Royal College of Psychiatrists
Faculty of General Adult Psychiatry
Annual Conference

14-15 October 2021

Conference Booklet

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
Detailed online feedback forms can be found by here:
Thursday 14 October - https://www.surveymonkey.co.uk/r/WD8QXN7
Friday 15 October – https://www.surveymonkey.co.uk/r/WY2QLN9

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

If you wish to tweet about the conference use @rcpsychGAP #gapsych2021

Posters
Poster viewing is available throughout the conference using the following links:

- Education and Training, Quality Improvement and Research: https://www.rcpsych.ac.uk/events/conferences/2021/poster-viewing-faculty-of-general-adult-psychiatry-annual-conference-2021-posters-(1)
- Service Evaluation/Audit: https://www.rcpsych.ac.uk/events/conferences/2021/poster-viewing-faculty-of-general-adult-psychiatry-annual-conference-2021-posters-(2)

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 14 October

Welcome from Vice Chair
Dr Jonathan Scott

Dr Jonathan Scott is a Consultant Psychiatrist in the Hammersmith & Fulham Crisis team (one day a week) and Chief Clinical Information Officer, he is also the Vice Chair of the Faculty of General Adult Psychiatry.

Plenary 1
Chair: Dr Mona-Lisa Kwentoh

Dr Mona-Lisa Kwentoh is a Consultant Psychiatrist in Hambleton and Richmondshire Crisis Resolution Team within Tees Esk and Wear Valley Foundation NHS Trust. She has held and continues to hold a number of educational roles including Honorary posts in Hull York Medical School and Teesside Universities. Her special interests include trauma informed care, psychosis, workforce wellbeing and equality & inclusion.

Can there be a decade of the biopsychosocial model?
Dr Derek Bolton

Dr Derek Bolton is Professor of Philosophy and Psychopathology at King's College London, Institute of Psychiatry, Psychology & Neuroscience, and formerly Head of Clinical Psychology in the Bethlem Royal & Maudsley NHS Trust. His clinical research interests are in paediatric OCD and anxiety disorders. He is the author with Grant Gillett of The Biopsychosocial Model of Health and Disease. New Philosophical and Scientific Developments. Palgrave Open Access, 2019. Available https://www.palgrave.com/gp/book/9783030118983.

Social relationships: key to understanding and treating psychosis
Professor Tom Craig

Difficulty in forming and sustaining personal relationships precede and accompany many psychiatric disorders. For example, early childhood maltreatment and bullying at school is found in the causal pathway for both common and severe mental illness and many symptoms of mental illness are understandable in the light of bullying and power imbalances in key personal relationships. In this talk Professor Tom Craig reflects on the evidence for these statements drawing upon evidence from past and ongoing clinical research with which he has been involved. Professor Craig argues that psychiatrists should be more active in developing and leading interventions that focus on the social and interpersonal networks of their patients.

Tom K J Craig MBBS, PhD, FRCPsych: Emeritus Professor of Social Psychiatry at the Institute of Psychiatry, Psychology and Neuroscience, King's College, London, and Past President World Association of Social Psychiatry.

Tom qualified in medicine at the University of the West Indies and trained in psychiatry in Nottingham UK. He was appointed as Professor of Community Psychiatry in 1990 based in the South London and Maudsley NHS Trust and was the psychiatric lead for the closure of Tooting Bec Hospital. His research includes services for first episode psychosis and current studies of the AVATAR therapy for auditory hallucinations.

Plenary 2
Chair: Dr Meda Apetroae

Dr Meda Apetroae is a Psychiatry ST5; Higher trainee representative for RCPsych General Adult Psychiatry Faculty; Academic Link Tutor for Physician Associate Studies, University of Hertfordshire and Mental Health Liaison Team, Lister Hospital

Anthropological observations of mental health systems
Dr Neil Armstrong

Psychiatry is the focus of an immense amount of research within the humanities and social sciences, but productive engagement with biomedical research is rare. At the same time, the contribution of service users is increasingly to seen as essential, but without a clear sense of how this might be achieved. Why is it so difficult to bring disciplines into dialogue? How might expertise by experience be integrated into the research process?

