order to continue postgraduate teaching

Methods

Following 8 weeks of virtual PGME, a survey was conducted using Survey Monkey to evaluate the experience of virtual PGME from the perspective of the presenters, facilitators and audience members.

Results

102 total responses (highest response rate from the audience, followed by presenters then facilitators). 55% of presenter responses were positive towards virtual PGME (29% neutral, 15% negative), and 42% of responses showed a preference for virtual PGME vs face to face (31% neutral, 27% negative). Facilitators responded more positively towards virtual PGME at 65% (22% neutral, 13% negative). They also showed a preference for virtual PGME vs face to face (65% positive, 18% neutral and 17% negative). Finally, the audience responded most positively (71%) to virtual PGME (13% neutral, 14% negative), but less positively comparing it with face to face (47% positive, 35% neutral, 19% negative). 81% of all respondents stated they would like PGME to continue using a hybrid model (face to face presentation shared with others remotely) once social distancing measures are relaxed.

A thematic analysis of respondents' free text responses was conducted. Themes of engagement, communication, accessibility, success, and health were identified. Frequently mentioned sub-themes included convenience, attendance, discussion, use of technology, communication and the social aspect. Participants largely felt that virtual PGME was more convenient and accessible, but also that it was more difficult to engage and communicate compared with face to face.

Conclusion

Most respondents felt that a hybrid model would be best going forward, which would balance the convenience and accessibility of virtual PGME with the social and communication aspects of face to face meetings. It was felt that better training in the use of technology, as well as the use of microphone integrated webcams, projectors with speakers and split-screen would improve the experience. Recording presentations could also be considered to improve accessibility for those unable to attend. Implementing this model would require financial support from the Trust.

13. Psychotherapy Referrals – Associations between assessment, attendance and outcomes

Dr Keval Patel, CT3, LPT. Dr Yamini Ram, ST8, LPT.

Aims and hypothesis

This study evaluates referrals to the Dynamic Psychotherapy Services (DPS) in Leicester for an association between attendance patterns during assessment and their suitability for Psychodynamic therapy. Struggling to engage in the assessment process could be a communication of struggling to engage in exploratory therapy, and could confer a greater likelihood of being deemed unsuitable for therapy. In addition, the study looks at the association with substance misuse and deliberate self harm.

Background

All referrals to the Dynamic Psychotherapy Service are initially triaged for referral criteria and offered an assessment meeting within 13 weeks of referral. Most assessments are carried out in 2 meetings and some can be extended to up to 6 meetings. Patients are assessed for suitability for Psychodynamic Psychotherapy and offered group or individual, long term or brief therapy according to their needs.

Methods

Data was gathered retrospectively and included all referrals between 1st April 2018 to 30th June 2018. A total of 56 patients notes were evaluated using a specifically designed data collection tool.

Results

Of the 56 patients, 27 were deemed suitable for psychodynamic psychotherapy and 29 were not. The unsuitable patient group had higher rates of poor attendance patterns (patient cancellation, late arrivals or non-attendance) when compared to the suitable patient group (72% vs 56%). There were more cancellations (38% vs 26%), late arrivals (45% vs 33%) and substance misuse (17% vs 4% more). There was also a lower proportion of current Self harm (7% vs 22%) in this group. Of note, there is a significantly higher proportion of patients with at least 1 non-attendance in the unsuitable patient group compared to the suitable group (48% vs 11%).

Conclusion

Overall there are higher proportions of a poor pattern of attendance in those deemed unsuitable for therapy. The most significant difference observed is nearly half of these

patients had at least one non-attendance compared to 11% in the suitable patient group. Nevertheless, we are unable to conclude definitively how many of those who do not attend will be unsuitable. Non-attendance and late arrivals could be a communication of struggling to do exploratory work, however it could also be a communication of various defences or transference reactions which could be worked through. Introducing a pre-assessment questionnaire could initiate early engagement into the exploratory work and may have potential to ease patients into this process.

14. Improving physical health monitoring and care in a forensic psychiatric secure service

Ms Nandine Paul, Medical student, King's College London ; Ms. Charlotte Palmer, Medical student, King's College London Ms Madeleine Landin, Medical student, King's College London Ms. Puneh Shahrjerdi, Medical student, King's College London

Aims and hypothesis

To empower patients to follow healthy lifestyle guidance. We aimed to achieve this through promoting psychical health initia-tives on inpatient wards and encouraging patients to engage with healthy lifestyle focus groups. Our objective aim was to reduce weight and waist circumference in 60% of patients compared to their pre-intervention measurements.

Background

Patients in the psychiatric inpatient setting are at increased risk of developing physical health complications due to their diet and lifestyle and the potential metabolic side effects of their antipsychotic medications. Psychiatric patients have a higher mortality rate and lower life expectancy than non-psychiatric patients owing to their physical co-morbidities (such as cardiovascular disease and diabetes mellitus). Thus, close physical health monitoring of psychiatric patients and health promotion is paramount to narrow this mortality gap and improve their future quality of life. Weight and waist measurements are important parameters to monitor in an inpatient setting, as they give an indication of a patient's cardiovascular and metabolic risk profile.

Methods

Patient weight and waist circumference data for 18 inpatients across 3 wards, was collected at baseline and weekly intervals throughout the 8-week intervention period. A qualitative questionnaire was also recorded to assess patient understanding of healthy lifestyle measures. Both interventions were designed and implemented with collaboration with patients, targeting areas that they felt would be most beneficial. Two PDSA cycles were completed:

1. Series of 4 weekly psychoeducation sessions followed by group exercise.
2. Introduction of patient healthy living diaries, detailing daily diet and exercise.

Results

Our data did not demonstrate any definitive impact of either intervention upon the waist circumference or weight. Furthermore, adherence to monitoring policy was low amongst staff, and lack of any standardised measurement methods resulted in significant operator-

dependent variations. However, analysis of the questionnaires showed a clear and consistent trend of knowledge improvement and understanding with regards to healthy living.

Conclusion

Whilst our primary aim of reducing patient weight and waist circumference was not realised, there was a significant positive im-pact on participant's knowledge. Our project also highlighted inconsistencies in weight and waist circumference measurement and data collection within the trust, providing reason for the trust to implement further quality improvement measures. We highlighted areas for future QI withinin the trust, putting forward suggestions to implement a standardised measurement protocol and staff training to combat inconsistencies in weight and waist circumference data.

15. Addressing Non-Attendance Rates for a Community Mental Health Team (CMHT) in Staffordshire, a Quality Improvement Project

Dr Leah Riley, ST6 in Forensic and General Adult Psychiatry, North Staffordshire Combined Healthcare NHS Trust (lead author); Dr Ravi Belgamwar, Consultant Psychiatrist, Honorary Senior Lecturer and Research and Development Director, North Staffordshire Combined Healthcare NHS Trust; Mr Dave Norcup, Information and Costing Associate, North Staffordshire Combined Healthcare NHS Trust; Mr Nicholas Wildin, Costing Manager, North Staffordshire Combined Healthcare NHS Trust.

Aims and hypothesis

The CMHT and the Trust's Costing Department discussed improving outpatient attendance. The primary driver was reducing non-attendance, improving patient experience. Secondary drivers included fewer re-booked appointments thereby reducing waiting times; and reducing the need to risk manage and decision-make for those who did not attend.

Background

The Costing Department found that previously, 26% of appointments were not attended (excluding cancellations), equating to £140/appointment (average), and £257,180 if appointments weren't refilled. Furthermore, Thursday and Friday appointments had higher non-attendance (28%), and 9-10am appointments had highest daily non-attendance (31%). Few appointments were booked after 1pm (16.6%); but 1-2pm had lowest non-attendance rates (16%).

Methods

Interventions took place from September to November 2019. Initially, telephone reminders began for New Patient appointments. As they are longer, these are more costly. Secondly, telephone reminders for 9-10am appointments. Telephone reminders were undertaken by administrative staff, meaning that appointments could be rearranged immediately, and the slot offered elsewhere. Appointments which were cancelled by patients or Trust were excluded. Telephone contact (unsuccessful or not) was recorded along with actual attendance. During the process there was a 'mishap' where a lack of communication and staff sickness meant that patients were accidentally not called for around 3 weeks. This mishap was included in the results.

Results

Using a run chart, pre-intervention attendance rate for New Patient appointments was 63.5%. During intervention, 59% answered the reminder call. Including the 'mishap' period, intervention attendance rates for those who answered rose to 77.2%. Excluding the 'mishap' period, attendance rates were 93% for those who answered. When including those who did not answer the reminder call, attendance rates were 70.1% (including 'mishap') and 77% (excluding 'mishap'). For 9-10am reminder calls, attendance rates rose to 97.3% (when answered), and 88% when unanswered. A pre-intervention period was not used for comparison as just prior to this intervention period, all New Patient appointments were being called, which may have skewed the data.

Conclusion

These are promising initial results, and as such, telephone reminders continued thereafter. A plan to compare these results and costings with text message reminders was in place, but the Coronavirus pandemic changed the team's way of working vastly to telephone/video consultations, disrupting this project due to administrative priorities. There may be further merit in reviewing however, whether virtual attendance rates are higher than face-to-face.

16. A Skipped Beat? A Review of Prevalence and Follow Up of Sustained Tachycardia in Patients Taking Clozapine

Dr Nathan Rouse CT2, CNWL NHS Trust; Dr Jessica Irwin, FY3, Guys and St Thomas' NHS Trust; Dr Samuel Glace, GPST2, LNWUH NHS Trust; Dr Massimo Bernini, Consultant, CNWL NHS Trust

Aims and hypothesis

Our hypothesis was that there would be a high prevalence of un-investigated tachycardia in patients receiving clozapine from the Brent Community Mental Health Team (CMHT). The aim was to survey the physical health of all patients prescribed clozapine by the Brent CMHT and provide guidance on how to support patients' unmet physical health needs.

Background

Clozapine's use is limited to treatment resistant, severe mental illness due to its side effect profile. One common side effect is persistent tachycardia which local guidelines suggest should be followed up with a cardiology review. Tachycardia can be a sign of underlying cardiac pathology and the sinus tachycardia associated with clozapine use can be symptomatic; contributing to clozapine discontinuation.

Methods

Electronic notes and the ZTAS registration list were checked revealing 181 on clozapine as of 10/06/20 who were receiving their prescription from the Brent CMHT. Authors reviewed patients' electronic records for heart rate recordings at the Clozapine clinic as well as for other prescribed medications. Any patient with evidence of a heart rate over 100 on more than one occasion or on a Beta Blocker for rate control was recorded. The highest HR value was recorded in patients found to be tachycardic.

Results

Over half of our patients on Clozapine had more than one reading of tachycardia at the Clozapine clinic or had medication for rate control (n=99). Only a small minority of these patients on rate control with a B-Blocker (n=10). No other chronotropic medications were prescribed in this population. Of the 89 patients who were not rate controlled, 35 had a HR101-110, 30 had a HR111-120, 19 had a HR121-130 and 5 had a HR>130. Assessment of recommendations to GP for onwards referrals and investigation was difficult due to lack of clarity within our records.

Conclusion

The prevalence of tachycardia in our population was higher (55%) than anticipated from existing literature(25%). Many of our patients were having repeated incidences of tachycardia recorded without evidence of adequate investigation or treatment. One potential reason appeared to be a lack of communication between staff at the clozapine clinic, CMHT and the patient's GP practice. A guideline was proposed for use by the CMHT to improve the prevalence of requests for investigations from the patient's GP. Patient symptom questionnaires were devised, allowing for rapid decision making by staff at the clozapine clinic, and template letters to be sent to the GP which included forwarding details for outcomes. This included a pathway to identify potentially life-threatening causes of tachycardia such as infarction or mycocarditis. Follow up would involve reviewing the prevalence of tachycardia and rate controlling medications to observe the uptake and efficacy of the proposed change to guidelines.

17. Quality improvement project to improve Cardio-metabolic Screening for patients on Care Programme Approach in a Community Mental Health Team

Dr Sarah Saxena, Specialty doctor, South West London and St George's Mental Health (SWLSTG) NHS Trust; Dr Alberto Gutierrez Vozmediano, Consultant Psychiatrist, SWLSTG NHS Trust; Sarah Moodie, Team Manager, SWLSTG NHS Trust; Katrina Walsh, Community Psychiatric Nurse, SWLSTG NHS Trust; Rumbi Mapfumo, Team Manager, SWLSTG NHS Trust.

Aims and hypothesis

We aim to improve monitoring of cardio-metabolic (CMA) health in patients on Care Programme Approach (CPA) to 80% in 6 months, based on guidelines provided by the National CQUIN goal for 2017 – 2019 for a completed assessment for each of the cardio-metabolic parameters with results documented in the patient's electronic care record. The hypothesis is that CMA monitoring is a deprioritised activity, largely due to poor patient engagement and ineffectual multidisciplinary working practices.

Background

People with severe mental illness, such as those under CPA, are at a higher risk of physical health problems which can lead to a 15 to 20 year premature mortality largely due to preventable illness. Factors that contribute include lifestyle choices (smoking, poor diet, physical inactivity), cardio-metabolic side effects of psychotropic medications and reduced access to healthcare often resulting in undetected conditions.

Methods

The study sample was 81 patients on CPA. A number of change ideas were implemented using the Plan- Do-Study-Act cycle involving patients and staff. These included raised awareness of physical health monitoring through discussion in multidisciplinary meetings; patient focus groups; assessment of barriers to CMA attendance at routine appointments; ensuring referrals to parallel physical health monitoring clinics; and creation of a GP Letter template to facilitate collection of information by primary care plus improved primary care links.

Results

At the start of the project, 62.4% of CMA data was completed in November 2019 for patients under CPA. After building awareness through patient and staff discussions, a 10% improvement was seen in December 2019. Following implementation of the other change ideas, the target of 80% was achieved in February 2020. Further improvements were noted

through coaching staff to support the more difficult to engage patients. This improvement has been sustained since. Latest data in July 2020 shows 91.3% of patients have had their CMA monitoring completed in the team.

Conclusion

Significant improvements to CMA can be made through a number of team-based interventions. Stronger patient engagement provides opportunities for open dialogue and removes potential barriers to assessment. Improvements are also not limited to the mental health team; the standardisation of processes and better information sharing with primary care providers can improve multidisciplinary working practices and CMA monitoring efficiency. We aim to evaluate if these measures improve clinicians' ability to provide interventions where needed, resulting in safer psychoactive medication prescribing and early detection of physical health conditions, particularly for higher risk patients.

18. Quality Improvement (QI) Project on Restrictive practice from Manual or Physical Restraints in Inpatient units at Lincolnshire Partnership Foundation NHS Trust from May – June 2020

Dr. Sophia Senthil, Specialty Doctor, LPFT

Aims and hypothesis

The pilot QI project was conducted to systematically evaluate the practice of restrictive interventions – use of manual or physical restraints across seven inpatient settings that included acute male, female, mixed, old age, intensive care, low secure and rehabilitation wards in LPFT during May – June 2020 which studied in depth 31 random separate restraints out of total 259 incidents during this period.

Background

NICE clinical guidelines on the short term management of aggression and violence in inpatient settings advocate the use of restrictive interventions only if de-escalation and other preventative strategies including PRN medications have failed, and there is potential for harm to patients and other people if no action taken, and it considers the use of de-escalation measures throughout restrictive practice interventions.

Methods

The project analysed on measures such as recording of the type of restraint, precursor event, whether verbal de-escalation and medication were utilized, timing of the incident, number of staff involved, ethnicity of the patient, duration of the restraint, in particular when prone type restraint was used, post incident review of the patient and staff, reflective practices of the incident that included MDT discussions, patient account and positive behavioural support planning.

Results

The verbal de-escalation measures were tried in approximate 75% of the restraints and of concern, it was less utilized in old age and mixed inpatient units. The medication PRN or regular either oral or intramuscular were utilized in about 80 % of the restraints and regular use was of high in PICU setting.

Conclusion

There is a need to improvise on collaborative detailed care –planning ,PBS plans to include restraint reduction tools such as My safety plan and advanced statements with patients, to calibrate visual data of restraints for regular review and to improve accountability, to

focus on training developments for staff to improve on de-escalation and handover process, and post incident reflective sessions to improve culture and morale in inpatient environment for staff and patients.

19. Are the rapid traquilisation NICE guidelines adhered to, in patients with agitated/aggressive behavior?

Dr.Sathyan Soundararajan, CT3, BCUHB NHS Trust; Dr.Asha Dhandapani,CT3, BCUHB NHS Trust; Dr.Rajvinder Sambhi, Consultant Psychiatrist, BCUHB NHS Trust

Aims and hypothesis

Objectives 1. To discover if more conservative steps, such as de-escalation and oral medications are being used and given chance to work before giving IM medications. 2. To find out if safe doses are being prescribed with appropriate medications 3. To discover if patients receive appropriate aftercare following rapid tranquilisation

Background

Violence, agitation and aggressive behaviour refer to behaviours that can cause harm to others or to the person with those behaviours, regardless of whether it is verbal, physical and intentional. These behaviours are common in health care settings. From 2013 – 2014, 68,683 assaults were reported against NHS staff in England, 69% of these were within mental health and learning disability unit.

Methods

The inclusion criteria: Adult patient (>18 years old), Admitted to the Heddfan unit during the 6 months of study period, Given rapid tranquilisation (i.m) Sample - All patients who had received rapid tranquilisation, in PICU from August 2019 to February 2020. Unlike the previous audit which was retrospective, this audit is a prospective one. Data was collected by core trainees. A table was created, with the key relating to the 13 questions asked in previous audit, which related to the standards listed above from NICE guidelines

Results

Following the previous Audit and a detailed discussion with the ward manager in Tryweryn in 2019 February regarding the results obtained, we then further took it forward with the TODAY WE TALKED INITIATIVE. This was the first part of QIP, here in restraints and enforced Rapid tranquilisation was looked into. This initiative reduced the coercive measures in dealing with aggression. The utilisation of de-escalation techniques and behavioural support plans that was person centred in turn brought down the rate of Rapid Tranquilisation successfully. Thus placing our PICU as having least restraints in UK in 2019 Following this QIP, we then formatted the proforma for Rapid Tranquilisation which included the services to be provided/ actions to be taken, Post Rapid Tranquilisation physical health monitoring and patients response to medication.

Conclusion

With the results from previous Audit, there were very few points that were adhered to. With the co-operation from the team in PICU, the results showed that all the that patients only receive rapid tranquilisation when truly necessary and that this is done in the safest manner possible; with appropriate monitoring afterwards and a discussion with the patient about the event.

20. Improving the assessment of capacity on an Acute Mental Health Ward

Dr Camilla Wratten, Core Psychiatry Trainee CT3 South London and Maudsley NHS Foundation Trust; Dr Oliver Batham Core Psychiatry Trainee CT3, South London and Mauudsley NHS Foundation Trust.; Dr Jonathan Beckett, Consultant Psychiatrist, South London and Maudsley NHS Foundation Trust

Aims and hypothesis

The aims were to improve the documentation standards of capacity assessments for patients on Rosa Parks ward at Lambeth Hospital. We aimed for 100% documentation of capacity assessments for patients admitted (both capacity to consent to admission and treatment) at the initial medical clerking and at the first ward round.

Background

The Care Quality Commission (CQC) recommends that capacity to consent to treatment and admission is recorded at the start of every inpatient admission. The CQC also recommends that assessments should be recorded in a standardised way. For a patient to be admitted informally they should have been assessed to have capacity to consent to admission.

Methods

Initial audit data was collected retrospectively from electronic patient records of ward admissions over a 2 month period. Interventions included introducing a ward round proforma, teaching interventions and reminder leaflets and posters.

Results

The introduction of a proforma for ward round entries, which included a section for capacity assessments lead to a consistent improvement in capacity documentation to 100%.

Conclusion

We believe this was due to difficulties reaching the entire workforce with the interventions, including locum doctors. The success of the Ward Round proforma in improving documentation of capacity assessments suggests that a standardised clerking proforma with a mandatory section for capacity assessments could ensure all patients have their capacity documented on admission to acute psychiatric ward.

21. An analysis of novel team working practices developed on psychiatric in patient wards during the COVID-19 response

Dr Richard Bailey, CT3 in Psychiatry, Cheshire and Wirral Partnership NHS Foundation Trust; Dr Kai Yin, GPST2, HEE North West; Dr Lauren Roberts, FY2, Countess of Chester Hospital NHS Foundation Trust; Dr Emily Lewis, Locum ST4 in Psychiatry, Cheshire and Wirral Partnership NHS Foundation Trust; Dr Penelope Morris, GPST2, HEE North West; Dr Nicola Chavasse, ST1 in General Medicine, Countess of Chester Hospital NHS Foundation Trust;Dr Annette Stiggelbout, CT1 in Psychiatry, Mersey Care NHS Foundation; Dr Jessica Hookham, GPST2, HEE North West; Dr Bayode Shittu, CT1 in Psychiatry, Cheshire and Wirral Partnership NHS Foundation Trust; Dr Sumita Prabhakaran, Consultant Psychiatrist, Cheshire and Wirral Partnership NHS Foundation Trust; Dr Peter Wilson, ST6 in Psychiatry, Cheshire and Wirral Partnership NHS Foundation Trust

Aims and hypothesis

To examine how a traditional team working paradigm on general psychiatric wards was adapted to suit new challenges faced during the COVID-19 pandemic.

Background

As the COVID-19 pandemic developed, healthcare settings were required to adapt to meet evolving patient need. Following a period of redeployment to designated “COVID Wards”, the authors considered how the new COVID approach to patient care, leadership and communication differed when compared to more traditional psychiatric team models. The authors considered how the pandemic had affected how we work as medics and our role in the wider Multidisciplinary Team.

Methods

We examined the new COVID approach to team working in the context of existing literature in the field of leadership, management and communication within healthcare settings. There was an analysis of the practical ways in which we set about working in our new environment and team structure.

Results

Retrospective analysis revealed we had adapted our means of communication - both between medics and the wider MDT. We pooled medical expertise across both hospital sites and were able to create a physical space which lent itself to collaborative working. The team convened several times per day to allocate tasks - in this way we “framed the work”

and were able to ensure there was a shared understanding of what was required each day. Through our pooled expertise we demonstrated more inclusive team working than had been possible previously. As COVID-19 presented us with new challenges, each individual opinion was valued, contesting the more traditional and hierarchical structure often observed within healthcare settings. A flexible approach meant we were able to adapt our routines to meet changing demands. A novel workspace meant we were able to utilise open and immediate communication and thus to deploy resources where they were needed most. Further on in the pandemic response, we were able to allocate team members to other wards in order to disseminate the specialist knowledge our team had acquired.

Conclusion

The challenges presented by COVID-19 on psychiatric in patient wards required novel team working approaches. Our experiences demonstrate that we are able to adapt our working style, both as individuals, and as a collective. These team working approaches may be fruitful even when not in pandemic conditions.

22. Borderline at the Frontline: A Systematic Review of Crisis intervention in Borderline Personality Disorder

Ms Heather Boagey, Medical Student, University of Oxford; Mr Connor Thompson, Medical Student, University of Oxford; Dr Robin Bendix-Hickman, FY1, University Hospitals Birmingham; Professor Kate E A Saunders, Honorary Consultant Psychiatrist, Oxford University Department of Psychiatry

Aims and hypothesis

We aimed to review existing studies of crisis intervention (of any modality) in borderline personality to establish whether advances had been made in understanding effective interventions for these patients.

Background

Borderline Personality Disorder (BPD) is characterised by instability of interpersonal relationships, punctuated by episodes of psychological crisis. Such crises are usually associated with a clear precipitating event or adverse situation, and feature behavioural disturbances or deliberate self-harm which may lead to presentation to the emergency department and require acute intervention. Despite the high prevalence of this condition and impact on health services, the most recent review of crisis interventions for BPD (published in 2012) found no randomised control trial evidence at the time of writing, but several studies in development.

Methods

A database search was conducted for randomised control trials of any intervention lasting less than one month in response to a crisis in patients with a prior diagnosis of BPD. Titles were independently screened by two researchers.

Results

Four studies met the research criteria; two featuring pharmacological interventions (clonidine and clotiapine), one implementing a joint crisis plan and one involving short term admission. Participant population was predominantly female. Exclusion criteria and definition of crisis varied between studies. Primary outcomes included deliberate self-harm, admission and self-reported scales. High allocation concealment bias and lack of provider blinding was noted across studies.

Conclusion

While it is reassuring that this topic has not been entirely neglected by clinical trials in recent years, the relative paucity of trials remains surprising given its impact on patients

and health services. This may be due to the difficulties in recruiting and running a trial in an emergency setting, and the reliance on positive interpersonal relationships in recruitment and compliance, and assumptions that interventions are not appropriate or positive for individuals with BPD. As emergency departments cope with increased demand and individuals face adverse consequences of the current pandemic and social unrest, evidence-based care is needed more than ever for this population.

23. Traumatic Brain Injury and Mania

Dr Megan Clark; Dr Archana Sasitharan, Foundation Year 2 Doctor, Mid and South Essex NHS Foundation Trust Dr Rupesh Adimulam, Consultant Psychiatrist, Essex Partnership University NHS Foundation Trust

Aims and hypothesis

We present a case report of a patient who presented with mania following a traumatic chronic subdural haematoma in the right fronto-parietal region. We propose that the traumatic brain injury (TBI) precipitated the mania leading to a diagnosis of bipolar affective disorder (BPAD). Therefore we hypothesise that a TBI can be an aetiological factor for a diagnosis of BPAD.

Background

The patient is a 52 year old female previously well and independent. She has a past medical history of controlled epilepsy on Lamotrigine and Levetiracetam. She has a past psychiatric history of post-natal depression and puerperal psychosis diagnosed in 1993. She has had no further input from mental health services.

Methods

The patient presented initially to her General Practitioner (GP) with right sided ear pain and headache, diagnosed then with impacted ear wax. After one week due to no resolution of symptoms she presented to Accident and Emergency (A&E). It was ascertained she had had a fall with a head injury a few weeks prior. Whilst in A&E, her Glasgow Coma Scale (GCS) dropped acutely to 4/15. A Computerised Tomography (CT) scan identified a “large subacute subdural haematoma in the right fronto-parietal region with mass effect on the right cerebral hemisphere and midline shift of 1.2cm to the left”. The patient was transferred to a tertiary neurosurgical unit undergoing an emergency right Burr hole evacuation. The patient re-presented eight days post-surgery with new onset agitation and confusion. There was no evidence of a re-bleed on a repeat CT scan. The patient was referred to psychiatry due to her behavioural disturbances (agitated and throwing things) and poor sleep. On mental state examination she displayed pressure of speech, flight of ideas, elated mood and grandiose delusions. She lacked insight and capacity.

Results

The patient required just over 11 weeks of inpatient treatment; she was started on intra-muscular (IM) Olanzapine 10mg once daily (OD) due to non-compliance and as required IM Haloperidol 5mg OD for agitation. After six days of no improvement the patient was treated with Zuclopenthixol Acetate receiving a total of 300mg (split over four doses) over six days.

This improved her symptoms; she was less agitated, able to speak coherently and had no psychotic symptoms. The patient was complaint with oral Olanzapine 20mg OD thereafter.

Conclusion

TBI can be a precipitant for a manic episode in those patients' who are predisposed to affective disorders.

24. Mortality associated to depression – a systematic review and meta-analysis protocol

Dr Tiago Costa, ACF, ST4 General Adult Psychiatry, Newcastle University and Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust; Emily Haworth, Psychology Student, Newcastle University; Dr Ryan Kenny, Research Associate, Evidence Synthesis Team, Newcastle University; Dr Ian McKinnon, Consultant Psychiatrist, Newcastle University and Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust; Professor Hamish McAllister-Williams, Consultant Psychiatrist, Newcastle University and Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Aims and hypothesis

The key questions are: Does the diagnosis of depression have an impact on cause-specific and all-cause mortality when compared to the general population?; Does anti-depressant treatment change that risk?

Background

Depression is a high prevalence, chronic and recurring condition. It is associated with excess all-cause and cause-specific mortality. This includes mortality from myocardial infarction (MI), heart failure and stroke, as well as cancer. Complexity is introduced by some evidence of increased mortality with pharmacological antidepressant treatment, though this could be confounded by indication. Patients with difficult to treat unipolar depression have significantly higher all-cause mortality than other depressed patients. This could be related to baseline severity, differences in underlying pathophysiology and/or evidence that effective treatment reduces mortality risks. In late life depression, increased mortality rates have been associated with antidepressants, even though the strength of that evidence varies by drug class and mostly comes from observational studies.

Methods

Medline, Embase, Scopus, Web of Science Core Collection, Cochrane Central Register of Controlled Trials and Database of Systematic Reviews will be used to conduct the search. Grey literature will also be considered for cross-checking of references. Cohorts, case-control studies, and randomized controlled trials will be included. Additional inclusion criteria will include studies of adult patients with depression (unipolar or bipolar), prescribed anti-depressant treatment (medication and/or neurostimulation) or not, with measures of mortality and follow-up duration ≥ 1 year. No restrictions on date or language of publication. Ethics approval will not be needed because the data used in this systematic review will be extracted from published studies.

Results

The risk of bias for the studies included in the meta-analysis will be assessed by the ROBINS-I for observational studies and the RoB 2 for randomised trials. The primary outcome of interest is mortality. It is expected that the most commonly reporting metric for this will be a mortality risk estimate, including a ratio and the associated measure of uncertainty. Where possible, pooled estimates of the risk ratio of mortality for the included studies will be assessed using a random effects meta-analysis, conducted in MetaEssentials.

Conclusion

This systematic review and meta-analysis protocol has been published in the PROSPERO international prospective register of systematic reviews, with the registration number CRD42020200812. Results will be disseminated by publication in a peer-reviewed journal.

25. Exercising During a Pandemic: The Mental Health and Wellbeing Benefits of Exercise for Medical Students and Newly Qualified Doctors During the COVID-19 Pandemic

Mr Conor Coyle, Medical Student, St George's University of London; Miss Hanya Ghazi, Medical Student, Hull York Medical School; Mr Ioannis Georgiou, Medical Student, University of Aberdeen

Aims and hypothesis

We aimed to identify activities medical students and newly qualified doctors found beneficial for their mental wellbeing and mood, during the COVID-19 pandemic. We hypothesised exercise to be the most common activity of survey respondents. We also hypothesised that survey respondents who exercised would report higher mood scores.

Background

There is currently little data upon the actions of medical students and newly qualified doctors, to help their mental wellbeing during the COVID-19 pandemic.

Methods

A survey was carried out, receiving 2075 responses from across the United Kingdom. 1909 medical students (92.0%) and 166 newly qualified doctors (0.08%). Participants were asked what activities they found beneficial for their wellbeing and mental health and to provide a numerical score of their mood (0 being the worst and 100 being the best mood they could be in). International Business Machines Statistical Package for the Social Sciences 25 (IBM SPSS) was used for the analysis of results.

Results

Exercise was the most common activity of respondents, 80.1% (medical students 83.7%; newly qualified doctors 72.3%). The mean mood score of all respondents was 51.8, (Standard deviation) (21.1). Participants who exercised had a mean mood score of 52.3 (20.7), significantly higher (P-value = 0.048) than those who did not, 49.8 (21.1). One-way analysis of variance revealed a statistically significant difference (P-value = 0.037) between the mean mood scores of the following groups: students who did not exercise 49.7 (21.2), students who exercised 52.0 (21.0), doctors who exercised 56.2 (22.7) and doctors who did not exercise 50.9 (19.1). Scheffe's post-hoc analysis revealed the statistically significant difference mentioned above was a result of the mean difference between students who did not exercise compared to doctors who exercised, who scored on average 6.5 points lower on mean mood scores.

Conclusion

Individuals who exercised (on average) reported a higher mood score than those who did not. This can be seen in both the medical student and interim foundation doctor subgroups. Exercise provides a positive impact on an individual's mental health and wellbeing. It is hoped more medical students and newly qualified doctors engage in exercise, for physical health and mental wellbeing benefits and that higher education providers and employers promote the importance of exercise for the wellbeing of their students and staff.

26. The impact of the COVID-19 pandemic on patients attending a clozapine clinic.

Dr Yvonne Fahy, Academic Track Intern, Galway University Hospital, Ireland; Professor Colm McDonald, Consultant Psychiatrist, Galway-Roscommon Mental Health Services, GUH, Ireland and Lecturer, NUIG School of Medicine; Dr Brian Hallahan, Consultant Psychiatrist, Galway-Roscommon Mental Health Services, GUH, Ireland and Lecturer, NUIG School of Medicine.

Aims and hypothesis

Aims: To assess levels of symptomatology in patients with pre-existing major mental illness who are attending mental health services for clozapine treatment, during the COVID-19 pandemic. Hypothesis: Patients receiving clozapine treatment typically have frequent contact with mental health services, due to full blood count monitoring, which is ongoing and may act as a protective factor.

Background

The impact of the COVID-19 crisis on populations with pre-existing mental health disorders remains unclear. It is imperative that the mental health burden of this pandemic be evaluated. Individuals with established major mental illness may be more vulnerable to the impact of COVID-19 restrictions as there are reduced supports available to them with discontinuation of day centre activities and group meetings, reduced availability of community and family supports.

Methods

A cross-sectional single-centre study was conducted by interviewing patients, using validated rating scales. These included Beck Anxiety Inventory(BAI) and Hamilton Anxiety Rating Scale(HARS). Likert scales, ranging from 0-10, assessing anxiety, mood, social and vocational functioning and quality of life (QOL) were utilised, and a free-comments section for patients was provided. Descriptive statistics were provided by using Microsoft Excel and SPSS in this analysis.

Results

The interview was offered to 131 patients attending the clozapine clinic, 65 of whom consented for participation (49.6%). Of those who responded, the majority were males (70.8%). The mean age of participants was 44.8 ± 10.4 years. Of those interviewed, 93.8% had a primary diagnosis of treatment-resistant schizophrenia. The median BAI score was 4.0 (min=0, max=30, IQR=10) and the median HARS anxiety score was 1.0 (min=0, max=4, IQR=1). Likert scale data demonstrated low levels of symptomatology and impairment, with median scores for anxiety=3.0, depressed mood=2.0, social functioning=3.0, occupational

functioning=0 and QOL=3.0. Fifty-five (84.6%) participants provided a comment regarding their experiences during COVID-19 pandemic, with responses grouped according to common themes, namely, neutral effects (20), negative effects (14), social impact (10), positive effects (5), media coverage inducing anxiety (4) and living with a mental illness (2).

Conclusion

The study highlights variations of how individuals are coping during the COVID-19 crisis. Quantitatively, there was quite low levels of anxiety and mood symptoms recorded in this patient cohort, perhaps it may be related to their regular contact with the mental health services through the ongoing clozapine clinic. Comments provided allow a detailed understanding of the patients' personal experience and concerns during the pandemic. They specifically emphasised the importance of social interaction and human connection in maintaining positive mental health.

27. Medical students' mood adversely affected by COVID-19 pandemic: An interim analysis from the SPICE-19 prospective cohort study of 2075 medical students and interim foundation doctors

Ioannis, Georgiou, Medical Student, University of Aberdeen; Dr, Soham, Bandyopadhyay, Foundation Year Doctor, University of Oxford; Bibire, Baykeens, Medical Student, Plymouth University Peninsula Schools of Medicine and Dentistry; Conor, S Gillespie, Medical Student, School of Medicine University of Liverpool; Marta, de Andres Crespo, University of Oxford; Mohammad Talha Bashir, Medical Student, University of Aberdeen; Professor, Ashok, Handa, Consultant, Nuffield Department of Surgical Sciences University of Oxford; Professor, Kate, E A Saunders, Consultant, Department of Psychiatry, Warneford Hospital University of Oxford

Aims and hypothesis

This study aimed to analyse the potential effects on mood and anxiety levels of newly appointed doctors and medical students following the disruptions caused by the COVID-19 pandemic on a personal, educational, and national level.

Background

Currently, we can only speculate on what the effects of the COVID-19 pandemic have been on medical students and interim foundation year doctors (FiY1). To support them appropriately both now and in the future, it is imperative that we understand the impact it has had upon them. This study assessed the effects of the COVID-19 pandemic on medical students and FiY1 doctors across the United Kingdom (UK), and the support that they sought and received.

Methods

A prospective, observational, multicentre study was conducted. All medical students and interim foundation year doctors were eligible to participate. Data was collected via an online survey questionnaire. Mood was quantified using a sliding scale from 0 (worst) to 100 (best).

Results

A total of 2075 individuals participated in the SPICE-19 survey from 33 medical schools. There was a significant ($p < 0.001$) decrease in participants' mood when comparing their mood before the pandemic to during the pandemic. Social distancing and more time at home/with family were the factors that respectively impacted negatively and positively the mood of the greatest number of participants. All areas of life included in the survey were found to have been significantly more negatively impacted than positively impacted ($p <$

0.001). 931 participants wanted more support from their university. Participants were mainly seeking support with exam preparation, course material, and financial guidance.

Conclusion

Medical and foundation schools need to prepare adequate and effective support. If no action is taken, there may be a knock-on effect on workforce planning and the health of our future workforce. When medical students return to their universities, there is likely to be a need for enhanced wellbeing support, adaptations in the short-term and long-term strategies for medical education, and provision of financial guidance.

28. COVID-19 pandemic: How have medical students helped the NHS during the crisis

Ioannis, Georgiou, Medical Student, University of Aberdeen; Adam, Hounat, Medial Student, University of Dundee; Conor, S Gillespie, Medical Student, School of Medicine University of Liverpool ; Jay J. Park, Medical Student, Edinburgh Medical School; Dr, Soham, Bandyopadhyay, Foundation Year Doctor, University of Oxford; Professor, Kate, E A Saunders, Consultant, Department of Psychiatry, Warneford Hospital University of Oxford

Aims and hypothesis

The primary aim of this study was to analyse the different factors affecting the decision of medical students to work within the healthcare sector during the COVID-19 pandemic. Additional aims were: a) The comparison of the psychological effects on medical students who worked within a healthcare setting versus those who did not b) The exploration of the psychological effects the employment of medical students in healthcare effects on their psychological wellbeing

Background

Medical students across the UK had the opportunity to work within the NHS to help alleviate the increased workload caused by the COVID-19 pandemic, with the psychological and social implications of this undertaking remaining unknown.

Methods

This was a cross-sectional, national UK study analysing how employment status within the NHS affected the self-reported pandemic anxiety scale (PAS) of participants. Participants were medical students or newly appointed doctors in the UK. Data was collected from 2075 participants by an online questionnaire.

Results

25.2% of the participants worked within the NHS. Working within the NHS significantly reduced the anxiety levels of participants on 3 out of 7 items of the PAS and increased the frequency by which participants felt cheerful and energetic. The most statistically significant covariates influencing the likelihood for participants to start work within the NHS were sufficient information on personal protective equipment (PPE) (OR 2.503, 95% CI OR: 1.882, 3.330) ($p<0.001$) and Ethnicity (OR 2.104, 95% CI OR: 1.514, 2.923) ($p<0.001$). Participants from Black Asian and Minority Ethnic (BAME) backgrounds were less likely to work within the healthcare sector ($p<0.001$) and scored significantly higher in 2 out of 7 PAS items compared to their White colleagues.

Conclusion

With a second COVID-19 wave predicted to affect the UK, it is important to prepare medical students before starting to work within the healthcare sector. Providing rigorous PPE training and addressing inequalities within the healthcare system could improve the number of people helping the NHS during future pandemics or any national public health emergencies.

29. Psychological Impact of Covid-19 and Mental Health Apps: A perspective on medical students

Ms Hanya Ghazi, MBBS, Hull York Medical School; Mr Connor Coyle, BSc (Hons), St George's University of London; Mr Ioannis Georgiou, MSc Genetics, University of Aberdeen

Aims and hypothesis

To discuss the potential role of mental health apps as means of coping with psychological impact of covid-19 like anxiety and depression

Background

Offering the perspective of medical students in the UK, we wish to add to the discussion regarding the use of mental health applications as a means of both coping and treatment. The COVID-19 pandemic poses a major threat to mental wellbeing and increases the risk of mental health problems like depression and anxiety (2). We agree that e health shows great potential in mental healthcare in a time where face to face treatment is unavailable. Currently, there is a lack of research demonstrating the coping mechanisms that medical students and FY1 doctors have used during the pandemic. Understanding these coping mechanisms is important because it helps us understand the needs of young healthcare professionals and shape the future of mental health care.

Methods

We took part in a prospective, observational study to assess the effects of the COVID-19 pandemic on medical students and interim foundation year doctors across the UK. The participants completed a voluntary survey exploring the mood of the participants and coping mechanisms that have had a positive impact on mental health.

Results

Over a 4-week period, a total of 2075 participants (Aged 18-59) responded from 33 medical schools, including 1909 medical students (92.0%) and 166 newly qualified doctors (0.08%). Results show an overall drop in the mood of respondents following the onset of the pandemic ($p < 0.0001$). Of 1886 participants, the most common activity reported to have supported mental wellbeing was staying connected with family and relatives using online tools (1595, 84.6%) and exercise (1590, 84.3%). On the other hand, the use of mental health apps was found to be the least common activity used by survey respondents to improve mental wellbeing (192, 9.3%).

Conclusion

Our study highlights an underutilisation of mental health apps by medical students and interim foundation doctors across the UK. Mental health applications can promote wellbeing where physical face-to-face support and monitoring by employers and medical schools is not possible. Moreover, such services can provide a platform for online consultations, group therapy and screening - whilst providing individual privacy, accessibility and reducing stigma of accessing mental health services (,). Thus, our study identifies a missed opportunity for the usage of additional mental health support by medical students and NHS staff - groups already susceptible to challenges with mental health and wellbeing ( ). It is important to implement positive coping strategies in medical students and FY1. Doctors now as research shows there is a link between doctor wellbeing and patient outcome - suggesting doctors who are able to care for themselves are more able to care for others – this is especially important during the COVID-19 pandemic ( ). This further highlights the importance of medical schools reaching out to students to monitor mental health through a mobile, digital platform. More research must be done into the use of mental health apps in the NHS and medical students. We agree with Torous et al in that utilization of telehealth and app tools during this pandemic will help shape the future of digital mental health care. We must be proactive in addressing challenges with mental health care provision, to prevent the development of a crisis in mental health care. Mental health applications are a means of coping that should be promoted in a time where physical communication is limited, more than any time before ( ).

30. Identifying digital communication markers of depression in borderline personality disorder, bipolar disorder and healthy control populations

Dr George Gillett, Academic Clinical Fellow, South London and Maudsley NHS Trust; Dr Niall McGowan, Post-doctoral Researcher, Department of Psychiatry, University of Oxford; Dr Niclas Palmius, Post-doctoral Research Assistant, Institute of Biomedical Engineering, University of Oxford; Dr Amy Bilderbeck, Honorary Member, Department of Psychiatry, University of Oxford; Professor Guy Goodwin, Senior Research Fellow, Department of Psychiatry, University of Oxford; Dr Kate Saunders, Associate Professor, Department of Psychiatry, University of Oxford

Aims and hypothesis

To explore the association between self-reported mood symptoms and use of digital communications in Borderline Personality Disorder (BPD), Bipolar Disorder (BD) and Healthy Control (HC) subjects.

Background

Digital phenotyping offers the potential to recognise early signs of mental health crises and predict episode course using remotely-collected digital data from patients' naturalistic environments. Objective digital communication metrics (phone call and SMS use) may represent novel biomarkers of mood in BD and BPD.

Methods

BD (n= 17), BPD (n=17) and HC (n= 21) participants used a smartphone application which monitored phone call and SMS messaging frequency and duration or length, alongside weekly self-reported mood (Quick Inventory of Depressive Symptomatology). Linear mixed-effects regression models were used to assess the association between digital communications and mood symptoms and episodes.

Results

Transdiagnostically, depressive symptoms and episodes were associated with increased cumulative incoming call duration (seconds; B=24.42, p=0.01). In BD, depressive episodes were further associated with decreased cumulative total call duration (seconds; B=-1598.62, p<0.01), cumulative outgoing call duration (seconds; B=-875.95, p=0.01), total SMS frequency (B=-28.78, p<0.01), outgoing SMS frequency (B=-12.42, p<0.01) and cumulative total SMS length (characters; B=-1463.73, p=0.02). However, these associations were not identified in BPD participants (p>0.05).

Conclusion

The association between self-reported depression and digital communications appears to be moderated by diagnosis. These results may inform our understanding of differential psychopathologies in BD and BPD patients. Future work could assess the association between trait-impulsivity, anxiety symptoms, manic symptoms and digital communication metrics. Together, this may facilitate the development of digital tools to aid clinical diagnosis and remote monitoring of patients' symptoms in their naturalistic environments.

31. Symptom screening tools for Borderline Personality Disorder – a literature review

Dr Anne-Marie Grew, Consultant Psychiatrist, Woodland View Hospital, NHS Ayrshire and Arran. Dr Shona Osbourne, CT3 doctor, Woodland View Hospital, NHS Ayrshire and Arran. Dr Everett Julyan, Consultant Psychiatrist, Woodland View Hospital, NHS Ayrshire and Arran.

Aims and hypothesis

To ascertain if a 'symptom rating tool' for Borderline Personality Disorder (BPD) has been created to monitor medication effects.

Background

Patients with BPD can pose difficulties for treating clinicians; with medications being largely ineffective alongside a superimposed risk of side effects, limited access to robust psychological interventions, and intermittent crises involving emergency services. Patients anecdotally report initial improvement with medication, only to find this is no longer "effective" after a period of time. This creates a cycle of; alternating medications, increasing doses and increasing side effects. This can leave treating clinicians feeling exasperated, with patients finding themselves 'stuck' in medical out-patient clinics. This literature review looks to establish whether 'symptom rating tool' in BPD has been created as a means for treating clinicians to streamline medication prescription and provide patients with a visual indication of which, if any, medication has indeed been beneficial.

Methods

A literature search with undertaken using the keywords: emotional instability, borderline personality disorder, emotionally unstable personality disorder, symptom rating tool. Article abstracts were independently reviewed and shortlisted by two authors (AMG, SO). Full texts were accessed and articles focussed solely on exploring the validity or diagnostic capability of BPD symptom screening tools were excluded. Further articles were accessed from original article reference lists, and from a further second literature review specifically searching for documented clinical use of BPD symptom rating scales.

Results

81 articles were included from the literature review. Following abstract reviews, 24 articles were selected for full text review. The majority of these articles utilised rating scales as diagnostic tools thus were excluded. Four rating scales were found within the literature for assessing general improvement in BPD symptoms, with only one article using a rating tool on 'effectiveness of the Systems Training for Emotional Predictability and Problem Solving (STEPPS) treatment programme versus treatment as usual'. No identifiable studies used

symptom rating tools to identify scoring improvements with different classes of medication.

Conclusion

BPD symptom rating scales are regularly utilised for diagnostic purposes, however there is limited use of rating scales to monitor treatment response to medications. Use of a symptom rating scale would be beneficial to allow clarity within psychiatric clinics as to which, if any, medications have been effective for each individual patient and remove multiple medication trials. Further research into symptom rating scales could ascertain the ability to reduce prolonged medication trials and create a patient-tailored treatment approach.

32. Illness Perceptions of Psychosis amongst British South Asians: An exploratory study

Mr Danish Hafeez, Univeristy of Manchester; Dr Aqeela Bhika, PhD Graduate, University of Manchester; Professor Nusrat Husain, Chair in Psychiatry, University of Manchester; Dr Nadeem Gire, Post doc and 4th Year Medical Student, University of Central Lancashire; Dr Inti Qurashi, Consultant Psychiatrist, Mersey Care NHS Trust

Aims and hypothesis

To test the psychometric properties of the IPQS in a British South Asian sample and increase understanding of illness perceptions of mental health in this group.

Background

Illness perceptions about mental health have been found to be significant predictors of outcome. British South Asians have increased rates of psychosis and are less likely to engage with mental health services. The Illness Perception Questionnaire for Schizophrenia has been used in a variety of contexts and populations. However, the validity and reliability of IPQS has yet to be tested in British South Asians.

Methods

A cross-sectional sample of 45 British South Asian patients completed the Illness Perception Questionnaire for Schizophrenia (IPQS) and additional measures to assess functioning, quality of life, psychopathology, anxiety, depression and attitudes towards medication. The Illness Perception Questionnaire for schizophrenia was further modified to make it culturally sensitive and fully appropriate for South Asians. The psychometric properties of the IPQS were analysed including internal consistency and discriminant and concurrent validity.

Results

All the subscales were largely independent from each other and correlations with other measures indicate the subscales were measuring their designed constructs. The subscales on the IPQS fell short of the desired range of internal consistency. In this exploratory study a lower threshold of Cronbach alphas of 0.6 can be considered acceptable, suggesting that the IPQS is valid for use within a British South Asian population.

Conclusion

This study is the first to test the IPQS on a British South Asian participant group and demonstrate likely validity for use in this population. However, future research is required in British South Asians, using a larger sample size to examine whether more appropriate levels of internal consistency could be reached and proving its validity.

33. Childhood Abuse and Deliberate Self-Harm (DSH) / Suicide: Is there a relationship?

Dr Shafia Khanum, FY2, Nottingham University Hospitals; Dr Nasreen Sanjrani, Consultant Psychiatrist, Lincolnshire Partnership NHS Foundation Trust.

Aims and hypothesis

Literature suggests that there is a significant and clinically relevant link between experiencing abuse in childhood and attempting DSH/suicide in adulthood. However, other factors have also been seen to contribute to the risk. Therefore, the link between childhood abuse and DSH/suicide attempt was looked at locally to see how far this is true.

Background

Child abuse is when a child is intentionally harmed by an adult or another child, which can be over time or a one-off action. It can be physical, sexual, emotional, or neglect. Abuse can be either in person or online. DSH is the deliberate act of hurting/harming oneself. This can be done in a variety of different ways. The most extreme form of self-harm is suicide where there is an intention to end life.

Methods

Data was obtained for all patients who were admitted to Pilgrim Hospital A&E following an attempt of DSH/Suicide for the period between July 2019 and September 2019. Patient identifiers were then used to scrutinise the patient records to obtain further details of the incident and previous relevant history.

Results

It was found that 32% of patients in the data set had experienced some form of abuse in their childhood, whereas 54% did not. 53% had other factors possibly contributing to their attempt. 31% both experienced abuse in childhood and had other factors present. According to the data, the most common abuse was sexual with physical following closely behind. Having a known psychiatric condition was the most common additional factor. It was also noticed that some patients in the data set had attempted DSH/Suicide multiple times.

Conclusion

It can be concluded that; more women compared to men are likely to attempt DSH/Suicide. There is definitely a strong link between experiencing suicide in childhood and attempting DSH/Suicide in adulthood (32%). However, there seems to be a stronger link between other influencing factors and attempting DSH/Suicide compared to childhood abuse and attempting DSH/Suicide (53% : 32%). Sexual abuse was the most common form of abuse

experienced by the patients in the data set and having a Psychiatric Condition was the most common influencing factor in the decision to attempt DSH/Suicide. 50% of patients in the data set re-attempted DSH/Suicide, 32% of them being female. More research is need into why patients re-attempt or attempt DSH/Suicide and also into the support in place for victims of abuse and the prevention mechanisms in place for DSH/Suicide.