This presentation suggests one set of answers to these questions. Dr Neil Armstrong draws on ongoing work for an anthropology book (with the provisional title Everybody Knows: Collaborative Ethnographic Working in Mental Health to be published by Routledge in 2022) which uses coproduced ethnography to promote interdisciplinarity.

Dr Armstrong suggests that researchers from outside psychiatry have tended to think too much in terms of knowledge and power and that the role of the institutional setting has been overlooked. The institutional setting is not just a limiting or constraining 'iron cage.' It redirects attention, redefines goals, and, even, introduces what philosopher Harry Frankfurt calls 'bullshit' into clinical practice.

This talk briefly considers how anthropologists have analysed institutions and what this means for mental healthcare, looking at how coproduced ethnography can be a method of tracing these abstract-seeming ideas as they play out in concrete, observable ways in individual lives.

Dr Neil Armstrong is a Stipendiary Lecturer in Social and Cultural Anthropology and Director of Studies for the Archaeology and Anthropology degree at Magdalen College, University of Oxford.

Dr Armstrong's work seeks to find productive ways of applying anthropological methods to mental healthcare research. He is particularly interested in how the institutional setting shapes so much of mental healthcare. Dr Armstrong's research aims to find ways that we might improve healthcare institutions rather than just focussing on developing new healthcare interventions.

Community Mental Health Transformation, making it a reality in Peterborough and sharing the solutions to our challenges
Dr Emma Tiffin, Dr Sam Halligan, Trish Barker-Barrett and Oliver Ayres

Brief summary of Mental Health Long Term Plan ambitions/national community mental health transformation achievements to date.

The Peterborough journey - achieving the vision/strategy for community mental health transformation - including challenges and solutions.

Dr Emma Tiffin has worked in mental health clinical leadership roles for over 17 years. She has led on the development of a sustainable integrated community-based mental health

service model in Cambridgeshire which includes a First Response Crisis Mental Health Service (FRS) and a Primary Service for Mental Health (PCMHS). These services bring together specialist mental health, primary care and community services via a place-based model. Both FRS and PCMHS have won national awards for innovation (2018, 2019) and are blueprint models in the Long Term Plan. Cambridgeshire is currently a national community MH exemplar site.

National advisor roles include development of the Community Mental Health Framework, Adult Eating Disorder and Coproduction guidance (2019), and in 2020 Emma was appointed as National Advisor for Community MH and Primary Care transformation.
Emma is a practising GP in Cambridgeshire and is the resident GP for BBC Radio Cambridgeshire.

In 2016 Emma was awarded the Health Education England " East of England Leadership Award for Service Improvement and Innovation" and in November 2017 was awarded "Healthcare Leader of the Year" at the national General Practice Awards.

Dr Sam Halligan is a Consultant Psychiatrist Peterborough Adult Locality Team and Primary Care Mental Health Service

Trish Barker-Barrett is a Digital and Community Engagement Team Manager / How Are You (H.A.Y.) Project Lead and Peterborough Exemplar – Project Management Team.

Oliver Ayres is a Digital and Community Engagement Coordinator at Cambridgeshire and Peterborough NHS Foundation Trust.

Plenary 3
Chair: Dr Abdi Sanati

Dr Abdi Sanati is a Fellow of the Royal College of Psychiatrists. He is a consultant in general adult psychiatry and the Academic Secretary of the General Adult Psychiatry faculty. Dr Sanati was the Chair of the Philosophy Special Interest Group of the Royal College of Psychiatrists from 2017 to 2021.