34. Burnout amongst Psychological Wellbeing Practitioners in Improving Access to Psychological Therapy services: A qualitative study exploring contributory factors and subsequent effects on patient care

Mr Abeku Koomson, Medical Student, Imperial College London; Ms Ahrabbey Sivananthan, Medical Student, Imperial College London; Mr Aznavar Ahmad, Medical Student, Imperial College London; Ms Keerthanaa Jayaraajan, Medical Student, Imperial College London; Mr Mohammed Haque, Medical Student, Imperial College London; Mr Mohammod Hussain, Medical Student, Imperial College London

Aims and hypothesis

The objective of this research was to identify factors which may contribute to burnout amongst Psychological Wellbeing Practitioners (PWPs) and to discern its detrimental effect on patient care.

Background

Improving Access to Psychological Therapies (IAPT) services provide evidence-based psychological therapies for anxiety disorders and depression. Among the IAPT workforce, PWPs are afflicted with high levels of burnout and attrition rates of 22%. Research has shown that the prevalence of burnout amongst PWPs could be as high as 68.6%, which is the worst in the mental health field.

Methods

Qualitative data collection was employed to attain in-depth insights regarding the issue of burnout from the perspective of the front-line workers of IAPT. This was facilitated through semi-structured interviews with eight PWPs from eight different IAPT sites in London. Thematic analysis via both latent and semantic approaches were used to explore and define the main concepts within the qualitative data. This was carried out using Clarke and Braun's Six Step Model.

Results

Three main themes which therapists identified as being contributory to burnout were revealed: 'Work Culture', 'Organisational Support' and 'Workload'. Within them were further subthemes which included large caseloads, lack of support and a work culture driven towards meeting difficult targets. Therapists highlighted the detriment of intense work pressures on patient care and shared their experiences of defaulting to cancelling appointments to cope with the heavy workload. They revealed that the pressure to rapidly get patients through the system led them to prematurely discharge some patients, which could have adverse effects on their outcome. Some therapists also discussed the helpful

strategies that their IAPT service has implemented to help avoid burnout amongst their workers.

Conclusion

The responses from the interviews were concordant with existing literature which suggests that the IAPT workforce is under pressure from high demand and concurrent high attrition rates. The main findings revealed that there are multiple factors which may contribute to burnout amongst PWPs, which potentially affects the quality of care that patients receive. Thus, the findings from this research could form the basis of a holistic approach to tackle PWP burnout and attrition, which is essential to ensure that the quality of patient care is not compromised. In light of the COVID-19 pandemic, increasing efforts to retain the IAPT workforce has greater relevance given the growing burden that this pandemic will have on mental health services.

35. Exploring healthcare professionals' views surrounding deprescribing antidepressants

Dr Deborah Cooper, Consultant Psychiatrist, NHS Lothian; Dr Rosemary Gordon, CT2, NHS Lothian; **Miss Sarah Mackay**, Medical Student, University of Edinburgh; Miss Emma Davies, Medical Student, University of Edinburgh; Miss Jane Yi Chiam, Medical Student, University of Edinburgh, Miss Kyi Lane Shune Kyaw, Medical Student, University of Edinburgh; Miss Millie Davies, Medical Student, University of Edinburgh; Mr Anan Ahmed, Medical Student, University of Edinburgh; Mr Ian Teh, Medical Student, University of Edinburgh

Aims and hypothesis

This study aims to explore healthcare professionals' attitudes towards deprescribing antidepressants. The research concentrated on the barriers that healthcare professionals face regarding deprescribing. Although the current literature regarding deprescribing is expanding, it was hypothesized that healthcare professionals would be unfamiliar with deprescribing as it is a relatively new concept. Due to a presumed lack of professional guidelines a further hypothesis was that healthcare professionals would have reservations deprescribing in clinical practice.

Background

Deprescribing; the process of discontinuing medication, is gaining prominence in medical literature with the push towards realistic medicine. With concerns about side effects as well as varying concerns about the addictive effects of antidepressants, being able to safely deprescribe antidepressants may have significant positive effects on the patients' welfare. On the other hand, with the unpredictable nature of depression and the impact uncontrolled depression can have on the patients' quality of life, healthcare professionals are forced to deliberate upon the benefits compared to the adverse effects of deprescribing.

Methods

Quantitative data was collected via an online-questionnaire consisting of 8 questions. The primary question type used was forced Likert scales. The questionnaire was sent to 168 healthcare professionals associated with the Royal Edinburgh Hospital and selected primary care facilities. Qualitative data was obtained through interviewing 8 healthcare professionals from various specialties.

Results

The majority of respondents were familiar with deprescribing. More secondary care health professionals claim to be 'very familiar' (51%) compared to those in primary care (15%). The

interviews and questionnaire found the commonest reason for deprescribing was to reduce side effects and medication burden. The challenges most frequently encountered by healthcare professionals were patient reluctance and uncertainty of patient outcome. The main hesitations healthcare professionals had concerning deprescribing were the potential effects it may have on doctor-patient relationships and the usefulness of existing guidelines to assist them in their clinical practice.

Conclusion

The majority of healthcare professionals were familiar with deprescribing. However, they faced varying barriers and had differing hesitations when deprescribing. The study contributes to the existing literature surrounding deprescribing. Nevertheless, there is still a need for further research and the production of guidelines in this area.

36. Will Aripiprazole Intramuscular Injection Help in a Patient with Delusional Disorder and Advanced HIV Disease? A Case Report

Dr Honida Mansour, SHO, CNWL NHS Foundation Trust Dr Jiann Lin Loo, Specialty doctor, CNWL NHS Foundation Trust

Aims and hypothesis

To describe a case of delusional disorder in a patient with a background of advanced Human immunodeficiency virus (HIV) & Hepatitis B virus (HBV) co-infection who improved with the combination therapy of short-acting intramuscular (SAIM), long-acting intramuscular (LAIM) aripiprazole and antiretroviral therapy (ART)

Background

To-date there is a limited evidence-backed regime for the treatment of delusional disorder. There is even more limited literature on the effectiveness of using combination therapy of SAIM and LAIM antipsychotics in patients with delusional disorder and complex physical health concerns.

Methods

A case report.

Results

A 52-year-old lady with underlying untreated HIV and Hepatitis B co-infection was admitted for physical aggression toward her husband. She had experienced 10 years of persecutory delusions with abrupt onset, characterised by the belief that her information was hacked as well as being served with poisonous food and medications intended to harm her. Her symptoms had resulted in severe mistrust toward healthcare professionals and her physical health deteriorated until she was unable to work, triggering a major depressive episode. There were no other features of psychosis or mania. Her body mass index (BMI) on admission was 14.9, Montreal Cognitive Assessment (MOCA) was 18, and Patient Health Questionnaire Depression Scale (PHQ-9) was 21. Her blood investigations were as follows: CD4 count 230 cell/mm^3, HIV viral load (VL) 316,228 copies/ml, and HBV VL 5,888 copies/ml. The remaining physical examination and investigations were clinically unremarkable and there were no features of HIV involvement in the central nervous system. The diagnosis of delusional disorder with major depressive disorder was made. Oral antipsychotics and antidepressants were offered but met with refusal. Hence, multiple SAIM aripiprazole was given and her delusions improved after seven injections, enabling her to accept oral medications and food. Subsequently, LAIM aripiprazole and ART was given after shared decision making. Two months post-discharge, she managed to sustain full-time

employment with the following improvement; BMI raised to 20.4, MOCA improved to 21, PHQ-9 reduced to 3, CD4 count raised to 400 cell/mm^3, HIV VL reduced to 162 copies/ml, and HBV VL reduced to 94 copies/ml.

Conclusion

The combination of SAIM and LAIM aripiprazole may be considered for patients with physical health concerns but not adhering to oral treatment and was effective in combination with ART in the treatment of a patient with advanced HIV and delusional disorder. Further clinical trials would help to elucidate the effectiveness of this regime.

37. Collateral Damage: The acute female inpatient psychiatric ward during lockdown

Dr Rebecca McKnight, ST6, Oxford Health NHS Foundation Trust (OHFT); Dr Katherine Reid CT3, OHFT; Dr Sunil Patel LAS/ST4, OHFT; Dr Olga Tsatalou, Consultant Psychiatrist, OHFT

Aims and hypothesis

To expand the Covid-19 literature by documenting the effects of the 2020 UK lockdown on reasons for admitted psychiatric patients' deterioration in mental state. We intended to examine reasons behind admissions and rates of delayed discharges compared to an analogous 2019 period.

Background

The novel severe acute respiratory syndrome coronavirus-3 (Covid-19) pandemic led to a 12-week UK 'lockdown' from March 23rd to June 23rd, 2020. Socioeconomic restrictions and rapid alterations in healthcare provision were immediately implemented. Evidence from prior pandemics suggests negative effects on mental health amongst those who have directly experienced infection and those who have not. The consequences of lockdown on mental health are unknown, and in particular the impact upon patients requiring acute psychiatric inpatient care.

Methods

Retrospective case series describing factors linked to deterioration of mental state in patients admitted to an NHS female acute psychiatric ward during the Covid-19 lockdown compared to 2019. Using anonymised routinely collected data from electronic health care records, pre-defined causative factors and evidence of delayed discharges were analysed for patients admitted March 23rd- June 23rd in 2020 and 2019. Students' t-test and Pearsons' chi-squared two-tailed tests with $p<0.05$ were used to determine significance.

Results

37 and 43 patients were included in the Covid-19 lockdown and 2019 groups respectively. Factors identified as causative in patients' mental state deterioration during lockdown were significantly different to during 2019. Cessation of recommended medications and health-anxiety were the 2019 most frequent factors, both significantly greater than in 2020 (51.2% vs. 32.4%, $p<0.01$; 44.2% vs. 24.3%, $p<0.01$). The primary factor identified in 2020 was cessation of work, study or meaningful activities during lockdown, a figure significantly higher than in 2019 (70.3% vs. 14%, $p<0.0001$). More patients experienced social isolation and financial stress versus 2019 (48.7% vs. 14%, $p<0.00$; 44.3% vs. 24.3%, $p<0.01$). Rates of delayed discharge were significantly higher during lockdown (40.5% vs. 2.3%, $p<0.01$). Delayed

discharges were primarily related to restrictions on availability of community support during lockdown.

Conclusion

Our findings demonstrate that the socioeconomic and healthcare restrictions during the Covid-19 lockdown were the primary reason for our patients' mental health deterioration. This is a learning point for planning healthcare during future pandemics.

38. Current Studies Evidencing the Role of Curcumin as a Neuroprotective Therapeutic Intervention for Schizophrenia: A review and recommendation

Ms Ranmini Philomin, Medical Student, Swansea University Medical School; Virginia H. Dale, Medical Student, Swansea University Medical School

Aims and hypothesis

Curcumin is being investigated as a therapeutic adjunct in the delivery of antipsychotic medication for patients with treatment resistive schizophrenic symptoms. This poster aims to demonstrate the findings of a literature review that examine the hypothesis that curcumin is an effective in improving outcomes for patients with schizophrenia.

Background

Persisting cognitive and negative symptoms have been linked to poor treatment outcomes in schizophrenia patients. Curcumin, a polyphenol derived from the turmeric route, has shown neuroprotective benefits in a variety of animal models and neuropsychiatric disorders including bi-polar disorder, obsessive compulsive disorder, post-traumatic stress disorder and autism

Methods

A systematic literature search was completed using three databases; Ovid Embase 1996-2020, PubMed MEDLINE and the Cochrane Database, to gather and review relevant publications. Key search terms used were “curcumin” and “schizophrenia”. Evidence quality, validity and reliability was assessed with findings and recommendations outlined to reflect the supporting evidence. The literature search identified four studies testing curcumin effectivity in humans.

Results

The studies all used a range of measures to monitor outcomes. Three out of the four studies included Positive and Negative Syndrome Scale (PANSS) to score impact of curcumin on patients. There were statistically significant ($p<0.05$) improvements in PANSS in two of the studies. Cognitive functioning such as working memory was only shown to be improved on one of the studies, and a different study showed an increase in Serum BDNF for patients in the treatment group.

Conclusion

Existing evidence indicates that curcumin is a promising drug with the potential for use as adjunct therapy in schizophrenia. Further research is required on a national scale, involving a greater number of participants, allowing for treatment arms that can be further

delineated by disorder severity. Future research must also focus on mapping the specific symptom improvements attributed to curcumin’s neuro protective effects.

39. Psychiatric comorbidity in X-linked Emery Dreifuss muscular dystrophy: a case report

Dr Diego Quattrone, Clinical Research Fellow and Honorary Consultant, South London and Maudsley NHS Foundation Trust; Professor Shergill, Consultant Psychiatrist, South London and Maudsley NHS Foundation Trust; Eromona Whiskey, Consultant Pharmacist, South London and Maudsley NHS Foundation Trust; Dr Katie Kopala, Core Trainee Year 3, South London and Maudsley NHS Foundation Trust

Aims and hypothesis

We report a case of an individual suffering with X-linked Emery Dreifuss muscular dystrophy (X-EDMD) and comorbid treatment-resistant schizophrenia (TRS). While there have been case reports of other types of muscular dystrophies and schizophrenia, to our knowledge no cases have been reported of X-EDMD and psychiatric phenotypes. It is possible that the X-linked genetic mutation for EDMD has a pleiotropic effect for neuro-developmental conditions, including intellectual disabilities and proneness to psychosis.

Background

Muscular dystrophy (MD) is a group of genetic diseases with progressive weakness and loss of muscle mass. X-linked Emery Dreifuss muscular dystrophy (X-EDMD) is a form of MD ranking among nuclear envelopathies, i.e. conditions characterised by an abnormal nuclear lamina network, including aberrant lamins, emerin and other lamin-binding proteins. MD may affect several other tissues besides skeletal muscle, including the brain. Indeed, there are case reports of mental disorders and MD. X-EDMD is caused by a mutation of the gene encoding for emerin, an inner nuclear membrane protein which provides structural support to the nucleus binding the linker of nucleoskeleton and cytoskeleton (LINC) complex. Indeed, mutations in genes encoding proteins of the LINC complex, such as SYNE1, have been also associated with schizophrenia, bipolar, and autism spectrum disorders

Methods

We report a case of an individual suffering X-EDMD and co-morbid treatment-resistant schizophrenia (TRS). We describe genotyped mutation, clinical characteristics, family history and treatments provided.

Results

Sequencing of the proband's DNA revealed a Single Nucleotide Variation (SNV) in exon 6 (1523C>G), resulting in premature truncation of the emerin protein. As well as discussion of this case, this individual's family history reveals other relations who have suffered with

suspected complications of EDMD with psychiatric and neurodevelopmental co-morbidities.

Conclusion

The relation between X-EDMD and schizophrenia is as yet undetermined. Given the presentation and family history in this case, we may speculate that the X-linked genetic mutation for EDMD has a pleiotropic effect for neurodevelopmental conditions, including intellectual disabilities and proneness to psychosis. Further research is needed to identify similar sporadic or familial cases which might have not been reported.

40. Online Resources for People Who Self-Harm and Those Involved in Their Informal and Formal Care: Observational Study with Content Analysis

Dr Daniel Romeu, CTI, Leeds Institute of Health Sciences; Professor Elspeth Guthrie, Professor of Psychological Medicine, Leeds Institute of Health Sciences; Dr Cathy Brennan, Associate Professor of Psychological and Social Medicine, Leeds Institute of Health Sciences; Dr Kate Farley, Senior Research Fellow, Leeds Institute of Health Research; Professor Allan House, Emeritus Professor of Liaison Psychiatry, Leeds Institute of Health Research

Aims and hypothesis

Our aim was to identify and describe UK-generated internet resources for people who self-harm, their friends or families, in an observational study of information available to people who search the internet for help and guidance.

Background

Despite recent fears about online influences on self-harm, the internet has potential to be a useful resource, and people who self-harm commonly use it to seek advice and support.

Methods

We applied systematic search strategies to the online grey literature. The different types of advice were then grouped according to inductive thematic analysis.

Results

We found a large amount of advice and guidance regarding the management of self-harm. This was grouped into help offered by professionals, help offered by non-professionals, and personal accounts of recovery. The most detailed and practical advice took the form of strategies to avoid imminent self-harm and reduce thoughts and impulses. However, this was limited to a relatively small number of non-statutory sites.

Conclusion

A lay person or health professional who searches the web may have to search through many different websites to find practical help. Our findings therefore provide a useful starting point for clinicians who wish to provide some guidance for their patients about internet use. Websites change over time and the internet is in constant flux, so the websites that we identified would need to be reviewed before making any recommendations to patients or their families or friends.

41. Oral health in mentally ill patients attending the outpatient clinic of Taha Baasher Psychiatric hospital , Khartoum.

Dr. Areej Serebel, Dental Intern, Ministry of Health

Aims and hypothesis

To identify the level of oral health as measured by the DMF in mentally ill patients in Taha Baasher Psychiatric Hospital.

Background

Mental illness has been very common lately and the mentally ill are a special population with their own particular set of needs and challenges. In general physical health of the mentally ill is poorer than that of the general population and oral health is especially neglected hence the desire to quantify this.

Methods

This study was a cross-sectional hospital based study conducted in the outpatient clinic of Taha Basher Psychiatric teaching hospital. The sample (90) was selected randomly from among the adult patient attendants who agreed to participate in the study in the following working days of the week for a month.

Results

The mean DMF was 4.91 +/-4.46 . It was positively correlated to age and duration of illness. It was higher in females and the biggest proportion was due to missing teeth and the smallest proportion was the filled teeth. There were no dentures used by any of the patients.

Conclusion

Those involved in the study reflect the poor level of oral health among the mentally ill population and this deficiency is unfortunately not receiving enough attention of care givers or mental health professionals. The dental community ought to establish a professional referral system with such facilities to facilitate patient care.

42. Validity and inter-rater reliability of a BPRS-Flow Chart (BPRS-FC) using raters with low clinical experience: a feasibility study.

Dr. Alberto Salmoiraghi, Consultant Psychiatrist/Medical Director/Honorary Senior Lecturer, BCUHB; Dr. Raj Sambhi, Consultant Psychiatrist, BCUHB; Dr. Steven Lane, Senior Statistician, Liverpool University; Dr. Shaheed Hussain, Consultant Psychiatrist, GMMH NHS Trust; Dr. Danielle Jackson, consultant clinical psychologist, KGL NHS Trust

Aims and hypothesis

The study evaluates the validity and inter-rater reliability of a specific tool to facilitate the use of the BPRS.

Background

The Brief Psychiatric Rating Scale is an assessment tool for a variety of psychiatric symptoms. One of the latest version is the 24-item BPRS modified by Ventura et al. (1993). This version provides anchor points, making the interview semi-structured. Despite the modifications over time, one important limitation of the BPRS is its inter-rater reliability when used by raters with low clinical experience. Two authors developed a flow-chart of questions (BPRS-FC) to facilitate the use of the BPRS by raters with low clinical experience.

Methods

The study evaluated the validity and inter-rater reliability of BPRS-FC. Patients were video-interviewed and clinicians with low and high clinical experience scored each item using BPRS and BPRS-FC. Correlation coefficient was calculated for each item

Results

The results indicate that BPRS-FC does not offer good validity or inter-rater reliability and cannot be used in research. However, an unexpected result for BPRS was that experienced clinicians trained in the use of the BPRS showed poor inter-rater reliability.

Conclusion

This study suggest that the use of BPRS in research and clinical settings may be limited by the amount of training and experience necessary for the use of the scale. It also suggest that the training should be explicit in published literature. This study is in line with others. Although the BPRS is a common scale used in research and other settings, we suggest further research targeting specifically inter-rater reliability.

43. Temporal trends in psychotic symptoms: repeated cross-sectional surveys of the population in England 2000-14

Dr Natalie Shoham, NIHR Fellow, University College London, Camden and Islington NHS Foundation Trust; Professor Claudia Cooper, University College London, Camden and Islington NHS Foundation Trust; Dr Gemma Lewis, University College London; Professor Paul Bebbington, University College London; Dr Sally McManus, NatCen Social Research

Aims and hypothesis

We aimed to find out, using data from the Adult Psychiatric Morbidity Surveys, whether the prevalence of psychotic symptoms in the general population of England increased between 2000 and 2014. We hypothesised that it had increased, based on the 2014 Adult Psychiatric Morbidity Survey, which suggested an increase in psychotic disorders over the same time period.

Background

It was not possible to tell, prior to this study, whether the apparent increase in psychotic disorders seen in 2014 was in fact a measurement artefact caused by higher rates of antipsychotic medication prescription. This is because receipt of antipsychotic medication was used, along with other variables, to determine the presence of probable psychotic disorder in the Adult Psychiatric Morbidity Surveys. The number of antipsychotic prescriptions dispensed annually in England has increased by 50% over the past decade. We do not know whether this is due to changes in prescribing practices, or an increase in the prevalence of psychotic symptoms. To our knowledge, no previous studies have investigated temporal trends in the prevalence of psychotic symptoms in non-clinical populations.

Methods

We used regression modelling and data from the nationally representative Adult Psychiatric Morbidity Surveys 2000, 2007 and 2014 to (1) test whether the prevalence of psychotic symptoms increased between 2000 and 2014; (2) compare prevalence of psychotic symptoms to the prevalence of being prescribed antipsychotic medication.

Results

There was a small increase in the odds of reporting psychotic symptoms in 2014 compared to 2000 (Adjusted Odds Ratio (AOR) 1.20, 95% Confidence Interval (CI) 1.02 to 1.40, p=0.026). By comparison, antipsychotic medication use doubled over this period (AOR 2.22, 95% CI 1.52 to 3.25, p<0.001).

Conclusion

While the rates of antipsychotic prescription in England doubled between 2000 and 2014, the odds of having psychotic symptoms rose only slightly. This suggests a trend towards increased use of antipsychotics that is larger than any increases in prevalence of psychosis. The impact of this on outcomes for people with psychotic symptoms warrants further investigation.

44. How many extrapyramidal and non-extrapyramidal side effects can a person experience from Aripiprazole? A Case Report

Dr Jibran Syeed, CT2, CNWL NHS Trust; Dr Jiann Lin Loo, Speciality Doctor, CNWL NHS Trust; Dr Sarita Paul, Consultant Psychiatrist, CNWL NHS Trust

Aims and hypothesis

To report a rare case of multiple aripiprazole-induced side effects including parkinsonism.

Background

As an atypical antipsychotic acting as a partial dopaminergic agonist, aripiprazole has a low rate of extrapyramidal side effects (EPS) and a reduction in prolactin levels. Most EPS are reported through case reports. Here we would like to enrich the literature with an unusual case of bipolar mania patient who developed both parkinsonism and akathisia with aripiprazole.

Methods

A case report

Results

A 24-year-old lady was admitted for unmanageable behavioural agitation with persistent elated, irritable mood associated, increased energy, reduced need of sleep, excessive talkativeness, spending spree and increased confidence for about a week. Her past history was major depressive episode characterised by depressed mood, anhedonia, self-neglect, guilt, hopelessness and anorexia, which were partially treated with fluoxetine a few years ago. Diagnosis of bipolar mania was made. Her initial Young Mania Rating Scale (YMRS) was 31 and Clinical Global Impression (CGI) was 7. Her physical examination, blood investigation and ECG were unremarkable. Aripiprazole was started at 5mg/day and increased to 20mg/day over two-weeks. Although her YMRS improved to 9 during the 3rd week, she reported multiple physical symptoms, including feeling stiffness and hand tremor. Further assessment revealed hypomimia, bilateral upper limb rigidity and bilateral leg swelling below the knees. Calf pain with a pruritic rash on her upper lateral aspect of her thighs followed the next day. Five days since the onset of symptoms she developed cog wheel and lead pipe rigidity, bradykinesia with shuffling gait and a resting tremor as well as an inability to sit still and restlessness associated with myalgia in both legs. Although her creatine phosphokinase was high at 360 IU/L, there was no vital sign instability and other features of neuroleptic malignant syndrome. Procyclidine injection had relieved the symptoms and hence, the diagnosis of parkinsonism and akathisia was made. Aripiprazole

was replaced with olanzapine upon shared decision making and regular procyclidine was given until all her EPS subsided. Her repeated creatine phosphokinase was 136 IU/L.

Conclusion

Despite the favourable side effect profile of aripiprazole, it is still poorly understood on the individual susceptibility, possibly due to different pharmacogenomic profile. Hence collaborative practice and shared decision making are always an essential component of evidence-based medicine to ensure patient's receive an effective tolerable treatment.

45. tDCS as a potential treatment for psychiatric illness

Mr Michael Trubshaw, Medical student, University of Nottingham Medical School; Mr Abdulrahman Shalabi, PhD Student, University of Nottingham Institute of Mental Health; Dr Lauren Gascoyne, Research Fellow, University of Nottingham; Sir Peter Mansfield Imaging Centre; Ms Alice Waitt, PhD Student, University of Nottingham Institute of Mental Health; Dr Najat Khalifa, Associate Professor and Consultant Forensic Psychiatrist, University of Nottingham Institute of Mental Health; Dr Katie Jones, Assistant Professor in Applied Psychology, University of Nottingham Division of Psychiatry and Applied Psychology; Dr George O'Neill, Associate, UCL; Professor Matthew Brookes, Professor of Physics, University of Nottingham Sir Peter Mansfield Imaging Centre; Dr Elizabeth Liddle, Associate Professor in Translational Mental Health, University of Nottingham Division of Psychiatry and Applied Psychology; Professor Peter Liddle, Professor of Psychiatry, University of Nottingham Division of Psychiatry and Applied Psychology

Aims and hypothesis

To investigate the potential for transcranial direct current stimulation (tDCS) as a treatment for psychiatric disorders.

Background

Treatments for psychiatric conditions thus far have largely been based on psychological and pharmacological therapies. However, after the identification of distinct brain networks linked to psychiatric illness, there is now scope for innovative treatment options that directly modify electrical mechanisms of neural signalling in localised brain regions. Cognitive control or 'top-down' executive processing includes attentional control, task switching and inhibition of undesirable actions. A myriad of conditions as diverse as schizophrenia and ADHD have been shown to be associated with cognitive control deficits. The dorsolateral prefrontal cortex (DLPFC) is a core node of the cognitive control network (CCN). Oscillatory brain activity in the alpha band is associated with neural inhibition. We hypothesised that stimulating the DLPFC with tDCS might alter oscillatory alpha power during the anticipatory period preceding a stimulus requiring cognitive control over an automatic eye-movement.

Methods

We recruited 41 participants from a healthy population who engaged in high-risk leisure activities and who were therefore likely to display higher than average impulsive traits. Participants were randomised to a single 20-minute session of either "active" or "sham" tDCS, which was administered while they performed an anti-saccade task inside a magnetoencephalography (MEG) scanner. We used wavelet analysis to extract the time

course of alpha power activity during the 800ms anticipatory period between cue and imperative stimulus in regions of the CCN: left and right DLPFC, Frontal Eye Fields and Intra-Parietal Sulcus. We also measured resting state alpha-band connectivity before and after the task.

Results

The Active tDCS group showed greater and more sustained DLPFC alpha power than the Sham group during stimulus anticipation. Following the task, both groups showed extensive increases in alpha band resting-state connectivity, but the Active group showed significantly greater increase in frontal connectivity.

Conclusion

Our results suggest that tDCS administered over the DLPFC acts to produce increased frontal alpha activity during stimulus anticipation in an anti-saccade task, for which a tendency to impulsive responses must be restrained. This is accompanied by plastic changes in CCN activity that persist at least transiently following the treatment and might be predicted to modify capacity for cognitive control. However, we have not yet shown that this increase in anticipatory alpha activity or increased alpha connectivity translates to improvements in behaviour. Subsequent analysis will assess anti-saccade accuracy and fluency by analysing eye-tracking data.

46. Aripiprazole may be associated with QTc Prolongation

Victoria Candy, Medical Student, Western University, London, Ontario; **Dr. Itoro Udo**, Consultant Psychiatrist, St. Joseph's Healthcare London & Western University, London, Ontario, Canada.

Aims and hypothesis

This case serves to deliver an educational update for psychiatrists on the cardiac effects of Aripiprazole.

Background

Psychiatrists often consider Aripiprazole to be a cardiac neutral medication. Hence it is considered a suitable choice in patients with cardiac diseases, especially involving cardiac rhythm. However, evolving evidence, mostly case reports, is beginning to show that Aripiprazole may also cause QTc prolongation and vigilance is needed when it is prescribed. Many practicing psychiatrists may not be aware of this update.

Methods

A case report is presented, with appropriate consent; this involved the treatment of Schizophrenia with Aripiprazole as the only antipsychotic and only medication taken by a patient with limited, previous cardiac history.

Results

A female patient in her 50s was admitted to hospital with suicidal ideation and parasuicidal behaviours. This presented an exacerbation of pre-existing psychosis. She had been treated for Paranoid Schizophrenia, presenting with auditory hallucinations and agitated behaviour. She was receiving IM Aripiprazole 400mg every 30 days. This was the only medication she had been taking. On admission, she was found to have QTc of 518 ms. Aripiprazole was discontinued and she was treated with Oral Clonazepam. QTc reduced to her normal of 477 ms. Aripiprazole was reintroduced, orally at 2mg daily and then 5mg daily, at hospital discharge. At 2 weeks follow up, QTc has increased again to 499 ms prompting the permanent discontinuation of Aripiprazole. Her past medical history was significant for intermittent prolongation of the PR interval and left bundle branch block. She did not have any significant history of electrolyte imbalances on or prior to admission.

Conclusion

Psychiatrists need to be aware that Aripiprazole may cause QTc prolongation. Maudsley's Prescribing Guidelines (13th edition) of 2018, has moved Aripiprazole from being of "no effect" to being of "low effect" group on QTc. Those currently listed as being of no effect are

Brexiprazole, Cariprazine and Lurasidone. The comprehensive cardiac evaluation of patients placed on antipsychotics continue to be of paramount importance.

47. Evaluating patients and healthcare professionals' understanding of voting rights for patients in government elections

Dr Mark Winchester, ST5 Doctor, Midlands Partnership NHS Foundation Trust; Dr Madiha Majid, CT2 Doctor, Coventry and Warwickshire Partnership NHS Trust; Dr Ashok Kumar, Consultant Psychiatrist, Coventry and Warwickshire Partnership NHS Trust

Aims and hypothesis

1) To understand whether mental health patients vote in government elections. 2) To ascertain the barriers that prevent them from doing so. 3) To explore ways in which mental health services can support patients to vote. 4) To determine whether mental health staff are aware of patients' right to vote.

Background

Members of Parliament (MPs) can influence decisions regarding the National Health Service (NHS) and mental health legislation. The general election on 12th December 2019 highlighted that many patients were not using their democratic right to vote. It also appeared that many staff members were not aware that patients under the Mental Health Act (MHA) were entitled to vote (except for those under 'forensic' sections of the MHA). We therefore conducted a survey to ascertain both patient and staff understanding of their democratic rights and to better understand how we could increase the rate of voting amongst psychiatric patients.

Methods

Two questionnaires were produced, one for patients and the other for staff members. This was tested by the clinical governance team before approval was granted. Data was collected at the Coventry and Warwickshire Partnership NHS Trust in the form of paper forms or electronically through a survey website. Forty-two patients and twenty-five staff members responded.

Results

No staff members had received formal training with regards to patients' right to vote. Over half of staff members incorrectly believed that patients under Section 2 or 3 of the MHA and those lacking capacity couldn't vote. More than half of the team members surveyed stated that they had not supported patients in registering or casting a vote. Roughly one third of healthcare professionals felt that it was their responsibility to promote patients' right to vote, with one third disagreeing and the remaining third unsure.

Conclusion

Basic training is required to improve staff knowledge of patients' voting rights, which should help improve their ability to support patients to vote. Trusts should have a clear protocol in place in the event of future elections, with information on who can vote, how to request a postal vote and the candidates in that area.

Case Report

48. Severe psychiatric disturbance and suicide attempt in a healthcare worker with COVID-19 and no psychiatric history

Dr George Gillett, Academic Clinical Fellow (CT1), South London and Maudsley NHS Trust; Dr Iain Jordan, Consultant in Psychological Medicine and Trauma Psychiatry, Oxford University Hospitals NHS Foundation Trust

Aims and hypothesis

To present the case of a 37-year-old healthcare worker with no psychiatric history, presenting with severe psychiatric disturbance and attempted suicide in the context of newly diagnosed COVID-19. We explore the likely predisposing and precipitating factors to his presentation.

Background

COVID-19, caused by Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) infection, remains an emerging disease with poorly-defined psychological sequelae. Previous reports have identified that confusion, low mood, anxiety and insomnia are associated with severe coronavirus infection, although the precise risk factors and mechanisms by which these symptoms develop are unclear. Emerging evidence suggests healthcare workers may be at greater risk of depression, anxiety and insomnia during the COVID-19 pandemic, although the prevalence of severe psychiatric symptoms among healthcare workers has not been thoroughly investigated.

Methods

We present the case of a 37-year-old healthcare worker presenting with severe psychiatric disturbance and attempted suicide following SARS-CoV-2 infection. We explore a number of potential contributing factors relevant to the case, including encephalopathy, severe worry, ethnicity and work-related stress.

Results

Following a prolonged admission to the intensive-care unit and general hospital setting, Mr A made a good recovery. He regained insight, was fully orientated, experienced no further symptoms of psychosis or suicidality and was keen to engage with mental health services. Since his discharge, Mr A has remained well.

Conclusion

We suggest this case may represent delirium or first-episode psychosis in the context of newly diagnosed COVID-19. Importantly, this case highlights the importance of vigilance towards psychiatric symptoms in patients with SARS-CoV-2 infection in both inpatient and community settings. The majority of research literature has focused on secondary psychiatric symptoms among COVID-19 patients already hospitalised for severe infection. This case may therefore highlight the need to further characterise the specific psychiatric sequelae of COVID-19 in community settings, which may be in part achieved by performing case-control serological studies as in previous epidemics.

Education and Training

49. Improving Clinical Handovers in Community Mental Health Teams – A Quality Improvement Project

Dr Adam Arshad, FY1, St Ann's Hospital, Dr Brian Douglas, Consultant, St Ann's Hospital

Aims and hypothesis

To improve the quality of clinical handovers amongst the West Haringey Community Mental Health Team (CMHT)

Background

Multidisciplinary team working is integral for the safe functioning of the CMHT. However, the confidence of team members in conducting clinical discussions varies and it is well known that poor clinical handovers result in an increased risk of clinical errors. We conducted a quality improvement project to enhance the standard of clinical handovers in the West Haringey CMHT.

Methods

The West Harringay CMHT consists of 18 members: 2 consultant psychiatrists, 1 psychiatric registrar, 1 psychiatric core trainee, 2 psychologists, 8 care coordinators, 1 dual-diagnosis worker, 2 team managers and 1 peer support worker. Baseline questionnaires were provided to all team members. Individuals then rated their own and their colleague's competency, on a 5-point Likert scale, six questions regarding the quality of clinical handovers they deliver and receive. The Likert scale for each question ranged from 1–5, with the following scoring: 1- not confident/not very good all the time, 2– not confident/not good majority of the time, 3– sometimes confident/good, 4– confident/good majority of the time, 5– always confident/very good After the baseline questionnaires were completed, a structured teaching programme was delivered. This teaching was 30 minutes in length and discussed: the importance of effective handovers, methods of structuring handovers (e.g. SBAR technique) and case examples. Repeat questionnaires were conducted 2 months later to assess for team reported improvements in their own and their colleague's technique. Differences in scores pre- and post- teaching were assessed by a paired t-test.

Results

All 18 individuals returned the baseline questionnaire, attended the teaching, and completed the post-teaching questionnaire. The following results were attained (mean baseline score vs. mean score 2-months after teaching): • Rate your confidence in presenting handovers: (3.2 vs. 4.5, p = 0.155) • Rate your confidence in structuring

handovers: (3.4 vs. 4.6, p = 0.225) • How confident are you with using tools (e.g. SBAR) to structure your handover: (2.0 vs 4.1, p = 0.008) • Rate your colleague's ability to present confidently (3.0 vs. 4.2, p = 0.032) • Rate the structure of your colleague's handovers (3.16 vs. 4.2, p = 0.41)

Conclusion

A structured teaching session, on the importance and methods to structure clinical handovers, can provide significant and lasting improvements in the confidence and quality of handovers in CMHT

50. Are we happy with virtual teaching and learning?

Dr Christopher Bu, CT2, Alder Hey Children's NHS Foundation Trust Dr Indira Vinjamuri, Consultant General Adult Psychiatrist, Mersey Care NHS Foundation Trust

Aims and hypothesis

To analyse the quality and satisfaction of the Local Academic Programme (LAP) at Mersey Care NHS FT as delivered on a virtual platform during COVID-19.

Background

As a result of COVID-19, education has changed dramatically, with the distinctive rise of e-learning whereby teaching is undertaken remotely and on digital platforms. These changes might be around to stay. Research suggests potential benefits of online learning, including increased retention of information. Mersey Care chose to adapt the existing format of the mandatory MRCPsych course using the online platform of Zoom to ensure that teaching continued through COVID-19. A subsequent survey was then delivered to evaluate quality and satisfaction.

Methods

An online survey using Google forms was circulated in June 2020 to all LAP attendees including qualitative and quantitative questions about the virtual teaching. Attendance figures were collected weekly.

Results

50 participants responded to the survey. Attendance on the virtual platform was significantly increased, mean values for face to face (48) vs virtual (65). Feedback reported improved accessibility; attending from multiple sites; ability to join on zero days and reduced travel burden. The technology boosted interactivity through the live chat feature, with presenters fielding live questions. The majority of respondents wanted virtual LAP to continue, possibly alongside some face to face LAP even after the pandemic situation improves. However, 18% reported technological accessibility issues relating to computer and phone microphones. The Journal Club struggled with an unsatisfactory trial of 'virtual breakout rooms', with patchy participation and technology issues.

Conclusion

The online platform allowed our LAP to proceed smoothly with no gaps throughout 2020 (compared to some other local areas that missed LAP sessions). Attendance was higher than usual with increased participation. Technology and accessibility were noted to be difficult for a minority. We have worked towards improving accessibility for all and

attendance in our current semester has been >90 per session. We are working to improve the virtual group work aspect, particularly in the journal club. An 'LAP Trainee Lead' role has been created and appointed to support development and improve satisfaction from virtual learning which has been received positively. Clearer guidance and expectations for virtual learning have been disseminated and the satisfaction survey will be repeated in 6 weeks. The Trust Quality Improvement Team is now involved in supporting the programme. More co-production with participants will continue.

51. New to psychiatry training? We got you!

Dr Sidra Chaudhry ST4 General and Old Age Psychiatry Trainee, SHSC NHS Foundation Trust Dr Nadia Imran ST4 General Adult Psychiatry Trainee, SHSC NHS Foundation Trust

Aims and hypothesis

1. Provide new trainees with support from senior trainees within the training scheme on an informal basis. 2. Provide senior trainees with opportunities to develop and practice skills required to become mentors, teachers and clinical/educational supervisors in future.

Background

A survey was conducted amongst core psychiatry trainees in the South Yorkshire training scheme to gauge the amount of support they received when they started working as a CT1. The 7 question survey also obtained feedback about the kind of support trainees would like to receive. Following this a programme was devised to ensure new trainees were given appropriate support in an informal setting from senior trainees within the scheme.

Methods

New CT1s were allocated to a senior Core Trainee buddy (CT2 or CT3) to help them settle into psychiatry training. Common topics covered were – registering with RCPsych portfolio as a PMPT, setting up the e-portfolio, preparing for ARCP and exam preparation. If the Buddy felt something was beyond their area of expertise, they could signpost the trainee to their clinical or educational supervisors for further guidance. The method and frequency of contact between the CT buddy and CT1 was left open according to their needs for support. This also helped new CT1s network with other trainees in the scheme and also provided various opportunities to obtain informal guidance at a trainee-to-trainee level.

Results

Towards the end of the six months, a feedback survey was conducted. The CT buddies shared that this experience had helped them develop leadership and management skills in preparation for future roles. The new core trainees reported feeling supported especially with issues surrounding e-portfolio and ARCP. (graphs will be shared on the poster)

Conclusion

The Core Trainee Buddy Programme has been a successful pilot project with mostly positive reviews from Core Trainees involved. CT buddies were also able to provide colleagues with support during the COVID-19 pandemic. Suggestions have been made to put more thought into allocations to ensure that the trainees are within the same trust or

at least in sync with regards to their training calendars. These ideas have been taken on board and we hope to bring about these changes with the next cohort of trainees.

52. All Reflections Cause Panic! - How to address the 'ARCP' of Reflective Practice within all Training Levels using a Shared Learning Approach

Dr Georgina Edgerley Harris, CT3, SWLSTG NHS Trust, Dr Maria Alonso Vicente, Consultant, SWLSTG NHS Trust

Aims and hypothesis

This study was designed to support medical colleagues in reflective practice and assess engagement with and depth of reflection by focusing on 'on action' rather than 'in action' reflections. Most teaching sessions focus on 'in action' reflective practice and we therefore wanted to develop a way of focusing on 'on action' reflective practice in order to make reflective practice more valuable.

Background

Doctors have become increasingly wary of reflective practice especially after high profile cases such as Dr Bawa-Garba where the use of reflective practice in GMC hearings has been brought into debate. All Doctors are subject to annual reviews of competencies (ARCP) and this includes the use of reflective practice to demonstrate continued professional development as suggested by the Royal College of Psychiatry. The GMC specifically state that time should be made available for reflection although it can be questioned how often this is routine practice. Schon identified two types of reflective practice: IN ACTION - reflecting on behaviour as it happens and ON ACTION - reflecting after the event to analyse the situation

Methods

The study was an observational, qualitative study focusing on reflective practice during an academic teaching session. Specifically designed reflective prompts were used to guide delegates alongside the use of other methods such as allocated time and written handouts.

Results

Emerging themes highlighted that reflective prompts and supporting material engage the reflector and appear to promote considered and 'on action' reflections. Allocated time for reflection ensured the majority of reflective forms were fully completed. Simple learning points were firmly acknowledged and there were secondary benefits noted for further education and care of service users.

Conclusion

With this promising demonstration, we hope the incorporation of reflective practice within teaching sessions can promote personal educational development and improve patient care as suggested by the GMC.

53. Regional Survey into Trainee Experience of Core Psychotherapy Training

Dr Lauren Evans, CT1, South West London and St. George's Mental Health NHS Trust Dr Georgia Belam, Consultant Psychiatrist, Surrey and Borders Partnership NHS Foundation Trust

Aims and hypothesis

This project aims to assess the experience of psychiatry core trainees who have undertaken core psychotherapy training (CPT), to identify what is experienced positively and potential areas of improvement.

Background

Psychotherapy is an necessary part of core psychiatry training, requiring one short and one long case to complete core training.

Methods

An anonymous online survey was drafted, containing both qualitative and quantitative questions, to assess trainees experiences of CPT. It was circulated via Trust email (locally) and Twitter (nationally).

Results

A total of 35 responses were received: 21 core trainees, 12 higher trainees, 1 consultant, and 1 staff grade doctor. 6 respondents had completed a short case only; 2 a long case only; 25 both; and 2 neither. Confidence in psychotherapy knowledge was rated on a 1-5 scale (1: significantly below average to 5: significantly above average). Theoretical knowledge improved from a 2.57 average before CPT to 3.63 following, and clinical application improved from 2.43 before to 3.66 following. Knowledge prior to delivering CPT was most commonly obtained from Balint group (71.4% of respondents) and MRCPsych courses (65.7%). The main barriers to obtaining psychotherapy experience were: accessing supervision (60.0% of respondents); not enough patients (53.3%); and a lack of guidelines on accessing supervision and patients (43.3%). Additionally, getting time away from day jobs was identified as a concern, particularly among LTFT trainees. Important learning points from CPT identified by trainees were: knowledge of psychoanalytic concepts, such as transference and counter-transference; differences between the theoretical models; an alternative approach to formulation; and how these skills can be useful in all clinical encounters, such as maintaining rapport, boundaries, and time-keeping. The useful role of supervision was also highlighted.

Conclusion

This project serves as an introductory look into how trainees view their experience of CPT, and potential areas for improvement. Themes for improvement, arising from qualitative responses, are: clear reading list, including introductory materials; clear guidelines at induction, including supervisor contact details; improved access to supervision; patients to be allocated; protected time for psychotherapy, with extra support for LTFTs; shadowing; increased choice of modality; and more formal teaching on psychotherapy. These are key areas to be targeted to improve the trainee experience, particularly for those who risk delays in their training.

54. Late to the party: Mental health professionals' knowledge on party drugs and harm reduction advice.

Dr Nataly Gibson, CT3, South London and Maudsley NHS Foundation Trust

Aims and hypothesis

The aims were to establish whether there was a deficit in mental health professionals' knowledge and understanding of party drugs and harm reduction, to give education on this subject, and to gain feedback on whether it is useful and/or important.

Background

Knowledge of illegal substances has long revolved around addictions in psychiatry training and not of party drugs and harm reduction. Reasons for this could include it being a fairly taboo subject and it being an area where information and advice change frequently. However, drug related deaths are at their highest since records began in 1993 and as our patients use them it is important that professionals are knowledgeable and can offer sound harm reduction advice.

Methods

A questionnaire of 10 questions on party drugs and harm reduction was devised using resources from charities 'The Loop' and 'Talking Drugs'. These questions aimed to test general knowledge in this area that would be expected from professionals. This questionnaire was given to Mental Health professionals in a busy South London Trust before and after teaching sessions on the subject. Feedback was then collected from the attendees on their experiences.

Results

There were only 44 % correct answers on the questionnaire before the teaching sessions. The high proportion of incorrect answers was spread across grades. This improved to 77 % correct answers after the teaching sessions. Feedback was overwhelmingly positive and attendees said that they would want further teaching on this. Lots of people were surprised at their lack of expertise in this area and agreed it was an important area to focus on going forward.

Conclusion

Party drugs and harm reduction knowledge is lacking in Mental Health professionals despite it being commonly seen in our patients. Tailored teaching sessions can help improve this and it seems most professionals would welcome it. In the future it may be useful to include this type of teaching as part of the official Psychiatry curriculum.

55. Peer Mentoring in Psychiatry: A trainee-led initiative

Dr Linda Irwin, ST6, Northern Health and Social Care Trust Dr Zoe Moore, ST6, Belfast Health and Social Care Trust Dr Stuart Brown, ST6, Belfast Health and Social Care Trust Dr Julie Anderson, Consultant, Northern Health and Social Care Trust Dr Stephen Moore, Consultant, Western Health and Social Care Trust

Aims and hypothesis

The aim of this initiative was to establish a peer mentoring network within Psychiatry Training in Northern Ireland. The scheme would be aimed at supporting Core (CT1) Trainees through their first year of training, with a peer mentor from within the cohort of Higher Psychiatry Trainees. It was hoped to be mutually beneficial to both parties.

Background

Entering a new training programme can be a particularly stressful time in any junior doctor's career. We wanted to ensure that our new CT1s were well supported and believed that a peer mentoring relationship, external to clinical and educational supervision, would bring added value. Given that mentoring was beginning to develop within other specialties locally, we decided to address the mentoring “gap” within our training programme.

Methods

New CT1s were encouraged to take part in the scheme via a presentation at induction as well as follow up emails. Higher trainees were sent information about the scheme via email and asked to apply if interested in mentoring a new CT1. Prospective mentors then attended a one-day training session. Two lead mentors, (also higher trainees), were allocated to oversee the scheme, with additional supervision from two lead Consultants. Mentor-Mentee matches were made based on information such as location, sub-specialty affiliations and outside interests. Mentoring pairs were advised about the intended frequency and nature of contacts. Check-in emails were sent halfway through the year and feedback evaluations completed at the end.

Results

The majority of participants thought the scheme was beneficial; 95% of trainees who completed the evaluations would recommend it. Mentees reported benefits in personal and professional development, whilst mentors reported improved listening, coaching, and supervisory skills. Mentee recruitment is increasing annually and mentor recruitment has doubled since the first year of the scheme. A small number of trainees fed back that 6 monthly rotations impacted on ability to maintain face to face contacts.

Conclusion

The majority of the feedback received from trainees has been positive and the scheme continues to grow. We are just entering our third year and have seen the greatest interest from prospective mentors and mentees to date. We are considering ways to overcome changes of location during the year, including use of video calling. We hope to extend the scheme to include trainees of other grades, and particularly those who are new to Northern Ireland.

56. Teaching on Remote Consulting for Black Country Trainees in Psychiatry

Dr Ahmed Jawad, Specialty Doctor in General Adult Psychiatry, Black Country Healthcare NHS Foundation Trust; Dr Amitav Narula, Consultant General Adult Psychiatrist, Black Country Healthcare NHS Foundation Trust

Aims and hypothesis

The aim of this teaching session was to equip trainees in psychiatry within the black country region with the skills required to take part in remote consultations with patients.

Background

COVID-19 has changed the way mental health services are delivered. In order to keep both staff and patients safe, remote consulting can take place to help avoid unnecessary face to face contact. The royal college of psychiatrists encourages remote consulting where safe and appropriate, as the alternative of no consultation at all is not preferable. The six Cs: competence, communication, contingencies, confidentiality, consent and confidence should all be applied in order for remote consulting to be successful. It is important that trainees are educated about this to ensure that they do not miss out on learning opportunities, as being exempt from outpatient clinics can narrow their repertoire.

Methods

An online teaching session would take place via Microsoft Teams. Microsoft PowerPoint will be used via the screen share function. Following the teaching sessions, a link will be sent out via the chat function on Microsoft Teams for all those in attendance to complete a feedback form. The feedback form would grade relevance, content and delivery. The ratings that can be given are extremely unsuccessful, slightly unsuccessful, neither successful/unsuccessful, slightly successful and very successful. A comment box will be available for additional feedback.

Results

The results from the feedback forms were very positive. There were 15 responses in total and 14 out of 15 rated both relevance and content as very successful. There was only 1 slightly successful response for both categories. For delivery, 13 out of 15 responses rated it as very successful and only 2 responses rated it as slightly successful. There were 8 comments in total, which were all positive.

Conclusion

In conclusion, the trainees clearly seemed to have benefited from this teaching session. This is because of the vast majority of responses rating relevance, content and delivery as

very successful. Moreover, all the comments were positive. The next step would be for trainees to apply what they have learned by engaging in remote consulting under supervision from a senior psychiatrist. I have developed a remote consulting assessment form, which I will include in the poster. The trainers in the trust have been tasked with completing the assessment form for their trainees by a certain date. The assessment form can be used as a work place based assessment. Feedback from both trainees and trainers will be taken following this.

57. Cognitive difficulties and Schizophrenia

Dr Daniel Kaitiff, Consultant Psychiatrist, Pennine Care NHS Foundation Trust Dr Saas Ahmed, GP trainee, Pennine Care NHS Foundation Trust

Aims and hypothesis

Cognitive difficulties cause a considerable difficulty for patients with schizophrenia. We will discuss a case that highlights these issues and consider how cognitive testing should still be considered part of the general adult assessment

Background

A patient with previously diagnosed schizophrenia presents with supposed negative symptoms of schizophrenia. To further complicate matters his family suggest that he has been abusing alcohol.

Methods

We discuss his initial ACE III assessment which did improve with antipsychotic medication. He continued to have difficulty with ADLs

Results

We continued to increase antipsychotic medication to consider if there may be further cognitive improvement. A balance was required with regards to some of his psychotic symptoms and antipsychotic medication causing Adverse effects.

Conclusion

This poster will discuss that cognitive assessments need to be considered during certain general adult assessments. We shall discuss the difficulties of diagnosing complex cognitive disorders in patients with schizophrenia and educate professionals on difficulties with moving these patients through the systme.

58. Integrating Mental and Physical Healthcare: A Massive Online Open Course

Dr Gabriella Lewis, CT2, SLAM NHS Foundation Trust Dr Camille Wratten, CT3, SLAM NHS Foundation Trust Professor Matthew Hotopf, KCL IoPPN

Aims and hypothesis

To deliver a Massive Online Open Course (MOOC) on interactions between physical and mental illness, focusing on depression and anxiety in chronic physical illness. Subsidiary aims included empowering patients and carers by improving their knowledge of common mental health problems in physical illness, improving skills of healthcare professionals (HCP) in managing mental health problems, reducing stigma surrounding mental health, encouraging HCP to provide integrated care, and creating an online community for shared discussion and learning.

Background

People with chronic physical health conditions commonly have comorbid mental health problems like anxiety and depression. This can decrease quality of life, negatively impact health outcomes and increase costs of healthcare. Recent evidence suggests integrating mental and physical healthcare can improve patient outcomes. Educating patients and carers about symptoms and management of mental health problems has been shown to improve response and remission rates, and reduces chances of relapse. Online learning improves access to those who lack resources, time or health to attend in person and has been especially important during the Covid-19 pandemic.

Methods

As part of the IMPARTS project (Integrating Mental and Physical Healthcare: Research, Training and Services) a 3-week online course was designed using multimedia resources, patient narratives, and interactive exercises and quizzes. This was digitalised by the King's Online MOOC Strategy Group and hosted on the FutureLearn platform. A video trailer was disseminated through mental and physical health charities worldwide and IMPARTS and Kings networks.

Results

The course has run in September 2018, January and September 2019, and June 2020. 26,986 people in total enrolled from over 150 countries. 13,096 of these were 'active learners', with over 7400 course finishers. In June 2020, 65% of survey respondents said the course was better than expected. 96% reported gaining new knowledge or skills and 75% reported sharing their learning with others. A Likert-questionnaire completed by attendees in

January 2019 showed student confidence and knowledge of depression and anxiety in physical illness increased from 26.06/35 to 32.5/35 ($p < 0.000$).

Conclusion

The IMPARTS MOOC has been popular with health professionals, patients, carers, and members of the public worldwide. It has improved attendees' confidence and knowledge of depression and anxiety in physical illness. Many of the students share their learning with others, resulting in wider public health benefits.

59. Physical health management for psychiatric inpatients with COVID-19; a small project aimed at assimilating new evidence, devising appropriate pathways and adopting suitable prescribing guidelines.

Dr Emily Lewis, Locum ST4 in Psychiatry, Cheshire and Wirral Partnership NHS Foundation Trust, Dr Penelope Morris, GPST2, HEE North West, Dr Nicola Chavasse, ST1 in General Medicine, Countess of Chester Hospital NHS Foundation Trust, Dr Richard Bailey, CT3 in Psychiatry, Cheshire and Wirral Partnership NHS Foundation Trust, Dr Annette Stiggelbout, CT1 in Psychiatry, Mersey Care NHS Foundation Trust, Dr Lauren Roberts, FY2, Countess of Chester Hospital NHS Foundation Trust, Dr Jessica Hookham, GPST2, HEE North West, Dr Kai Yin, GPST2, HEE North West, Dr Bayode Shittu, CT1 in Psychiatry, Cheshire and Wirral Partnership NHS Foundation Trust, Dr Sumita Prabhakaran, Consultant Psychiatrist, Cheshire and Wirral Partnership NHS Foundation Trust, Dr Peter Wilson, ST6 in Psychiatry, Cheshire and Wirral Partnership NHS Foundation Trust

Aims and hypothesis

To outline pathways which were important in the management of psychiatric inpatients' physical health care during the COVID-19 pandemic.

Background

In the face of the COVID-19 pandemic, trainees in their psychiatric rotations formed a new team to provide medical cover to general psychiatric wards on which patients with either suspected or confirmed COVID-19 were cohorted. The team's priority was to focus on physical health safety and infection control for patients whose mental health needs could not be met in less restrictive settings out of hospital. This shift in focus meant integrating existing guidelines for aspects of physical health care and assimilating ever-evolving evidence and information regarding the novel virus to ensure optimal patient care.

Methods

There were six distinct areas in which we identified certain care needs for this patient group. We adopted national and local guidelines.

Results

The various management pathways are outlined in the poster and cover: Advance Care Decisions, VTE Prophylaxis, Vitamin D prescribing, Antibiotic prescribing, Escalation and End of Life care.

Conclusion

As outlined in RCPsych guidance 'if a patient displays COVID-19 symptoms, their physical healthcare takes priority'. This led to changes in the organization and structure of daily clinical work on the wards. As well as the necessary infection control measures we adopted care pathways and prescribing protocols to optimize the physical healthcare provided to our psychiatric inpatients with suspected or confirmed COVID-19. This information may well be relevant for some time as we continue to practice in an ongoing pandemic.

60. Teaching Leadership and Followership through Simulation

Dr Ella McGowan, CT2, Black Country Healthcare NHS Foundation Trust Dr Naomi Shorthouse, CT2, Black Country Healthcare NHS Foundation Trust

Aims and hypothesis

The aim of the simulation teaching session was to highlight the importance of leadership and followership through a practical approach and to build on the leadership skills taught in the MRCPsych course. The secondary aim was to build interest in psychiatry for the foundation doctors by providing a stimulating teaching session.

Background

Simulation based learning is commonly used in physical health settings to help teach participants about the importance of human factors. High fidelity simulation usually requires expensive equipment however, evidence suggests that low fidelity simulation can just as effective. In my trust there is currently no simulation based learning for trainees.

Methods

The intervention was simulation based teaching focusing on leadership and followership skills for Foundation Doctors, Core Psychiatry Trainees and General Practice Trainees. The simulation involved three participants: one unable to see, one unable to use their hands and one unable to speak. Together the three participants had to work out how to assess and manage an informal patient who had tied a ligature and wanted to leave the ward whilst an inpatient on an acute psychiatric ward.

Results

Eight trainees attended the teaching session. None of the trainees had done a psychiatry based simulation session before but seven of them had done physical health simulation sessions before. Feedback from the trainees was positive. Following the session they all agreed they were more aware of how human factors had impact in their job roles, they agreed they could identify when they should act as the leader and they felt more able to voice their opinion within a team. Some encouraging comments included: "The Simulation was very realistic. Good discussion. It has given me more confidence" "Good discussion about human factors. I am more aware of how to use them in a practical situation." "Consideration of delegating roles and leadership"

Conclusion

In conclusion we believe that effective simulation based teaching can be achieved with a low fidelity environment to help highlight the importance of human factors when

assessing and treating patients. We are planning further simulation sessions to be delivered to this cohort of trainees. We want to share this teaching idea so it could be used in other trusts.

61. Advantages, disadvantages and pitfalls of using an online communication platform to deliver junior doctor induction in a psychiatric setting during the Covid 19 Pandemic

Dr Joanna Pegg, ST6, Black Country Healthcare NHS Foundation Trust. Dr Gemma Horton, ST6, Black Country Healthcare NHS Foundation Trust. Dr Amitav Narula, Consultant Psychiatrist, Black Country Healthcare NHS Foundation Trust.

Aims and hypothesis

We aim to discuss the advantages, disadvantages and pitfalls of using an online communication platform to deliver junior doctor induction in a psychiatric setting.

Background

The COVID-19 pandemic and its associated social distancing measures has presented significant challenges in the delivery of teaching and training. A particular challenge is induction of new junior doctors into specialist placements such as psychiatry. The GMC states that 'effective induction is crucial to enable transition to working in a complex, unfamiliar environment.'

Methods

A task group was set up to design the content, structure and format of the proposed online induction. A range of speakers were asked to contribute to the agreed topics either live on the online platform, or by pre-recording videos to be played during the induction. Two facilitators were selected to co-ordinate the two day induction by introducing speakers, queuing presentations and collecting feedback, which was via a questionnaire.

Results

Over the 2 day induction overall, 76% of people strongly agreed or agreed that the sessions were useful, interesting and well organised. 25% more people agreed that live presentations compared to pre-recorded videos were more interesting and useful. Participants would have preferred more interaction overall.

Conclusion

Based on feedback, online communication platforms are an innovative and effective method of delivering junior doctor inductions. Innovative technology was utilised to allow new content such as a virtual site tour. The facility to record the session also proved useful for junior doctors to catch up on any missed content due to other commitments. Pitfalls noted include internet connectivity issues negatively impacting upon the quality of teaching and decreased interaction between tutors and trainees, something which may

be problematic when inducting junior doctors into a specialist setting like psychiatry. Introduction of more interactive content may increase trainee participation.

62. Mirror, Mirror, for us all? - Attitude towards personal therapy amongst Core Psychiatry Trainees

Aleksandr Sapunov (Core Trainee), Kenny Chu (Core Trainee), Katherine Kennet (Specialist Registrar)

Aims and hypothesis

The aim of this project is to explore the attitudes towards personal therapy with regards to professional and personal development for a trainee psychiatrist.

Background

Having personal therapy is a core component of psychiatric training in some countries. In UK, it is mandatory for medical psychotherapy higher trainees but not for core trainees. Personal therapy uptake appears to be in decline. Yet anecdotally, therapy is felt by psychiatry trainees to be beneficial to the development of a psychiatrist.

Methods

An online survey was created comprising of 10 multiple choice questions with options to leave comments to encapsulate thoughts and qualitative experiences. This was disseminated to all current core psychiatry trainees in the North Central London Deanery via email.

Results

23 respondents completed the questionnaire. Of these, 4 had undergone personal therapy. Respondents found personal therapy improved understanding and application of psychodynamic theories, and deepened understanding of therapeutic relationship. Barriers to starting or continuing therapy were explored in all respondents and cost was most frequently reported, followed by time commitment. No respondents listed personal therapy as not being helpful. The majority felt that personal therapy should be in the curriculum in some form. Individual comments of respondents will be analysed and added to the poster.

Conclusion

Less than a fifth of respondents have had personal therapy and the majority found the experience positive. There appears to be a strong support for personal therapy to be included within the curriculum both from those who have had therapy and those who haven't. The feeling within the cohort is there is much to be gained personally and professionally, albeit limited by cost and time commitments. The route into therapy for medical psychotherapy trainees is well guided via the curriculum, but should this support

be extended to all psychiatry trainees? We look to the expanded ideas within the poster to stimulate further conversation about the implications of personal therapy for psychiatry trainees.

63. Deeper than Skin: A regional collaborative trainee-led psychodermatology service – one year on!

Dr Stephanie Ball – Consultant Dermatologist, Dermatology Department, Royal Victoria Infirmary, Newcastle upon Tyne NHS Foundation Trust **Dr Soraia Sousa** – ST6 Specialist Registrar in Adult General Psychiatry, Cumbria Northumberland, Tyne and Wear NHS Foundation Trust Dr Sarah Brown – Consultant Liaison Psychiatrist, Cumbria Northumberland, Tyne and Wear NHS Foundation Trust

Aims and hypothesis

This study represent an evaluation of the outcomes and reflection and challenges of establishing a new regional collaborative trainee-led psychodermatology service at the Newcastle-upon-Tyne Hospitals NHS Foundation Trust (NuTH).

Background

NuTH is one of the largest acute Trusts in the United Kingdom with a tertiary catchment area of 3 million people. Despite its many specialist dermatology services, the absence of Psychodermatology services in the North East was evident and dermatologists in the area reported feeling under-confident in managing psychodermatology consultations and prescribing psychopharmacological medication. The British Association of Dermatologists [BAD] Working Party Report recommends all regions in the UK should have at least one Psychodermatology service with a trained Consultant Dermatologist with expertise in Psychodermatology. In October 2019, the first NuTH Psychodermatology Clinic took place as a joint clinic bringing together a dermatology specialist and a psychiatry higher trainee. The aim was to initiate a cost-effective, flexible, sustainable and collaborative regional psychodermatology service to improve the lives of patients suffering from psychocutaneous diseases, via replication of the novel trainee-led model, pioneered by colleagues in Edinburgh.

Methods

The joint Psychodermatology Clinic takes place one a month with initial appointments running for 1 hour and follow-up appointments for half-hour. Patients are asked to complete three measures prior to attending the appointment: Patient Health Questionnaire-9 (PHQ9), Generalized Anxiety Disorder-7 (GAD7) and the Dermatology Life Quality Index (DLQI). The resulting data has been submitted to descriptive analysis.

Results

Between October 2019 and June 2020, a total number of 19 patients were seen at the clinic; 6 of these patients attended via virtual consultation (Attend Anywhere) due to the

coronavirus pandemic. The average age of attendees was 43 years old and the majority were women (n=14, 74%). The average scores during the first visit were 16.2 for PHQ9, 12.6 for GAD7 and 13.1 for DLQI. Most patients who attended the clinic were diagnosed with some degree of mental health disorder (n=18, 95%) with depression (n=9, 47%), skin-picking disorder (n=5, 26%) and anxiety (n=4, 21%) leading. Out of the 19 first visits, 9 patients were discharged, 2 of which were referred for secondary mental health services and 4 to primary care psychological therapies.

Conclusion

Whilst the gold-standard for psychodermatology clinics may be to have consultant clinicians with dedicated psychodermatology subspecialism, this trainee-led service increased flexibility in setting up a new clinical service able to address a gap in the management of people with skin and mental health conditions.

Service Evaluation and Audit

64. An Attempt to Improve Admission Clerking with Audit: Experience from Milton Keynes

Dr Saba Ansari, SAS,CNWL Trust (Lead); Dr Jiann Lin Loo, SAS, CNWL Trust(Lead); Dr Honida Mansour, SHO, CNWL Trust (Team Member); Dr Soham Bandyopadhyay, FY1, CNWL Trust (Team Member); Dr Fabia Fayyaz, SHO, CNWL Trust (Team Member); Dr Tariq Khan, Consultant, CNWL Trust (Supervisor); Dr Sabrina Pietromartire, Consultant, CNWL Trust (Supervisor)

Aims and hypothesis

To ensure an admission clerking include important information for the management of mental health and physical health issue and also the administrative purpose

Background

Given the COVID-19 pandemic has changed the inpatient psychiatric practice significantly, this audit was undertaken to establish if the admission clerking includes the important information necessary for the management of mental and physical health of patients admitted to the Campbell Centre. This is the first audit that looks into mental health, physical health, and administrative aspect of clerking documentation in the Campbell Centre. The aim is to develop a template that facilitates junior doctors' admission clerking process to improve patients' care, consistent with the vision of "CNWL Physical Health Strategy Year 2 2020-21".

Methods

This audit is conducted in the Campbell Centre in Milton Keynes of the Central and North West London NHS Foundation Trust (CNWL), involving all 37 inpatients registered on the Campbell Centre on 9th July 2020 and a re-audit on all 34 inpatients was conducted on 19th August 2020 to complete the audit loop. The admission clerking was reviewed for documentation of predefined components of mental health and physical health assessment within 24 hours based on three selected standard guidelines based on the Royal College of Psychiatrist Core Training Curriculum and CNWL guidelines. Good compliance is defined as 80% or more of the clerking consists of the mentioned components. Upon completion of the first audit, a clerking template was created as part of the interventional quality improvement initiative for the use of junior doctors during admission

Results

Generally, the clerking admission consists of the essential information, including legal status, chief complaint, history of present illness, past psychiatric history, past medical history, treatment history, personal and social history, mental state examination, physical examination, mental capacity assessment, electrocardiography, and essential blood investigations. Nevertheless, certain important information was not routinely documented, which included: family history, substance use history, allergic history, risk assessment, forensic history, and anthropometric information. Despite effort of intervening through the creation of new clerking template, only the screening of blood borne viruses showed improvement.

Conclusion

The minimal improvement might be attributed to the fact that locum doctors are not aware of the new clerking template. More focused intervention is required to ensure further improvement on the clerking documentation, which has been planned as the second part of the quality improvement project.

65. Is Mental State Examination being adequately performed via telepsychiatry

Dr. Muhammad Ali Awab Sarwar, Senior registrar, Abdus Sami Psychiatry Trust Lahore, Pakistan; Dr. Aimen Atta, Demonstrator, Department of Psychiatry and Behavioural Sciences, Rahbar medical and dental college Lahore, Pakistan.

Aims and hypothesis

To identify deficiencies in recording initial mental state examination (MSE) conducted via telepsychiatry and compare them to usual face-to-face consultations.

Background

The covid-19 outbreak and consequent lockdown restrictions led to challenges in the delivery of mental healthcare. Therefore, telepsychiatry arrangements and protocols were quickly devised to tackle an increasing need. Telepsychiatry was opted at the Trust for all patients except those who lacked internet access or were unsuitable for it. As useful as Telepsychiatry can be, it can limit the capability of clinicians to conduct thorough assessments especially where objective mental state examination (MSE) findings are required.

Methods

Initial assessment notes for all 65 adult patients who attended an initial consultation via telepsychiatry from 1st April 2020 to 30th June, 2020 were included. Data was collected from the Electronic Medical Record (EMR). Patient identifiable data was not included. Each of the ten components of MSE as agreed by the trust were reviewed, and categorized as either recorded or not recorded. The data was compared to that for all 84 patients seen via usual face-to-face consultation from January 1st 2020 to March 31st 2020.

Results

29 (44.61%) telepsychiatry assessment notes had fully recorded and 6 (9.2%) had absent MSE, compared to 58/84 (69.04%) fully recorded and no absent MSE among face-to-face assessments respectively. Most common omissions for telepsychiatry in descending order included affect (36.92%), perceptual disturbances (33.8%) and cognitive functions (30.7%), followed by insight and judgment (21.5%), appearance and behavior (18.46%), form of thought and associations (18.46%), thought content (15.38%), suicide, self-harm and homicidal thoughts (10.77%), mood (10.77%), and speech and language (9.2%).

Conclusion

Initial assessments carried out via telepsychiatry in an outpatient setting show a significant decline in the number of completed MSE's, with most common omissions in determining

affect, perceptual disturbances and cognitive functions. While reasons may include technical difficulties, unfamiliarity with technology for doctors and patients or difficulty establishing rapport, structured feedback from patients and clinicians is required. The importance of individual components of MSE in every assessment will be emphasized in weekly academic meetings, and face-to-face re-assessments will be offered to patients that are not assessed adequately over telepsychiatry.

66. Audit on Knowledge about PPE and correct 'Donning and Doffing'

Dr. Saurabh Bahl, CT1, CNWL NHS FT; Dr. Alan Cross, ST6, CNWL NHS FT; Dr. Ruchit Patel, Consultant Psychiatrist, CNWL NHS FT

Aims and hypothesis

The aim of this audit is to ascertain whether community mental health staff across all disciplines in the Early Intervention Psychosis Team, and community mental health team (CMHT) understand and can apply the correct techniques and order of items when donning and doffing personal protective equipment (PPE). We also tried to ascertain understanding regarding use of PPE in common scenarios likely to be encountered by community mental health staff.

Background

Covid-19 has spread globally and was declared a pandemic on March 11, 2020, by WHO. The best way to prevent and slow down transmission is by being well informed about the COVID-19 virus, the disease it causes and how it spreads.

Methods

We carried out a prospective audit with a help of a questionnaire and tried to ascertain current level of knowledge and understanding with regards to correct use of PPE amongst the community mental health staff. The standards used were local standards that 100% of staff should have understanding about correct use of PPE. During the first cycle of audit 19 responses were received. Based on initial results, interventions were applied to increase this level of knowledge amongst staff. Interventions included a teaching session, placement on posters around the building, and circulation of email containing information on correct PPE use amongst staff. A further re-audit was done to check if the interventions have been successful and to identify gaps in knowledge. The second cycle of audit received 14 responses.

Results

No one answered correctly regarding correct donning and doffing sequence of PPE. This increased to 50% and 36% respectively following the interventions. Knowledge about correct items of PPE in settings of ward and home increased by 50 % following the interventions. Staff were also asked about the duration for which a surgical mask could be worn and this increased from 5 % to 85 % following the interventions after 1st cycle of audit. Knowledge about correct items of PPE during CPR increased from 10 % to 64 % following the interventions. Only 26 % staff had answered correctly on what was allowed to be worn

within the NHS ‘bare below elbow’ policy which increased to 85 % following the interventions.

Conclusion

Knowledge about correct use of PPE is essential to prevent spread of infection among the patients and staff. Local teaching sessions and PPE posters at major locations can improve knowledge about correct use of PPE amongst staff.

67. Completion of ECGs for patients admitted to four acute general adult mental health wards

Dr Paul M Briley, CT2 Academic Clinical Fellow, Nottinghamshire Healthcare NHS Foundation Trust; Dr Sudheer Lankappa, Clinical Associate Professor, Consultant Psychiatrist, Nottinghamshire Healthcare NHS Foundation Trust

Aims and hypothesis

To assess the proportion of patients admitted to acute general adult psychiatry wards who have an ECG conducted within 24 hours, 48 hours, 1 week, and any time, relative to their admission date. To pilot an intervention to increase the proportion of patients having ECGs during their stay

Background

The admission ECG is critically important, due to the increased risk of cardiovascular disease in patients with severe mental illness, and because several psychiatric medications of significant clinical value can prolong the QT interval, predisposing a patient to a cardiac arrhythmia

Methods

A random sample of 80 patients admitted to four acute adult mental health wards in Nottinghamshire during 2019 (20 patients per ward) was obtained from the Health Informatics team. Electronic patient records were reviewed to assess, for each patient: when an ECG was first offered; whether the patient accepted their first offered ECG; and when patients first accepted an ECG

Results

96% of patients were offered an ECG during their inpatient stay – 64% at admission, and 84%, 89%, and 93% within 24 hours, 48 hours, and the first week of admission. A third of patients refused their first offer of an ECG. Reasons for refusal included paranoia, anxiety and agitation, fear of the apparatus, not wanting to remove clothing, and not wanting physical contact. Of those patients who refused their first ECG, over half of these continued to refuse ECGs throughout their stay. In total, 1 in 6 (13/80) patients persistently refused an ECG. 1 in 4 (20/80) refused an ECG for at least two weeks. ECG refusers were significantly more likely to have a primary diagnosis of a psychotic illness (70%) than ECG acceptors (37%), $\chi 2(1) = 6.565$, $p = 0.010$

Conclusion

A quarter of psychiatric inpatients refused ECGs for at least two weeks from the point of admission, and ECG refusers were more likely to have a psychotic illness. Reasons for refusal were understandable in the context of a patient's illness or reasons for admission. An alternative option to 12-lead ECGs for such patients would be of considerable value. One such option is a handheld ECG device that does not require significant set up or body exposure. We have developed a Standard Operating Procedure for use of one such commercial device that is able to record six-lead ECGs, and we have begun a pilot of the device for inpatients who persistently refuse 12-lead ECGs

68. Somatisation During COVID-19 Lockdown in a Central London Emergency Department

Dr Pollyanna Cohen; Dr Jacob King, Academic Clinical Fellow ST1, Imperial College London & Central and North West London NHSFT; Dr Rizal Ashroff Ali, Locum Consultant Emergency Medicine and Mental Health Lead, Emergency Department, University College London Hospital; Dr Sergio B Sawh, Consultant in Emergency Medicine, Emergency Department, University College London Hospital

Aims and hypothesis

We aimed to better characterise the number of patients attending our Central London emergency department (ED) with symptoms most likely representing somatic symptomatology of underlying psychological distress during the COVID-19 lockdown in England.

Background

Somatic symptoms, representing the physical instantiation of psychological distress, are common in the Emergency Department setting. Although there are only few previous rigorous studies on the topic, estimates suggest around 15-20% of adult patients present with medically unexplainable physical symptoms despite substantive appropriate follow-up, and a large portion of these are thought to represent somatisation. For a number of reasons including clinician understanding, often nebulous nomenclature, frequent clinical need for further investigation before diagnosis can be safely established, and practical considerations including limitations in hospital coding systems, getting an accurate sense of this patient group is difficult.

Methods

We used the hospital electronic notes system to extract all ED attendances with either a mental health (MH) 'presenting complaint' (PC) and/or a MH discharge diagnosis (SNOMED coding) during COVID-19 lockdown in England from 23/03/20 to 05/07/20 into an excel spreadsheet where results were analysed using pivot tables.

Results

779 patients made up 928 attendances. 88 patients (11%) who attended more than once contributed to 237 attendances (26%). The most common mental health diagnosis on discharge was 'Anxiety disorder' (189/928). 158 (17%) of those with eventual mental health discharge diagnoses presented with physical symptoms, most commonly 'Chest pain' diagnosed as 'Anxiety disorder' 48/158 attendances (30%), followed by 'Palpitations' diagnosed as 'Anxiety disorder' 25/158 attendances (16%). 29/712 attendances (4%) with a

MH PC had ‘No abnormality detected’ as the diagnosis. 54/928 attendances (6%) with a ‘blank’ PC had a MH diagnosis. 1 attendance diagnosis was coded as somatisation.

Conclusion

This is the first study of which authors are aware to approach likely somatic symptoms by identifying them from those with a mental health discharge diagnosis. Methodological barriers at multiple levels impede the ability to capture the true extent of somatisation in the emergency department. We suspect inconsistency among clinicians’ identification of likely somatic symptoms and approach to discharge coding and plan to establish a teaching session for ED staff on somatisation and take steps to improve coding, including allowing an option for ‘suspected somatisation’. Improved identification of this patient group may lead to a more appropriate referral for their on-going management, save unnecessary repeat investigations and repeat ED attendances.

69. There's No Smoke Without Fire – An audit to assess if we are doing enough as clinicians to prevent smoking on acute inpatient Mental Health wards

Dr Georgina Edgerley Harris, CT3, SWLSTG NHS Trust; Dr Kate Lockie, CT1, SWLSTG NHS Trust; Dr Dhulakshi Sachithananthan, GPST, Kingston Hospital NHS Trust

Aims and hypothesis

To identify whether the Smoking Cessation guidelines set out by the Trust as directed by NICE were being met – Targets were 100% compliance with standards: Were Doctors organising Nicotine Replacement Therapy (NRT) prescription for all smokers ideally within 30 minutes of admission or at any point throughout the patients' hospitalisation? Were any member of clinical staff giving brief intervention to the patient's who do smoke during their inpatient admission? Was smoking status obtained on the patient's admission to the ward?

Background

In October 2017, South West London and St George's Mental Health Trust became completely smoke free. Public Health England state that nationally, 33% of people with mental health problems smoke compared to 18.7% of the general population and this rate is increased to 64% of service users in mental health hospitals. The World Health Organisation recognise that patients with severe mental health disorders have a 10-25 year reduced life expectancy compared to the general population and that the vast majority of these deaths are secondary to cardiometabolic disease for which smoking is a major risk factor. Smoking cessation promotion is the responsibility of all clinical members of staff

Methods

This is a cross-sectional survey and data was collected retrospectively over a 3 month period (60 patients). We re-audited the data after 1 year (49 patients) in response to recommendations made (smoking cessation steering committee, raising ward awareness, inclusion of smoking cessation as part of admission criteria). The data was collected by using the patient clinical notes system – RIO.

Results

The ward was consistently not meeting the 100% target of gaining admission information regarding smoking status or giving brief intervention at any point during admission. Both these objectives worsened in the second audit cycle. NRT being prescribed within 30 minutes of admission or patients being offered NRT at any point throughout the admission did not meet the 100% target however this outcome did improve slightly on re-audit.

Conclusion

There has been an increase in the use of E-cigarettes over this time. Despite recommendations being implemented since the first audit cycle, there has been minimal improvement noted which may be a reflection of this. We would therefore recommend any further research/policies to include the use of e-cigarettes.

70. Are Urine Screening Tools Being Used as Part of the Admission Process - An Audit

Dr Joseph Farmer, CT2, Coventry and Warwickshire Partnership NHS Trust; Dr James Unitt-Jones, FY1, Coventry and Warwickshire Partnership NHS Trust; Dr Gholamreza Chalabyanloo, Consultant Psychiatrist, Coventry and Warwickshire Partnership NHS Trust

Aims and hypothesis

To audit the number of patients who are offered and receive urine screening on admission to a female general adult inpatient ward.

Background

In the Trusts Physical Examination of Service Users during Admission to Hospital Policy, urine screening has been included as part of the physical examination process. The screening includes pregnancy test, urine drug screen and urine dip for urinary tract infection (UTI). Such tests will identify any organic causes of mental health disturbances, such as infections and substance use. In the event of pregnancy, it will also guide medication therapy and overall management. This audit will identify the percentage of new admissions being offered and receiving urine screening to compare to the target of 100%.

Methods

All new admissions to Westwood Ward (female inpatient ward, at the Caludon Centre, Coventry and Warwickshire Partnership NHS Trust) between 01/07/2019 to 01/10/2019 were identified retrospectively. 58 patients were identified and included in the project. No exclusion criteria. Retrospective review of patient documentation, including Carenotes (online patient notes system) and initial clerking documentation (paper notes system). Looking for evidence of: 1. Urine testing being offered, and carried out, 2. Urine testing being offered, and declined, or 3. No evidence of urine testing. If the urine screen was done, information relating to the tests undertaken were recorded.

Results

Of the 58 cases; 22% received a urine drug screen, with 29% being offered but refusing, and 48% not being offered a urine drug screen, 16% received a pregnancy test, with 34% being offered but refused, and 50% not being offered, and lastly, only 26% received a urine dip test for markers of a UTI, with 24% being offered but refused, and 50% not being offered.

Conclusion

The Trust policy identifies urine drug test, urinalysis and pregnancy test as tests that should be undertaken on admission. The findings show that urine screening was not routinely and

consistently completed on admission to Westwood Ward. As a result, the audit findings will be presented to the trust, including junior doctors and nurses, along with a view to adjust trust policy to include better documentation and prompting of urine screening, as well as steps to ensure the presence of the required test kits on the ward. There will then be a re-audit in 6 months after implementation of the action plan to re-measure performance.

71. Streamlining the ADHD drop in clinic

Dr Rosemary Gordon CT3 REAS NHS Lothian; Dr Oluwadara Oyewole FY2 REAS NHS Lothian; Dr Deborah Copper Consultant REAS NHS Lothian

Aims and hypothesis

To assess the rate of completed medication titration and ongoing effectiveness of the ADHD drop in clinic.

Background

The ADHD drop in clinic was commenced in February 2019 in order to reduce the time taken to reach maintenance dose of medication for ADHD. This was audited in 2019 and showed the introduction of the clinic reduced the time from commencing medication to reaching maintenance dose was reduced from 18.6 weeks to 10 weeks.

Methods

A review of all patients (N=24) referred to the drop in clinic between August 2019- January 2020. Information was collated through electronic notes (TRAK) and included date of referral, attendance at drop in clinic and date of discharge.

Results

Following referral, 19 (79%) of the 24 patients attended the drop in clinic. Of these 19 patients; 2 (11%) stopped attending, 12 (63%) were discharged back to GP and 5 (26%) were continuing to titrate in the clinic. Of the 12 patients who had completed their titration, the median time for titrating was 9.5 weeks (reduced from 10 weeks in 2019) and ranged from 1 week to 26 weeks.

Conclusion

Following the initiation of the clinic the time from commencement to completion of titration continued to improve. However there remained some issues regarding the organization of the clinic. This included a significant number of patients not attending the clinic and being lost to follow up and no standardised way of keeping the list of patients referred up to date. In order to negate these issues an ADHD drop in clinic standard operating procedure (SOP) and a separate 'neurocognitive clinic' caseload was developed on TRAK. The SOP included a protocol for cross checking the caseload once monthly and template letters including a 'drop in clinic reminder letter' and 'non attendance discharge letter to GP' with instructions with how to re-refer straight to the clinic if the patient wished treatment in the future. The new caseload was added in order to maintain an accurate list of all the current patients who had been referred to the drop in clinic. The drop in clinic

has now ran for two years and ongoing audit will continue in order to continue to streamline and expand this service. Both paper and PDF copies of the SOP are available for both admin staff and clinicians in order to maintain uniformity in the running of the clinic.

72. Audit of antipsychotic physical health monitoring in a primary mental health care setting.

Dr Katherine Johnston, CT2, Bluestone Hospital Southern Trust Dr Eimear King, Consultant Psychiatrist, Bluestone Hospital Southern Trust

Aims and hypothesis

The National Institute for Health and Care Excellence (NICE) guidance for first episode psychosis stipulates that it is the responsibility of the secondary care team to monitor service users' physical health and the effects of antipsychotic medication for at least the first 12 months or until the person's condition has stabilised, whichever is longer. It outlines the baseline and monitoring investigations recommended when commencing a patient on an antipsychotic. Our aim was to assess the current level of physical health monitoring within a primary mental health care setting, against the NICE standard.

Background

Metabolic syndrome is relatively common in patients on long term antipsychotic medication. Metabolic syndrome is associated with an increased risk of cardiovascular disease and all-cause mortality. All components of metabolic syndrome are potentially reversible, therefore this is an area of significant morbidity and mortality which can potentially be avoided.

Methods

A sample of 9 patients, who are currently open to the primary mental health care team and are prescribed a therapeutic dose of an antipsychotic medication, were included in the audit. Their physical health parameters were reviewed against the NICE standards at three different time frames; baseline, 12 week and annual monitoring. The measurements assessed were weight, pulse, blood pressure, blood glucose, glycosylated haemoglobin (HbA1c) and lipid levels at each stage of monitoring, in addition to a prolactin level and an electrocardiogram (ECG) at baseline and waist circumference at baseline and annual monitoring.

Results

At baseline monitoring between 0-3 patients out of 9 achieved each physical health parameter measured (as outlined above). At 12 week monitoring between 0-3 patients out of 8 eligible patients achieved each parameter measured. At annual monitoring between 0-2 out of 4 eligible patients achieved each parameter measured. (One patient from the sample was not yet due 12 week monitoring, and five were not yet due annual monitoring at the time of the audit.)

Conclusion

This audit revealed that the current approach to antipsychotic physical health monitoring within the primary mental health care team, is not meeting the NICE guidance standards. We have developed an improvement plan, including the use of an agreed pathway with a local physical health monitoring clinic. The results of this intervention will be re-audited against the same NICE guidelines.

73. The impact of the covid-19 pandemic on south kensington and chelsea community mental health team (sk&c cmht): a qualitative survey

Dr Amrita Joottun, CT3, West London NHS Trust; Dr Anna Morawski, CT2, West London NHS Trust; Dr Stefania Chaikali, CT2, West London NHS Trust; Dr Sanrika Naidoo, ST4, East London NHS Foundation Trust

Aims and hypothesis

As the country scrambles to keep up with the latest COVID-19 guidance, we take a moment to pause and reflect on the impact that the pandemic is having on SK&C CMHT. The aim of this project is to explore the perspectives of healthcare workers on how Covid 19 has affected the clinical care and working environment at this outpatient team.

Background

Various revisions have been made to mental health service worldwide. Telepsychiatry is now at the forefront of care delivery while the remote working is consolidating its place in our practice. Measures have also been taken to minimise the risk of viral transmission such as social distancing, physical screening prior to in-person reviews and use of Personal Protective Equipment (PPE).

Methods

Using maximum variation sampling, 10 participants were selected within various roles: 2 nurses, 2 social workers, 2 doctors, 2 administrative staff members, 1 psychologist and 1 team manager. Semi-structured interviews were conducted individually. The material was coded and analysed, using content analysis.

Results

Four core themes emerged from the data: 1.The changes made to the service provided by the team 2.Using technology to minimise face-to-face contacts 3. The feeling of safety in the workplace 4.Increased feeling of bonding and team working Working from home was praised for its flexible and time-saving attributes but was found to have induced feelings of stress and isolation. While telephone contacts is efficient and helpful in providing support, the lack of visual cues to inform assessments is a prominent disadvantage. Although video consultations nullify this problem, only 30% of the participants had used video calls for clinical contacts with patients. A notable reason for this was the worry of being recorded. 80% of the participants reported that social distancing measures were not strictly adhered to in the workplace. Nonetheless, all the participants, who had worked in the office, reported feeling safe at work. The survey also reflected a positive working experience within the team and with external services during these challenging times.

Conclusion

With telepsychiatry becoming a key player, the need for formal guidelines and accessible technology has become increasingly pertinent to guide safe and ethical delivery of care to patients across all levels of functional abilities.

74. Off-label Prescribing of Quetiapine in South Locality Crisis Teams, Northumberland Tyne & Wear NHS Foundation Trust

Dr Mamta Kumari, ST4 Registrar, Northumberland Tyne & Wear NHS Foundation Trus;t Dr Arun Gupta, Consultant Psychiatrist,Northumberland Tyne & Wear NHS Foundation Trust; Peter Clarke, Locality Lead Pharmacist,Northumberland Tyne & Wear NHS Foundation Trust

Aims and hypothesis

This audit will determine the frequency of off label prescribing of quetiapine and compliance with agreed at standards within Trust Policy (UHM PGN 02 PPT PGN 08) – Physical Health Monitoring of Patients Prescribed Antipsychotics and other Psychotropic Medicines. NICE CG178, General Medical Council Ethical Standards, Royal College of Psychiatrists – College Report CR210. The main objectives of the audit were to determine if:

- Patients have been appropriately informed of off-label status and consent given/recorded
- Alternative licensed treatment used first/ruled out
- Appropriate communication on transfer of care where indicated.
- Appropriate physical health monitoring completed.

Background

Quetiapine is associated with various side effects including metabolic syndrome, QTc interval prolongation. Given these risks, patients should be fully informed of the expected risks and benefits of treatment, and the limited evidence base for off-label prescribing. There is also an issues around the transfer of prescribing across the interface with primary care

Methods

The sample consisted of 50 patients randomly selected from the crisis team caseload.

- .Data reviewed in this audit was taken from a six months period.
- Records audited were obtain from RiO(electronic records) and prescription charts.
- Data analysis was started in January 2019 and completed in March 2019. The audit tool was a dichotomous scale questionnaire based on NICE guidelines.

Results

4 patients from the sample (8%) were prescribed off-label quetiapine. 100% -had physical health monitoring completed as per Trust policy. . 100 % - off-label indication been clearly documented in notes. . 100 %-Consent to treatment was documented.. 100 % had medication reviewed in the previous 6 months.. 75% had licensed medication were used or

ruled out before considering off-label quetiapine use . 25% risks/benefits of treatment were documented as part of a patient discussion.. 25 % had documented evidence that alternative treatment options were discussed.. 25% had documented evidence of Community consultant/GP consent/agreement was obtained before transfer of prescribing. 75% had a documented plan for review of quetiapine for treatment efficacy and side effects. 50% had a documented plan in place for ongoing physical health monitoring

Conclusion

Suggested a wider audit may be required with greater patient numbers and which specifically filters for patients prescribed quetiapine. Audit result has been shared with Crisis team members,Medicines Optimisation Committee and South Locality Quality Standards Committee.

75. Physical healthcare monitoring of patients initiated on antipsychotic medication on acute adult wards

Dr Andreas Lappas, ST4, Cwm Taf Morgannwg University Health Board; Dr Mahendra Kumar, Consultant Psychiatrist, Derbyshire Healthcare NHS Foundation Trust

Aims and hypothesis

We aimed to audit the compliance to the LESTER-Tool monitoring upon initiation of antipsychotics on our acute adult wards, but also action upon abnormal results and referral to specifically designed Trust-led LESTER-Tool community clinics.

Background

Patients with severe mental illness(SMI) have higher mortality and morbidity rates contributed by SMI and use of antipsychotics, including metabolic side effects. The National Institute for Health and Care Excellence(NICE), the National Clinical Audit of Psychosis(NCAP) and our Trust have policies in meeting 100% compliance for all LESTER-Tool parameters.

Methods

Standards: LESTER-Tool parameters should have 100% compliance at baseline, weekly for 6 weeks and 3 months. All abnormal results should have been acted upon to treat acute pathology and minimise the cardiovascular risk in the long-term. All consenting patients should have been referred to the community clinics for LESTER-Tool follow-up post discharge. Data collection was carried out retrospectively using discharge prescriptions in the pharmacy to identify a cohort of inpatients initiated on an antipsychotic during their admission between April and August 2019. Exclusion criteria: patients who made a capacitated decision to refuse physical health monitoring; patients on high-dose antipsychotic therapy and clozapine. Electronic patient records were reviewed to identify compliance with standards.

Results

35 scripts were identified from 6 acute adult wards. 30 patients were eligible when our exclusion criteria were applied. The compliance of baseline, weekly for 6 weeks and 3 monthly LESTER Tool checks was poor. QRisk performed the worst at 0% compliance. BP & Pulse achieved 100% compliance. Although acutely abnormal blood results and ECGs were acted upon promptly with compliance ranging between 65%-100%, performance was worse in terms of interventions targeting abnormal lipid profile(0% compliance) and actively promoting a healthy lifestyle(compliance ranging from 0%-62.5%). Comparing baseline, weekly for the first 6 weeks and 3 monthly checks, compliance for the later was

poorer than baseline. Only 13% of the discharged patients were referred to the Trust's LESTER-Tool community clinics.

Conclusion

To improve performance, clinicians should participate in the newly developed LESTER-Tool training programme, utilise community LESTER-Tool clinics, incorporate parameters into the care-plans using electronic tools, and educate patients about the importance of their physical health in relation to mental health. A re-audit should be carried out in one year's time after implementation of the Trust's strategies of physical healthcare improvement.

76. Audit of 'as required' (PRN) prescriptions on an adult inpatient psychiatric ward

Dr Stefan McKenzie, CT2, RDaSH NHS Foundation Trust Dr Suveera Prasad, Consultant Psychiatrist, RDaSH NHS Foundation Trust

Aims and hypothesis

The audit aimed to assess if 'as required' (PRN) prescriptions of psychotropic medications on an adult inpatient psychiatric ward were being prescribed safely and according to trust guidelines.

Background

PRN or 'as required' medication has been defined as unscheduled medication which, when prescribed, may be administered at the nurses' discretion if the need for it arises. PRN psychotropic medication is often required in the management of acute psychiatric symptoms, but its use also has a number of potential disadvantages and risks. Therefore it is important that there is a clear rationale for prescribing PRN medications, and that these are prescribed safely and correctly.

Methods

All PRN prescriptions for psychotropic medications for all patients on an adult inpatient psychiatric ward on a given day were included, and each prescription was assessed against the audit criteria. The audit criteria were based on the trust's "Safe and Secure Handling of Medicines" policy. The audit standard for all criteria was 100%. Following implementation of recommendations, this was re-audited.

Results

In the initial audit (10 June 2020), 100% of prescriptions had an indication, clear dose, maximum dose within 24 hours, a dose within BNF limits, and complied with T2/T3/section 62. 89% of prescriptions had a minimum interval. When prescribed oral and intramuscular (IM), 86% had a minimum interval between oral and IM. Only 38% of PRN prescriptions had been reviewed in the last 7 days. Where there was a dosage range, 0% of prescriptions had advice on when to use different doses. Results were discussed with the MDT and communicated with the doctors working on the ward. In the re-audit (4 August 2020), all criteria (for which there was data) scored at least 90%. Where there was a dosage range, 90% of prescriptions had advice on when to use different doses (0% in initial audit). 100% of prescriptions had been reviewed in the last 7 days (38% in initial audit).

Conclusion

Initial audit results showed that PRN medications were generally prescribed according to trust guidelines, but including advice if there was a dose range was not done and most prescriptions had not had a recent review. Following simple recommendations, these two aspects improved to 90% and 100% respectively on re-audit. To attempt to maintain and improve these results, these topics will now be covered in the e-prescribing training for all doctors and regular re-audit should be done.

77. An audit to evaluate Next of Kin documentation in a regional mental health service.

Dr Bethany Mitchell, Foundation Year 2, Mersey Care NHS Foundation Trust; Dr Adam Temple, Foundation Year 1, Mersey Care NHS Foundation Trust; Dr Indira Vinjamuri, Consultant Psychiatrist, Mersey Care NHS Foundation Trust

Aims and hypothesis

To assess if Next of Kin (NoK) information is documented in patient e-records.

Background

Studies have indicated the need to improve the NoK's participation in a patient's care as an equal partner. The policy in most NHS trusts is to ask patients to nominate who is next of kin formally, on admission to hospital. This would help with decision making processes and in our caseloads, help with locating disengaging patients. We noticed that many patients had no identified contacts or NoK; therefore this audit was completed to assess the extent of the issue.

Methods

Data was collected from a random sample of 25 current inpatients & 25 outpatients at Mersey Care NHS Foundation Trust, total n=50. Electronic records were manually searched for patient details, NoK, other contacts & any address or telephone number listed. An audit standard of 100% compliance for documentation of NoK on patient electronic records was set.

Results

Only 44% of patients (n=22) across both groups had NoK listed on their electronic record; to stratify this further, 67% (n=10) of community patients & 48% (n=12) of inpatients had a NoK specifically listed. No significant difference was found between the community & inpatient groups (p=0.57). Additionally, no significant difference (p=0.59) in recorded NoK was found between sexes ; 47% (n=15) of Females had a NoK listed & only 39% (n=7) of Males listed a NoK. Although a large number did not have a NoK listed, 72% (n=36) of patients had 1 or more contacts recorded. The majority had their own address & contact numbers listed, 96% of inpatients (n=48) & 98% of community patients (n=49) respectively.

Conclusion

Overall, recording NoK data does not meet the expected standard in the inpatient and outpatient setting. Although sample size is small, we can conclude there is room for improvement in documentation. This would be key to patient safety and collaborative working. It would also bridge the gaps between physical and mental health care, especially

co-production with patients and families. We are working with our Patient safety team to improve this by perhaps implementing a 24-hourly reminder on the system to notify users to record a NoK and improve staff vigilance in documentation. Another cycle of data collection is needed to assess if improvements have been made.

78. Physical Health Monitoring for Patients on Antipsychotics: An Audit in Primary Care

Ms. Krsna Mohnani, Final-year Medical Student, Norwich Medical School; Ms. Zoha Aftab, Final-year Medical Student, Norwich Medical School

Aims and hypothesis

The objective of the audit was to analyse whether adult patients on antipsychotics have been monitored annually as per current recommendations, with the aim of improving physical health monitoring in this population.

Background

Antipsychotics are widely prescribed in the UK, but their use is limited by their extensive side effect profile, including adverse metabolic consequences. The National Institute of Clinical Excellence, the British National Formulary and the Maudsley Prescribing Guidelines in Psychiatry all recommend annual monitoring of physical health parameters to intervene and thus prevent these complications. Despite this, rates of monitoring across the country are currently low at approximately 29%, which leads to increased morbidity and mortality and increased costs for the healthcare system long-term.

Methods

The audit was conducted in a three-site general practice surgery in the East of England, analysing a twelve-month period between 2018-2019 in 40 adults (>18 years), half of whom were on the Severe Mental Illness (SMI) Register. Data was collected on the occurrence of an annual review, as well as whether the following ten physical health parameters had been measured: weight/BMI, waist circumference, pulse, blood pressure, blood lipids, fasting blood glucose/HbA1c, alcohol consumption, smoking status, diet and activity levels.

Results

95% of patients had been seen annually and the rates of individual parameter monitoring varied from 0-77.5% and therefore did not meet the 80% target. The overall standard for 80% of patients to have ≥8/10 parameters measured was also not met. Waist circumference was persistently missed, whilst other parameters were addressed 50% of the time or more. A difference was also noted between SMI and non-SMI groups, with the average number of parameters addressed out of ten being 6.57 and 5.38 respectively. The rural site also appeared to have the lowest rates of monitoring.

Conclusion

Our audit highlights a great need for physical health monitoring to be improved in adult patients taking antipsychotics, most notably in rural areas. This can be done by educating

professionals who will be conducting the review, providing a ‘check-list’ for one to follow during an appointment, and implementing an alert system on SystmOne as a reminder to schedule an annual review and a telephone call as a reminder to the patient, as the 12-month mark approaches. These improvements will be assessed with a re-audit in the near future.

79. Psychotropic medications and Driving

Dr Sunitha Muniyappl Hanumanthappa,ST7, TEWV NHS Foundation Trust; Dr Lucy Allender, Specialty Doctor, LYPFT NHS foundation Trust; Dr Sarah Ruxton, CT2, LYPFT NHS Foundation Trust

Aims and hypothesis

To evaluate current practice in community mental health setting with regards to documentation of driving status and advice given at the initiation or dosage change of psychotropic medications against Section 4 of the Road Traffic Act 1988.

Background

It has been estimated that up to 10% of people killed or injured in road traffic accidents (RTAs) are taking psychotropic medication. Patients with personality disorders and alcoholism have the highest rates of motoring offences and are more likely to be involved in accidents.

Methods

Collected by Informatics team at LYPFT using Paris cluster tools.

Results

We looked at 36 patients who were open to the South East and South West community Mental Health Team at the time of data collection, which was in June 2019. Driving status was documented in 25% (9 out of 36) of the cases. 5 out of 9 (55%) patients where documentation of driving status was undertaken were drivers. Only in one case there was documentation about driving advice provided by the medical practitioners (3% of cases or 1/36). As per the objectives, our current practice fell short of the suggested DVLA standards of advising every patient of their responsibility to inform the DVLA of any psychiatric medication which may impair driving ability or of any increase of this. We have successfully evaluated our current practice by auditing these medication changes and also auditing which of our patients are current drivers.

Conclusion

In our audit, as shown above there was a poor compliance with the standards among assessing clinicians, but the most worrying finding in the results was the absence of any records whether patient was a driver. It was indeed far from following good practice guidelines. Whether driving for leisure, commuting to work, or driving for professional purposes, implications can be serious if mental illness is of a nature or severity to affect patients' ability to drive. It is the responsibility of the clinician seeing the patient to give appropriate advice to patients and document this in the patient record.

80. Audit on the BMI Documentation in Discharge Letters of Patients Discharged on Anti-Psychotics

Dr Youstina Nagiub, CT2, NHS Lanarkshire

Aims and hypothesis

The primary aim of this audit was to assess the level of BMI documentation in discharge letters of patients discharged on anti-psychotics. Secondary aims included assessing BMI documentation on and throughout a patient's admission. It was expected that BMI would be poorly documented in discharge letters but well documented on and throughout a patient's admission.

Background

Anti-psychotic use is associated with metabolic syndrome due to causing weight gain, BMI increase, blood glucose impairment and an increase in total cholesterol. The metabolic dysfunction associated with anti-psychotics has a negative impact on patients' morbidity and mortality. Patients with severe mental health illness "show a 53% higher risk of having cardiovascular disease" with a subsequent 85% higher risk of death from it compared with the general population. Anti-psychotic use is identified as an "actionable moderator" of cardiovascular disease. According to NICE guidelines, patient monitoring for those on anti-psychotics should include "weight, weekly for the first 6 weeks, then at 12 weeks, at 1 year and then annually. An audit performed in Hairmyres Hospital in 2016 concluded that BMI was not commonly documented in discharge letters. This audit is therefore the second cycle to assess if any improvements have been made since 2016.

Methods

A note was taken of all the discharges during the months of January, February and March 2020 in two general adult psychiatry wards. The online drug charts were examined to determine which patients were discharged on anti-psychotics. Their discharge letters were then read to identify if BMI was documented or not. The relevant nutrition forms were also checked to see if their BMI was documented on admission and updated throughout their inpatient stay.

Results

55% of patients were discharged on anti-psychotics. Only one of the 71 patients discharged on anti-psychotics had a BMI documented in their discharge letter. Olanzapine and Quetiapine were the most commonly prescribed anti-psychotics. 79% of patients had a BMI documented on admission and 73%'s BMI was updated throughout their admission.

Conclusion

This audit concluded that: anti-psychotic prescription in the University Hospital of Hairmyres is common, documentation of BMI in discharge letters is very poor but documentation of BMI on and throughout admission is good. To raise awareness of this issue, the findings of this audit were presented at the departmental teaching meetings as well as the Clinical Governance meeting.

81. Audit of end of life care in a secure hospital

Dr Owen Obasohan, Specialty Doctor, TEWV NHS Trust; Dr Deepak Tokas, Consultant, TEWV NHS Trust

Aims and hypothesis

To measure the standard of care provided to patients who had a natural and expected death whilst in secure care at Roseberry Park Hospital.

Background

The Leadership Alliance for the Care of Dying People (LACDP), a coalition of 21 national organisations, published One Chance to get it Right – Improving people's experience of care in the last few days and hours of life in June 2014. This document laid out five priorities for care of the dying person focussing on sensitive communication, involvement of the person and relevant others in decisions and compassionately delivering an individualised care plan. Mallard Ward is a low secure psychiatric ward for older age men suffering from cognitive difficulties and significant physical comorbidity in addition to a severe and enduring mental illness. The patient population is such that it will remain the most appropriate placement for some patients until their death. It is therefore vital that staff members on Mallard Ward, and indeed in all parts of the Trust, are aware of the priorities for care of the dying person and that care is provided in accordance with these priorities.

Methods

The data collection tool was adapted from End of Life Care Audit: Dying in Hospital, a national clinical audit commissioned by Healthcare Quality Improvement Partnership (HQIP) and run by the Royal College of Physicians. Data was collected from both electronic and paper records. Result: ·There were three natural and expected deaths in secure care.

- All the 3 patients were resident on Mallard Ward.
- The cause of death was cancer for 2 patients and heart failure for 1 patient.
- 2 out of the 3 patients died on Mallard Ward while 1 died on the medical ward of the acute trust hospital.
- The level of care provided for the 2 patients who died on Mallard ward was largely consistent with the 5 priorities listed while for the patient who died on the medical ward it wasn't very clear from the documentation.

Results

- There were three natural and expected deaths in secure care.
- All 3 patients were resident on Mallard Ward.
- The cause of death was cancer for 2 patients and heart failure for 1 patient.

- 2 of the 3 patients died on Mallard Ward while 1 patient died on the medical ward of the acute trust hosp.
- The level of care for the 2 patients who died on Mallard ward was largely consistent with the 5 priorities while it wasn't clear from the documentation for the patient who died on the medical ward

Conclusion

It is imperative that mental health services work in collaboration with physical health and palliative care services so they are able to continue providing a high level of care to this patient group. Clinicians and staff involved in the care of dying patients also need to be adequately trained

82. Clinical audit of compliance with National Institute of Clinical Excellence (NICE) Obsessive compulsive disorder guidance CG31: Obsessive compulsive disorder-treatment clinical guideline.

Dr Ogba Onwuchekwa,ST4, TEWV NHS Trust; Dr Sumeet Gupta, Consultant Psychiatrist, TEWV NHS Trust; Dr Sefat Roshny, ST5, LYPT NHS Trust

Aims and hypothesis

The main aim of undertaking the audit was to ascertain the level of compliance of our trust, Tees ESK and Wear Valleys NHS Foundation Trust to the NICE Obsessive compulsive disorder and dysmorphic disorder treatment guidance order CG31. To find out the reason for the non-compliance to the guidelines and to determine from the different teams in the trust about ways of helping improve this. It is hypothesised that following this, the level of compliance with the NICE guidance would improve.

Background

OCD is one of the common psychiatric problems. It's reported prevalence is about 2-3% in the population. However, we noticed that very few patients' access specialist mental health services and quality of care has also been very variable. Hence, this audit was conceived.

Methods

All patients (512) with the diagnosis of OCD as per ICD 10 receiving care from CMHTs (adult) were included . That constituted about about 2 % of estimated OCD patients in the catchment area. A sample of 47 patients were selected for analysis. The data was retrieved from the patients' electronic record system (Paris) using a standardised audit proforma and analysed.

Results

A total of 47 records were assessed for the purposes of this audit from 16 teams, with only 2 teams showing noteworthy practice achievements. Brief individual CBT was consistently discussed as an initial assessment either face to face or by telephone 85% (40/47). However, a very small proportion of patients completed the therapy. Exposure and response prevention was not commonly offered. Almost all patients were treated with SSRIs. However, only 7.5 % were tried on Clomipramine and atypical antipsychotic drugs were used in 2.5%. For patients that are re-referred for further occurrences of OCD or BDD there was no evidence that a system was in place for the patients to be seen sooner rather than put on a routine waiting list.

Conclusion

Only a small proportion of OCD patients access specialist mental health services. Although most patients were informed about the psychological therapy, only a small proportion of patients underwent a formal psychological therapy .Exposure and response prevention is not commonly offered in CMHTs .Lastly Clomipramine is underused in CMHTs.

83. Summary of findings from the Accreditation for Working Age Inpatient Mental Health Services (AIMS-WA) Thematic Report: 2017 - 2019

Ms Natasha Penfold, Deputy Programme Manager, Royal College of Psychiatrists; Ms Emma Quilter, Project Officer, Royal College of Psychiatrists; Mr Alex Nugent, Project Officer, Royal College of Psychiatrists

Aims and hypothesis

The first edition of the AIMS-WA Thematic Report explores the performance of 45 member wards who completed both the self-review and peer-review stages of the accreditation process in 2017 to 2019, against the 6th Edition Standards for AIMS-WA. It is aimed at ward staff, senior management, patients and carers as well as anyone who has an interest in acute inpatient services.

Background

The Accreditation for Working Age Inpatient Mental Health Services (AIMS-WA) was established in 2006 to promote better standards of care within mental health inpatient wards. The Network is one of around 30 quality networks, accreditation and audit projects organised by the Royal College of Psychiatrists Centre for Quality Improvement (CCQI). The AIMS-WA Network was created as a result of the findings of the National Audit of Violence 2003-2005 which highlighted the concerning high prevalence of violence on acute wards, but also concluded that examples of good practice were going unrecognised. Since the first set of AIMS-WA standards were published in September 2006, the Network has grown to include over 130 member wards/units.

Methods

Contextual data was obtained from the 'starter forms' which are completed by wards at the beginning of their self-review period. Data showing whether a ward was marked as 'Met' or 'Not Met' against a given standard were taken from the decisions included in the draft report written following each ward's peer review visit. Decisions as to whether a ward had met or not met standards were made by the peer-review teams based on evidence obtained from both a ward's self-review and subsequent peer-review visit. This evidence included: Patient questionnaires, Carer questionnaires, Staff questionnaires, Health record audits and Policy and documentation checks.

Results

The performance of the wards is broken down and presented in this report according to six key themes which comprise of: patient experience, patient centred care, carer engagement, staff experience and wellbeing, safety and therapies and activities. There are

32 separate findings, including: 15% of patients are not being provided with welcome packs, 42% are not being offered a copy of their care plan and the opportunity to review it and 11% of carers did not feel involved in discussions about the patient care treatment and discharge planning when they were given consent to be involved.

Conclusion

The report concludes with 6 main recommendations for areas in which wards can improve in. In 2022, a further thematic report will be published for wards who undertook the accreditation cycle on the 7th editions standards. Comparisons will be made to the findings in this report.

84. Section 136 lapses- Too obscure to notice?

Dr Yathooshan Ramesh, CT3, BEH NHS Trust

Aims and hypothesis

The author audited the number of S136 lapses due to lack of an available bed that adhered to the local policy in relation to medical review, capacity assessment and duty of candour.

Background

Changes in mental health law in December 2017 resulted in the validity period of S136 being reduced from 72h to 24h. This resulted in an increase in S136 lapses due to lack of an available inpatient bed. When this occurs, the legal grounds to continue detaining an individual are dubious. Local guidance advises that patients should be informed with an apology if this occurs (duty of candour), and a senior medical review with mental capacity assessment should be undertaken.

Methods

This audit retrospectively collected data over a 2-month period between November and December 2018 from a hospital in North London. Clinical notes were reviewed in all patients whose S136 had lapsed due to lack of bed availability. This data was used to inform changes in the Operational Protocol for the Place of Safety (PoS), and information was disseminated in a presentation at the junior doctors' induction. Data was re-audited over a 2-month period between June and July 2020.

Results

Of the 18 lapses identified in the 2018 cycle, 72% had a senior medical review, 56% had a capacity assessment and 61% received an apology as per duty of candour. Of the 20 breaches in the 2020 audit cycle, this figure was 0% in all three domains. In 40% of cases, patients were in seclusion at the time their S136 lapsed.

Conclusion

The interventions we used had failed to bring about change in the way S136 lapses have been managed. In fact, the information was completely lost within the cohort of doctors involved in the re-audit cycle. We suspect that the operational protocol was not easily accessible, and that we overemphasised the impact of information dissemination at induction. The audit also demonstrated an alarmingly high usage of seclusions in patients who remain in the PoS at the time of lapse, which further emphasises the importance of patients being informed of their rights. The author will be producing a poster of the protocol for the on-call rooms, and delivering a lecture within the second month of the new

trainees' rotation once trainees have familiarity with the usual S136 processes and to address any concerns regarding implementation.

85. Clinical Audit of Mental Health Act (MHA) documentation for patients on section 3 staying 90 days and over in adult wards at Roseberry park hospital

Dr Rohini Ravishankar, ST6, TEWV NHS Trust); Dr Raj Kumar, Consultant Psychiatrist, TEWV NHS Trust; Dr Edwina Moedbeck, F2, NTH Trust; Dr Maryam Khatoon, F1, NTH Trust

Aims and hypothesis

To audit the compliance of MHA documentation for patients on section 3 staying 90 days and over in adult wards at Roseberry park hospital

Background

There is an expectation of high standards of Mental Health Act documentation in detained patients. These standards are set out in MHA code of practice, Trust guidance for new admissions (24 hour medic review to assess capacity and consent) and Action plans following previous CQC visits. The guidelines for MCA1 forms came into effect in October 2018 and was initially piloted on PICU, then rolled out to all the wards at Roseberry park hospital from May-June 2019.

Methods

We collected data from all inpatients on section 3 staying 90 days and over, in Adult acute and rehab wards on Roseberry park hospital between the time period 28/10/19 – 04/11/19. Using a designated audit data collection tool, information was gathered from each patient's electronic record pertaining to the standards.

Results

16 patients records were identified as meeting criteria of staying 90 days and over detained under section 3 of MHA. Out of these 7 (44%) patients were on acute wards and 9 (56%) at rehab ward at the time of audit. Days in Hospital - Ranged from 120 days to 664 days, average being 295 days and median of 186 days. 81% of patients had documented capacity assessment in the form of case note entry and MCA1 form on admission. Only 10 (62%) of patients had their capacity to consent recorded at 3 months. —Out of 16 patients, 7 had capacity to consent and T2 form was completed in all and recorded in case notes. —Out of 9 patients who lacked capacity to consent, SOAD request was sent in 7 (78%) patients but recorded in 5 (56%) of them. —Out of the 9 patients lacking capacity, T3 form was documented only in 4 (45%) patients but T3 form authorisation was discussed with patient and evidenced in case notes in only 1(11%) case.

Conclusion

There needs to be improvement in MHA documentation for detained patients. To circulate the action plan to all involved wards and Re-audit in a years time.

86. A service evaluation of referrals to the mental health North Tyneside Community Treatment Team querying a diagnosis of Bipolar Disorder

Dr Niraj Ahuja, Consultant General Adult Psychiatry, CNTW; Dr Ambrina Roshi, ST5, CNTW NHS Trust

Aims and hypothesis

The aim of this service evaluation was to see how many patients referred from primary care with query bipolar disorder had a diagnosis of bipolar disorder.

Our previous work (Round 1; 2014-15) showed that only 23% of referrals were given a diagnosis of bipolar disorder post-assessment by the community mental health team (CMHT). As the referral numbers have increased significantly, we repeated our service evaluation with a larger referral number. Our hypothesis was that > 23% of query bipolar disorder referrals would have a correct diagnosis of bipolar disorder about CMHT assessment.

Background

In recent years there has been an increase in primary care referrals to CMHTs querying bipolar disorder. However, mood instability can be feature of several conditions and an incorrect diagnosis is likely to be associated with significant harm by inappropriate psychopharmacological treatment and a delay in starting other appropriate treatments.

Methods

Primary Care referrals to the North Tyneside West CMHT from January to September 2018 were reviewed and those referred for query bipolar disorder were included in this study. 2019 and again in June 2020.

Results

From round 1 to round 2, percentage numbers of query bipolar disorder referrals have marginally reduced from 23% to 20%. The number of patients with bipolar disorder has improved from 19.5% (4/41) to 29.6% (24/81) from Round 1 to 2. However, only 4 (4/52; 8%) new diagnoses of bipolar disorder were made in Round 2 as compared to 2 (2/41; 4.9%) in Round 1. In Round 2, 46% (24/52) of new referrals for a query of Bipolar Disorder were diagnosed with Emotionally unstable personality disorder or traits (ç).

Conclusion

Literature suggests that there is an overall rise in suspicion of Bipolar Disorder as compared to 10 years ago. Our figures over the last 5 years show that number of referrals for query bipolar disorder have ranged between 20-23%. Although there appears a higher number of

correct bipolar disorder diagnoses, many had a pre-existing diagnosis and the number of new bipolar disorder diagnoses remains low. Correct detection of EUPD/T (Emotionally Unstable Personality Disorder/Traits) as a differential diagnosis in some and a co-morbid diagnosis in others is a valid focus of primary care education whilst not forgetting to look for bipolar disorder using collateral history, mood disorder questionnaires (such as HCL-32) and mood diaries.

87. Audit (08/2018-01/2019) and Re-Audit (08/2019-01/2020) of Utilisation of the 'Mental Health Transfer Checklist' Proforma, during Transfer from Acute Medical Hospitals (Liverpool University Hospitals NHS Foundation Trust-LUHFT) to Psychiatric Hospitals (Me

Dr Aamer Shamim, Staff grade doctor, Merseycare NHS Trust; Dr Jaye Brunning, FY1 Doctor, Merseycare NHS Trust; Dr Qaiser Javed,Consultant Liaison Psychiatrist, Merseycare NHS Trust

Aims and hypothesis

Testing the compliance and completion rate of a 'Mental Health Transfer Checklist' Proforma created in accordance with local hospital policies.

Background

Development of the proforma occurred following serious incidents in which medically unstable patients were prematurely deemed medically fit and discharged to Psychiatric Hospitals (PHs).This led to readmission to Acute Medical Hospitals (AMHs), with inadequate handover between services being the main identifiable cause. The checklist was designed to improve safety of patient transfer from AMHs to PHs through ensuring patients are medically ready and by improving communication between the two trusts.

Methods

Data were collected retrospectively from 08/2018-01/2019 and again from 08/2019-01/2020. Notes were obtained from Mersey Care electronic systems. Notes were scrutinised for presence of the proforma, quality of completion, number and reasons for readmission from MCFT to LUHFT following medical optimization. Readmissions were defined as admissions to LUHFT up to one month following discharge with evidence of on-going concerns.

Results

08/2018-01/2019: 6597 referrals were made from LUHFT to psychiatric liaison services. 5.9%(387/6597) were admitted to MCFT. 7.8%(30/387) of MCFT admissions were later readmitted to LUHFT. Of those readmitted, 10%(3/30) had on-going acute medical concerns prior to admission to MCFT. The proforma was present in 6.9%(27/387) of admissions from LUHFT, 0%(0/27) were fully completed.

The findings were shared and discussed with appropriate teams both in acute physical health and mental health hospitals and steps were taken to raise awareness of the proforma before completing a second audit.

08/2019-08/2020: 5666 referrals were made from LUHFT to psychiatric liaison services. 3.0%(160/5666) were admitted to MCFT. 4.3%(7/160) of MCFT admissions were later

readmitted to LUHFT. Of those readmitted, 14.3%(1/7) had on-going acute medical concerns prior to admission to MCFT. The proforma was required in 43%(69/160) of admissions from LUHFT of which 73.4%(69/94) were present. 34%(32/94) were fully completed.

Conclusion

There was a reduction in readmission of cases from PHs to AMHs over the re-audit period. The proforma served as structured guidance and evidence of medical fitness at time of transfer. Form attachment on case notes is not 100% indicating need for further education within AMHs and PHs with plans for future re-audit. Recommendation also made to standardise filing name on electronic notes to enable easy accessibility.

88. Evaluating the impact of trainee research and audit forum in NHS Grampian

Dr. Nadiya Sivaswamy, speciality doctor, NHS Grampian

Aims and hypothesis

To provide a platform for trainees of all grades in Royal Cornhill Hospital, NHS Grampian, Aberdeen, to present their projects. The objective is to set up a platform for presenting research, audits, quality improvement measures by psychiatric trainees and measuring their impact influence on the attendees

Background

Psychiatric trainees are required to complete audits in accordance with Annual Review of Competency. The audit Group meeting regularly held in Royal Cornhill Hospital is used to discuss completed audits. In NHS Grampian, a study was performed to evaluate the impact of the psychiatric trainee audit forum in Royal Cornhill Hospital, Aberdeen, with the present results based on meeting on 12 Feb 2020. Psychiatric trainee presented their audits in the forum which was also attended by other trainees, non-trainees, hospital managers and consultants.

Methods

Questionnaires were sent online via Zoho survey to Core & Higher Trainees, FY2 and GPST (17 in total of which 9 responded) in RCH. An initial pilot meeting was held on 8th May 2019 and the results of present survey is based on a meeting at the held in Lewis Room, Recovery Resource Centre, 1pm to 2 pm on Wednesday 12th February. Approval from the Medical Director, who is part of the team, was sought. A poster was created to advertise the event and emails sent out to medical and managerial staff at 8, 4 and 2 weeks. Trainees were invited to present on a first come first serve basis. A brief talk on Quality Improvement was delivered by a Consultant Psychiatrist who was involved in the inception of this forum, followed by one audit presentation by a psychiatric trainee. Attendance counted as 1 hour of CPD. A second meeting was arranged initially for April 2020 however had to be cancelled due to COVID-19. The meeting was promoted at the Junior Doctor's Committees.

Results

The meeting was attended by consultants (77%) and core trainees (23%). All attendees had presented at local meetings, most had presented at national meetings with only 3 having presented at international meetings. Over 70% had completed at least 4 audits previously.

Conclusion

Suggestions included encouraging more trainees to attend and present projects by awarding of a local prize,and nominating a person/team to present at next meeting. Due to the COVID-19 a subsequent meeting was cancelled therefore further comparison of results was not possible.

89. Appraisal of completion of assessment document

Dr. Nadiya Sivaswamy, speciality doctor, NHS Grampian

Aims and hypothesis

To improve the quality of care provided based on information available in the assessment document. The objective is to appraise and improve the information available by recording information in the assessment document

Background

The assessment document used for patients at Royal Cornhill hospital, Aberdeen forms a standard template to record the presenting complaints and past history of every patient referred for assessment or admission. The document provides a condensed version of all salient features of a patient's often vast and prolific background. There is a requirement for all sections of the document to be completed so information is available at a glance to anyone involved in that patient's care including colleagues who may not be familiar with the patient's background. An audit was undertaken to appraise the completion of various sections of part 1 & 2 of the assessment document.

Methods

An audit was registered with the quality improvement team after permission was obtained from the clinical director of mental health service, NHS Grampian. A list of patients admitted to Royal Cornhill hospital, NHS Grampian for January 2020 was obtained from the health intelligence department at NHS Grampian. A random time period of 2 weeks from 01 January to 15 January 2020 was selected for the audit and yielded 23 patients of which 3 patients whose details were not available on online (CCUBE) were excluded. Part 1 and 2 of the assessment document were investigated. In part 1 Risk, substance misuse, Psychiatry history, Medical history, personal history, forensic history, mental state examination, formulation, risk assessment & plan were considered. In part 2 medicine reconciliation form with one and two sources of information, allergies, medication history, medical history, observations. Physical examinations included cardiovascular system, respiratory system, gastrointestinal system, neurological exam, cranial nerves exam, power, tone, sensation, reflexes. ECG and admission blood testing were also appraised. The reaudit was undertaken appraising the same criteria.

Results

Forensic history was not completed in 42% of patients. Family history was completed in 21% of patients. Admission bloods were not recorded in the assessment document in 72% of patients. 94% patients had ECG performed at admission. In the reaudit, there was an

improvement in completion of the medical history, family history, personal history, forensic history, MSE, formulation and risk assessment sections. There was no change in completion of Psychiatric history, plan and risk sections

Conclusion

The audit & reaudit evaluation demonstrated improvement in completion of certain sections while other sections were equivocal. Another study taking a indepth look at the same criteria while accounting for other variables is required.

90. Quality of Psychiatry Home Treatment Team Discharge Summaries at Dorothy Pattison Hospital, Walsall: An Audit

Eleanor Naccarato, Student, University of Birmingham, Birmingham; **Dr Shalini Sundararaman**, Consultant Psychiatrist, Dorothy Pattison Hospital, Walsall; Dr Pratapa Murthy, Consultant Psychiatrist, Dorothy Pattison Hospital, Walsall

Aims and hypothesis

The aim was to audit current practices and assess whether there was consistency between the discharge summaries and with the current guidelines. This information would help in identifying any problems with the discharge summaries, to see if any practices could be improved and find specific recommendations for further improvement in the quality of these summaries.

Background

Crisis resolution and home treatment teams (CRHTs) are commonly used for adults aged 16-65 years old with severe mental illness [1]. Home treatment teams (HTTs) allow patients to be treated in the least restrictive environment, causing the least possible disruption to their lives [2, 3]. Prior to discharge from the home treatment team, patients are seen for a discharge assessment and a discharge summary is written (or discharge letter) [4, 5]. The discharge letter is then sent to all teams involved in the patient's care, including the general practitioners (GPs), community teams and specialist services within 24 hours [5, 6]. Clearer use of subheadings has also been suggested for ease of finding particularly pertinent information [4]. NHS numbers are essential [7]. Summaries should cover why the patient was admitted and how their condition has changed during their time with the HTT [6]. They should also cover details of the discharge assessment, which should include risk of suicide, and provide a plan for a potential repeat crisis [5, 6]. The plan should also cover details of medications, treatments and support provided, as well as physical health needs and evidence of health promotion. Mental capacity assessments, safeguarding issues identified, and information given (regarding diagnosis or treatment) in the assessment should be recorded, followed by the time of discharge, when the patient leaves the unit [7]. The plan should then go on to address any arrangements that have been made for ongoing care, monitoring or follow-up, and who the patient is expected to see for these [8]. The letter can be broadly split into a person summary and a psychiatric summary [9]. The person summary addresses ethical or cultural factors, social factors, lifestyle factors, and health. The psychiatric summary focuses more on the details of admission, the treatment given and the discharge plan.

Methods

A sample of 20 Home Treatment Team discharge summaries of patients from Dorothy Pattison hospital was retrospectively audited. The audit covered discharge summaries selected randomly from three different doctors working within the HTT (two consultants and one speciality trainee). This covered discharges over a 4-month period, from the start of April 2020 to the end of July 2020.

Results

Patients covered the range of ages normally seen in HTTs, being aged 20-63 years old. It was found that there was consistent reporting (100%) of the patient's name and NHS number. However, age was not reported (0%) and date of birth (DOB) was not reported in every discharge summary (95%). Psychiatric diagnosis, psychotropic medications and reason for referral to the HTT were recorded (100%), however there was poor reporting of physical health conditions (although 45% mention some aspect of the patient's physical health at some point in the summary, only 20% had a dedicated section for it). Admission and discharge date were recorded (100%), but discharge time was sometimes also forgotten (present in 70%). Although risk assessments were recorded in each summary (100%), historical risk was not mentioned in all of these (present in 80%). Similarly, mental state examination (MSE) was recorded in all the studies, but it was only signposted in 95%; in 5% aspects of a MSE were covered within the clinical notes. Of the 95% with a dedicated section to the MSE, 10% were marked as unavailable and 15% as incomplete, however, 90% of patients were assessed remotely, thus patient appearance and behaviour could not be assessed. Whether the patient had capacity to consent to treatment was recorded in 100% of the discharge letters and management plans were also recorded. The team which the patient was discharged to was listed (100%), but where the patient should get their medication from was poorly recorded (35%). There was also poor planning for crisis situations, with only 75% listing a number for the patient to call should they be concerned about their mental health. There was no record of patients being informed about the need to inform DVLA about mental health conditions, particularly those with psychotic symptoms (0%), and there was little record of lifestyle advice being given in the discharge review (30%).

Discussion

Problems with the discharge summaries are primarily due to missing information. Key information could be presented more clearly by further use of headings [4]. This would be particularly useful for highlighting any physical health aspects from the clinical history, along with any past, present or future risks and any mental state examination findings. Employment status should be another demographic feature recorded, as unemployment

has a negative impact on the patient's mental health [10]. Patients should be informed regarding the rules surrounding driving with a mental health condition, particularly if experiencing psychotic symptoms [11]. Such patients should fill in an M1 form from the Government website to send to DVLA [12]. DVLA may tell them to stop driving and surrender their licence [13]. Similarly, it is important for the patient to make changes to their lifestyle and daily activities, to try to improve their mental health [14]. Lifestyle factors, such as frequency of physical and mental activity, alcohol consumption, smoking or BMI, all affect mental health. Nonetheless, lifestyle advice was rarely given or noted in the discharge summary. All patients should receive relevant lifestyle advice, such as smoking cessation. Contrary to popular belief, quitting smoking is associated with reduced depression, anxiety and stress, so this fear of worsening symptoms when stopping what they do to cope should be dispelled [15]. Moreover, it is also important to advise cessation for better psychotropic medication function; tobacco smoke can increase their metabolism, resulting increased doses of medication, with an associated increase in side effects. A physical health section would be important for covering the other medical conditions the patient has and the medications that they take. This information is important for several reasons: some medical conditions may present with similar symptoms to psychiatric conditions, the presence of chronic conditions may cause deterioration in mental health, and medications for any physical health conditions may interact with psychotropic medications that the mental health practitioners may wish to prescribe [16-18]. Finally, the management plan should include a crisis plan, which would not only include who to contact in a crisis, but also any indicators of relapse and coping strategies that the patient can use when they notice these [6]. Patients should also be assigned a care coordinator, listed as a key contact, who should be present at the review or informed of the plan going forward [7].

Conclusion

The main issues highlighted were regarding the recording of physical health aspects or recommendations given to the patient about lifestyle changes. Physical health should be briefly summarised in its own section on the discharge summary, listing briefly the patient's medical history, with any conditions they have and the medications they take (with their dosage). Clinicians should give lifestyle advice, either verbally or through pamphlets, with particular focus on advising patients to inform DVLA of their diagnosis, stop smoking and start exercising more. Mental health professionals filling in a discharge summary should also enter the key information concisely, splitting it into sections signposted with relevant subheadings. A repeat audit will be performed in 6-9 months to evaluate adherence to the recommendations and see if improvements are achieved.

Limitations

The main limitation of this audit was the small sample size of 20 discharge summaries, from one hospital, potentially making the results less reliable.

91. Organization and CMHT Representation at CPA meetings on admission and discharge on inpatient adult psychiatry wards at Lynfield Mount Hospital.

Dr Mahira Syed; CT2, BDCFT Dr Ritvik Gangula; WAST, BDCFT Dr Himanshu Garg; Consultant and Project supervisor, Clinical Director Community Adult Services, BDCFT

Aims and hypothesis

To improve practice in accordance to care programme approach (CPA) both at the time of admission and discharge on an inpatient adult psychiatric ward and to establish whether RCPsych standards are being followed.

Background

CPA approach was introduced in England for the first time in 1993 to coordinate the needs of patients with complex mental health disorders. The Royal College of Psychiatrist Centre of Quality improvement has given clear standards for both inpatient services and CMHT participation in CPA meetings.

Methods

Retrospective analysis of electronic records of 45 randomised inpatient admission to 3 acute adult inpatient wards between 1st September to 31st December 2019 was done to determine timing of both admission and discharge CPA meetings and that they were held within college recommended time frame. It was further evaluated if member of community team/ care coordinator (CC) was invited to the meetings and if they were attended by them.

Results

Admission meetings:62% cases had a CPA meeting at the point of their admission to a ward and only 33% of this were held within a week of admission. In 71% cases, there was the documented evidence of formal invitation to a member of community team/CC for attendance at admission CPA meeting. CC attended 86% of admission CPA meetings.

Conclusion

It was recommended that an improvement in communication was needed between inpatient and community teams through proper planning and documentation of both CPA meetings & invitations to CMHTs. The facility of virtual attendance through use of digital technology like MS Teams needs to be promoted. It was also felt that adequate time notice needs to be given to all the relevant parties both professionals and family members. CMHTs are advised to encourage the culture of nominating alternate team members in case of the

absence of CC. The recommendations would inform the Trust policy and the audit cycle would be completed in 6-12 months to evaluate improvement in the above figures.

92. How many extrapyramidal and non-extrapyramidal side effects can a person experience from Aripiprazole? A Case Report

Dr Jibran Syeed, CT2, CNWL NHS Trust; Dr Jiann Lin Loo, Speciality Doctor, CNWL NHS Trust; Dr Sarita Paul, Consultant Psychiatrist, CNWL NHS Trust

Aims and hypothesis

To report a rare case of multiple aripiprazole-induced side effects including parkinsonism.

Background

As an atypical antipsychotic acting as a partial dopaminergic agonist, aripiprazole has a low rate of extrapyramidal side effects (EPS) and a reduction in prolactin levels. Most EPS are reported through case reports. Here we would like to enrich the literature with an unusual case of bipolar mania patient who developed both parkinsonism and akathisia with aripiprazole.

Methods

A case report

Results

A 24-year-old lady was admitted for unmanageable behavioural agitation with persistent elated, irritable mood associated, increased energy, reduced need of sleep, excessive talkativeness, spending spree and increased confidence for about a week. Her past history was major depressive episode characterised by depressed mood, anhedonia, self-neglect, guilt, hopelessness and anorexia, which were partially treated with fluoxetine a few years ago. Diagnosis of bipolar mania was made. Her initial Young Mania Rating Scale (YMRS) was 31 and Clinical Global Impression (CGI) was 7. Her physical examination, blood investigation and ECG were unremarkable. Aripiprazole was started at 5mg/day and increased to 20mg/day over two-weeks. Although her YMRS improved to 9 during the 3rd week, she reported multiple physical symptoms, including feeling stiffness and hand tremor. Further assessment revealed hypomimia, bilateral upper limb rigidity and bilateral leg swelling below the knees. Calf pain with a pruritic rash on her upper lateral aspect of her thighs followed the next day. Five days since the onset of symptoms she developed cog wheel and lead pipe rigidity, bradykinesia with shuffling gait and a resting tremor as well as an inability to sit still and restlessness associated with myalgia in both legs. Although her creatine phosphokinase was high at 360 IU/L, there was no vital sign instability and other features of neuroleptic malignant syndrome. Procyclidine injection had relieved the symptoms and hence, the diagnosis of parkinsonism and akathisia was made. Aripiprazole

was replaced with olanzapine upon shared decision making and regular procyclidine was given until all her EPS subsided. Her repeated creatine phosphokinase was 136 IU/L.

Conclusion

Despite the favourable side effect profile of aripiprazole, it is still poorly understood on the individual susceptibility, possibly due to different pharmacogenomic profile. Hence collaborative practice and shared decision making are always an essential component of evidence-based medicine to ensure patient's receive an effective tolerable treatment.

93. Evaluation of Video consultations in community mental health setting

Dr Sadia Tabassum Javaid, ST4 dual GA and OA Psychiatry, North Staffordshire Combined Health Care NHS Trust; Dr Ravindra Belgamwar, Consultant Psychiatrist GA Psychiatry, North Staffordshire Combined Health Care NHS Trust

Aims and hypothesis

To evaluate the overall experience and satisfaction with AA video consultations in adult CMHT.

Background

The increased use of the digital world is evident via Ofcom Tele Report 2019. UK Government's Five Year Forward View and initiatives, such as 'Digital First', aim to reduce face-to-face consultations. Past reports have shown video consultations to be non-inferior to face-to-face consultations in systematic reviews and qualitative studies.

The contagious nature of the Covid-19 outbreak limited face-to-face consultations. This led to video consultations via Attend Anywhere (AA). AA is accessed anywhere via the web on Google or Safari with a good internet connection. It provides a single, consistent entry point with an online waiting area on the service's webpage.

Methods

1. Two separate questionnaires were designed, one each for service users and staff, to capture relevant information at the end of AA consultation. Additional clinical questions for staff included.
2. Data were collected anonymously for 2 months from 1st April 2020.

Results

Total respondent 44= 20 service users and 24 staff.

For Service Users:

The respondents' age range was 19-62 years, 80% females. The majority were follow-ups with three new assessments. About half of them had previous contact with the staff. 15 consultations were carried out by the doctor, four by the psychologist, and one was a joint doctor-psychologist consultation.

95% reported their overall experience to be very good-good. 90% found it easy to use: 95% said they would use it again.

For Staff:

The respondents' age range was 30-50 years, 87% females. The majority were follow-up assessments with one-third new. 16/24 respondents were doctors and eight psychologists. 58% had a previous meeting with service users.

83% reported the overall experience as very good to good: one third felt it's time-saving. 100% reported it's easy to use, would re-use and recommend to others.

For clinical questions, the responses were very good-good as Rapport 87%; Risk assessment 83%; care plan 83%; History taking 78%; Mental state/Cognition 66% and providing support 65%.

Conclusion

Overall, the majority of respondents at an Adult CMHT found video consultations easy to use with readiness to use them again. Video consultations offer several advantages over telephone reviews, e.g. for developing rapport, assessing mental state, etc.

This data is limited to the pilot project and a detailed review is planned for qualitative information with a larger cohort. Following this successful pilot and promising results, video consultations have been rolled out to other trust clinical areas.

94. Impact of Covid-19 on the Mental Health of CMHT patients

Dr Lauren Unsworth, ST4, LYPFT Dr Khadeeja Ansar, CT2, LYPFT; Dr Guy Brookes, Consultant Psychiatrist, LYPFT

Aims and hypothesis

To evaluate the impact of COVID-19 on the mental health of service users of the NW CMHT and to consider how the service can respond to this impact. To gain an understanding of emotional states, thought processes and coping strategies at the start of the pandemic and then after easing of lockdown.

Background

The unprecedented changes to our way of life due to the pandemic starting in January 2020, along with worrying news about the pandemic rapidly worsening in the UK and the changes in provision of health services, had the potential to have a significant impact on people's mental health.

Methods

A questionnaire was conducted via telephone interview, containing quantitative and qualitative questions to ask service users about their current emotional state, thought processes and coping strategies, comparing this to how they felt before the start of COVID-19.

Results

39 respondents completed the questionnaire during the first round. 21 of these responded again in the second round.

Conclusion

Although there were a lot of variations, overall people reported worsening in their mental health as the Pandemic continued. CMHT faces additional pressures which have to be taken into account for planning service provision.

95. Physical health monitoring of patients initiated on antipsychotic medication in the Psychiatric Intensive Care Unit

Dr Silva Vartukapteine, Basic Specialist Trainee Year 3, St Patrick's Mental Health Service, Dublin Ireland; Dr Orlagh Deighan, Basic Specialist Trainee Year 1, St Patrick's Mental Health Service, Dublin Ireland; Dr Seamus O'Ceallaigh, Consultant Psychiatrist- Psychiatric Intensive Care Unit, St Patrick's Mental Health Service, Dublin Ireland

Aims and hypothesis

To evaluate the physical health monitoring of patients initiated on antipsychotic medication in Psychiatric Intensive Care Unit (PICU), St Patrick's Mental Health Services and ensure its adherence to the standards of practice from internal Hospital policy, NICE guidelines and The Maudsley Prescribing Guidelines in Psychiatry.

Background

Antipsychotics are a group of medications which are frequently used in psychiatric acute care settings both as acute management and long-term treatment. Due to adverse effects of antipsychotics, close monitoring of weight, cardiovascular and metabolic indicators is mandatory to ensure patient safety.

Methods

Retrospective and concurrent chart review completed of patients admitted to PICU over a period of 3 months, January to March 2019; 29 service users met the inclusion criteria for the first audit cycle. Data were collected from patients' electronic medical records regarding physical health monitoring and compared with the pre-determined standards of practice. Following multiple interventions aimed at improving the practice (educational sessions, e-mail reminders, nursing checklist, recommendations re electronic physical health care plans, reviewing and simplifying internal policy), second audit cycle was carried out, which included seven month period from December 2019 to June 2020; 25 service users met the inclusion criteria.

Results

Compliance with most baseline blood tests was high in both audit cycles (88-100%), with exception of prolactin (27%, improved to 54%). During the second audit cycle there was notable improvement in baseline weight, BMI and ECG monitoring (up to 75-100%). Significant shortcomings were identified in ongoing blood test, ECG and weight monitoring, compliance varying between 10-41% in the 1st audit cycle. In the 2nd audit cycle some of the parameters slightly improved; however, overall compliance remained sub-optimal (under 33%), with exception of blood pressure monitoring (improved to 64%).

Conclusion

In this service there is a designated Consultant and team for PICU separate from lower care setting wards – this can lead to changes in treating teams during inpatient stay thus interfering with continuity of care. Difficulty keeping track of these standards may also be secondary to busy clinical setting. This audit demonstrates the need for repeated education sessions to all clinical staff and introducing regular reminders in clinical practice. We also propose to incorporate a pre-populated electronic care plan for anti-psychotic monitoring which would act as a reminder for staff to monitor physical parameters, ensure appropriate communication to GP and encourage collaboration with service user to engage in their own health monitoring.

96. Identifying demographics and risk factors for transfer to a Psychiatric Intensive Care Unit: Service Evaluation of an Adult Inpatient Mental Health Service.

Dr Kirsty Ward, CT1, Rotherham, Doncaster and South Humber NHS Foundation Trust; Dr Suveera Prasad, Consultant Psychiatrist, Rotherham, Doncaster and South Humber NHS Foundation Trust

Aims and hypothesis

To identify risk factors and assess demographics of patients from an adult inpatient mental health unit which may increase the risk of admission to a Psychiatric Intensive Care Unit (PICU).

Background

There is need to ensure that mental health services adapt to the increasing demand for inpatient beds, particularly beds within specialist services such as those at a PICU. There has been limited literature investigating risk factors for transfer to PICU.

Methods

We conducted a retrospective analysis of electronic records of 85 patients from an adult mental health unit from 4th March 2019 – 5th August 2019. Demographics, admission details, social history, diagnosis as per the ICD-10, physical health comorbidities and discharge details were recorded. We compared two cohorts; those who required admission to a PICU and those who did not. A follow up period of six months was included to assess re-admission risk. Odds ratios, P values and confidence intervals were calculated with 95% confidence interval.

Results

Eighteen (21.2%) service users were admitted on a PICU. They were more often male, single and younger (mean age 39.7 [SD 12.7] years versus 43.7 [SD 14.5]). PICU admissions were more likely to have a positive forensic history (P=0.009, CI 1.437-12.733), more likely to require seclusion (P= <0.0001, CI 4.987-77.727), senior physical health input (P=0.026, CI 1.204-18.887) or assessment at an acute hospital (P=0.015, CI 1.430-25.671). History of substance misuse (P=0.074, CI 0.898-10.112) and police involvement during admission (P=0.443, CI 0.483-5.283) were more frequent in PICU cohort but did not reach statistical significance. Substance misuse disorders (F10-19 diagnoses) were more frequently observed in the PICU cohort (OR 1.46, CI 0.444-4.775) and Schizophrenia and schizoaffective Disorder (F20-29 diagnoses) were less common (OR 0.48, CI 0.142-1.620). The PICU cohort were more likely to be discharged to another PICU and to be readmitted.

Conclusion

We identified demographics, social characteristic and admission related risk factors which were associated with an increased risk of requiring PICU admission. Patients admitted to PICU showed a trend towards substance misuse. The patients admitted to PICU more often required input for physical health issues. This demonstrates the need for specialist services such as PICUs to adapt to the needs and demographics of the service users and also allows clinicians to identify individuals who may require increased support.

97. Audit of the use of Hypnotic Medications in Mental Health Inpatient Units in Central Area, Betsi Cadwaladr University Health Board

Dr. Laura Williams CT3 BCUHB; Dr. Vikram Bhangu CT2 BCUHB

Aims and hypothesis

We have noticed that in the inpatient psychiatric units across North Wales we do not follow a protocol when prescribing hypnotics, and therefore the advice and treatment we are giving to our patients is not always uniform and may not be evidence-based. We wanted to complete this audit to understand deficits in our prescribing practices and attempt to improve these for the benefit of our patients.

Background

Insomnia is defined as a 'disturbance of normal sleep patterns commonly characterised by difficulty in initiating sleep and/or difficulty maintaining sleep'. There are variations in sleep length and quality both for an individual night to night, and between individuals, however the majority of us will need between 7-9 hours per night to feel rested and refreshed. Hypnotic drug therapy should be kept for use only when simple non-pharmacological methods such as sleep hygiene advice have failed.

Methods

The first audit cycle reviewed the notes and medication charts and collected data of all inpatients in the Central area of BCUHB, i.e. the Ablett Psychiatric Unit and Bryn Hesketh Unit. The data was collected on 10/05/20 using the audit proforma. The standards followed were NICE TA77 Guidance on the use of zaleplon, zolpidem and zopiclone for the short-term management of insomnia.

Results

Of all 34 inpatients audited, 8 patients (24% of total inpatients) took a hypnotic to provide symptomatic relief of insomnia. 6 of these 8 patients (75%) used Zopiclone (first line treatment). 0% had been given sleep hygiene advice and only 38% of those on hypnotics had a sleep chart in use. 0% had a stop or review date and 0% had had a discussion with their doctor about tolerance and withdrawal effects. We found that 100% of patients had avoided switching from one to another which is in line with the guidance.

Conclusion

The main areas where we have fallen down are giving sleep hygiene advice, use of sleep charts, giving a review/stop date, and having a conversation with patients about the risk of tolerance and withdrawal effects. Utilising sleep charts for every inpatient may solve this

issue but also will create more work for pressed nursing staff. Formal training on CBT for insomnia is another idea that has been put forward which could be delivered to our patients. We also would like to see a protocol or guideline which is specific to our Trust.

98. Service Evaluation of the Mental Health Assessment Service (MHAS) in Dudley

Dr Mark Winchester, ST5 Doctor, Midlands Partnership NHS Foundation Trust; Dr Amitav Narula, Consultant Psychiatrist, Black Country Healthcare NHS Foundation Trust; Dr Rachel Davis, Associate Specialist, Black Country Healthcare NHS Foundation Trust; Dr Ella McGowan, CT2 Doctor, Black Country Healthcare NHS Foundation Trust

Aims and hypothesis

1) To assess how well MHAS meets the service specification.
2) To ascertain areas of good practice.
3) To examine whether the referral form is being used in an appropriate manner.
4) To elucidate areas of good communication and whether any improvement can be made.

Background

MHAS is the access system into mental health services for patients aged 16-65, with a general practitioner (GP) in Dudley, who are not currently open to secondary care. Assessments are completed by a medic, community psychiatric nurse or jointly. It aims to identify the most appropriate care pathway for patients. This audit was a comprehensive assessment of how effective MHAS is at ensuring patients are adequately triaged.

Methods

10 cases from each month between April 2018 and March 2019 were randomly selected from all anonymised MHAS referrals. 120 cases were reviewed in total. A proforma was developed based on current practice, previous audits and service specification. A team of four doctors assisted in the data collection and only electronic health records (EHR) were reviewed.

Results

88.3% of referrals were recorded on the EHR. Only 61.7% of referrals used the proforma with the other referrals mostly being in the form of a letter, which often missed out information vital to the triaging process. Only 4.2% of referrals are from Primary Care Mental Health Nurses (PCMHN) with 85.8% arising from GPs. Urgent referrals were not discussed with MHAS via telephone contact in about 60% of cases. The majority of patients had telephone screening completed the same day and were then discussed the next working day at the daily referral meeting. Although a brief summary for the GP was being sent the same day in all cases, over half of the comprehensive assessments were not being sent within the five day time frame.

Conclusion

All referrals must be uploaded to the EHR and completed using the service's proforma. PCMHNs may be currently under-utilised or effectively doing their jobs at managing mental health patients in primary care. GPs regularly referring via letter require further training and support to use the proforma. The proforma may require simplification to make it easier to complete. The service specification requires review as it makes unrealistic demands of the service. All referrals must be discussed at the daily referral meeting. Further investigation is required to understand why MHAS is struggling to meet time frames for appointments and letters.

99. Assessing depression on admission to a hospice inpatient unit

Dr Felicity Wood, ST7 Psychiatry, Leeds and York Partnership Foundation Trust; Dr Paul Ashwood, Consultant in Palliative Medicine, Mid Yorkshire Hospitals NHS Trust; Dr Emma Lowe, Consultant in Palliative Medicine, Wakefield Hospice

Aims and hypothesis

The aim of this audit was to establish and improve how well depression is assessed and managed on admission to hospice and during the course of admission.

Background

Depression is prevalent but often undiagnosed and undertreated in hospice settings.

Methods

An initial audit was carried out of all admissions to Wakefield hospice between April and June 2018. The electronic GP notes were accessed to determine if an established diagnosis of depression was recorded. Written hospice notes were then reviewed. Demographic information was collected as well as whether depression was assessed on admission, and whether it was rated. If mood was recorded as low, it was noted whether a plan was in place regarding this. The medical entries during admission were also read to see if depression was assessed during the course of admission.

Results

Data was available on 61 of the 87 patients admitted during the period. Less than a third of depression diagnoses documented by GP were noted on admission. In 48% of cases depression was assessed on admission. When recorded as being low in mood, there was rarely a plan specified in managing this. In only 6% of all notes was a rating score recorded for depression. In 10% of cases, there was some review of mood made during the course of admission. Following this, staff training was implemented. A change was made to the clerking proforma to prompt an assessment of mood. A re-audit was then carried out between February and March 2019 using the same method. During this period, 30% of admissions had an existing diagnosis of depression documented on the GP notes and 22% had existing depression documented on the admission clerking. Formal mood assessment was carried out on 60% of new admissions. Of the patients where mood was documented as a problem, only 10% had a plan recorded to manage this.

Conclusion

Assessment of depression increased following staff education and the change to the clerking proforma. However, 40% are still not having a mood assessment documented.

Mood was infrequently documented during the course of admission. When depression was noted, there was not often a plan documented for managing or reviewing this. The recommendations are to include more detailed screening questions in the clerking proforma with a prompt to use formal screening tools if appropriate. Low level psychological support is routinely provided in a hospice setting. Education to recognise and document when this is provided would be useful.

100. Physical Health Monitoring of patients treated with Clozapine in East - Specialist Psychosis Team, EPUT.

Dr Oksana Zinchenko, CT1, NHS Highlands; Dr Ratna Ghosh, Consultant Psychiatrist, Essex Partnership University NHS Foundation Trust; Dr Srujan Ande, Locum Consultant Psychiatrist, Essex Partnership University NHS Foundation Trust

Aims and hypothesis

To ascertain performance against the standards set by The Prescribing Observatory for Mental Health (POMH – UK) guidelines on physical health monitoring of patients prescribed Clozapine in E- Specialist Psychosis Team and to identify areas of improvement in practice. We focused on compliance with practice standards 6 and 7 following Action Plan outcome of Audit 18007: POMH Topic 18A "The use of Clozapine" and compared with results from national audit based improvement programme conducted in July 2018 by The Prescribing Observatory for Mental Health (POMH – UK).

Background

Clozapine clinics are based in Colchester and Clacton – on – Sea. We checked if the core physical health measures were documented during the past year of clozapine treatment: blood pressure, body weight/BMI/waist circumference, general physical examinations, blood glucose (or HbA1c), plasma lipids. Also we looked whether the following discretionary physical health measures were documented during the past year of clozapine treatment: ECG, Echocardiogram, CRP, troponin.

Methods

Sample size 125 patients. Inclusion criteria: any patient 16+, the current episode of clozapine treatment is more than 1 year. Information collected via review of recorded documentation on the Trust's electronic system. Data collected from 3 -16 July 2020.

Results

Yearly recording of general physical examination was completed in 98.4 % of subjects, compare to 72% in 2018. Yearly recording of blood pressure, pulse rate was completed in 99.1 % of subjects, compare to 72 % in 2018.Yearly body weight, glycaemic control and plasma lipids measure were documented in all three parameters in 87%, two parameters in 8% and 1 parameter in 5% of subjects. 100% of patients were reviewed annually by medical staff.

Conclusion

The routine physical examination performed within medical review and Clozapine Clinic is primarily an evaluation of risk of metabolic syndrome and lifestyle related physical issues. It does not constitute a full physical health screen and service users and their GPs should be aware of this. Clinic letters format must include the relevant headlines: physical health check, plasma level, annual blood tests, ECG, smoking status, side effects, relevant health promotion advice. Medical staff to ensure that results of the annual health check and routine monitoring are communicated to the GP. Results of the blood tests be signed and given to the admin secretary for scanning on to the electronic record and to be forwarded to the GP. No financial sponsorship to declare. The authors have no financial conflict of interest with regard to the content of the audit.

Notes