The Bitterest Pills: a re-evaluation of the pros and cons of long-term antipsychotic treatment
Professor Joanna Moncrieff

In this presentation Professor Joanna Moncrieff looks at evidence for the benefits and risks of long-term treatment with antipsychotic drugs in people with psychotic disorders. Professor Moncrieff will explore the problems with the evidence base including abrupt discontinuation and lack of long-term follow-up of randomised cohorts. She will also outline two contrasting ways of understanding how psychiatric drugs exert their effects: the disease-centred and the drug-centred models of drug action. Professor Moncrieff will look at the lack of evidence for the traditional disease-centred view of antipsychotic drug action, that is the idea that they counteract an underlying brain disease or abnormality. She will present evidence supporting the alternative drug-centred model, which suggests that antipsychotics 'work' by inducing an altered mental and physical state. Professor Moncrieff will explore the implications of the drug-centred model for clinical practice, especially long-term treatment.

Professor Moncrieff will then describe the RADAR trial, a randomised trial has been set up in the United Kingdom to provide more information on the long-term outcome of a gradual process of antipsychotic reduction and discontinuation. This is a multi-centre trial involving people with schizophrenia and related disorders who have had more than one episode and the primary outcome is social functioning. The trial started in 2016 and 253 participants

have been enrolled and randomised. The trial is scheduled to finish in June 2022. Professor Moncrieff will present some data showing how participants compare with other potentially eligible patients in mental health services.

Professor Joanna Moncrieff is Professor of Critical and Social Psychiatry at University College London, and works as a consultant in community psychiatry at the North East London Foundation Trust. She has researched and written about theories of drug action, the subjective experience of taking psychiatric drugs, decision making, the history of drug treatment and the history, politics and philosophy of psychiatry more generally. She is currently leading an NIHR-funded study of antipsychotic reduction and discontinuation, called the RADAR study (Research into Antipsychotic Discontinuation and Reduction). She is one of the founders and the co-chair person of the Critical Psychiatry Network. She is author of numerous papers and several books including The Bitterest Pills: The Troubling Story of Antipsychotic Drugs; The Myth of the Chemical Cure (Palgrave Macmillan); A Straight Talking Introduction to Psychiatric Drugs (PCCS publishers).

Undiagnosed ADHD among unionized drivers in Ghana: Public Health and Policy Implications
Professor Thaddeus Ulzen

Road traffic accidents (RTAs) are among the leading causes of mortality worldwide. Road traffic accidents (RTA) are among the leading causes of mortality in sub-Saharan Africa. They are multi-factorial in origin but neuro-cognitive function of drivers contributes about 25% of the variance of most accidents. The commonest disorders that contribute to RTAs include Attention Deficit Hyperactivity Disorder (ADHD), Specific Learning Disabilities (e.g.Dyslexia), Autism Spectrum Disorder (ASD) in adolescents and young adult drivers and Mild Cognitive Impairment (MCI) and Dementia in older drivers.

This study examines an aspect of ADHD and driving in the Ghanaian context. The vehicles of Ghanaian unionized drivers are over-represented in fatal road accidents.
Many males that drop out of school in Ghana, a population at risk for attention-deficit hyperactivity disorder (ADHD), find employment by joining driver's unions. Untreated ADHD has been linked with higher rates of RTAs.

The objectives of this cross-sectional analysis is to determine the following among unionized drivers in Ghana: 1) the prevalence of ADHD, and 2) the association between self-reported ADHD risk and driving behavior. Data comes from participants' responses (200 unionized drivers and 171 community controls) to a 6-item ADHD Self - Report Scale (ASRS), the Driving Behavior Survey (DBS), and a culturally adapted version of the Jerome Driving Questionnaire (JDQ-GH). The self-reported prevalence of ADHD was 17.6% for the unionized drivers and 7.8% for the control group ($\chi 2 = 7.7$, $df = 1$, $p = .006$). Also, ADHD drivers endorsed that they were more likely to pay bribes to police and having worse driving behaviors across among both unionized drivers and controls. Study findings suggest that increased awareness of ADHD and possible screening of drivers for ADHD with subsequent evaluation and treatment may result in prevention of vehicle accidents.

Professor Thaddeus Ulzen MD DCP FGCP FRCP(C) graduated from the University of Ghana Medical School in 1978. He completed his postgraduate training in Child, General Psychiatry and Clinical Psychopharmacology at the University of Toronto in 1985. He is Professor & Chair of the Department of Psychiatry and Behavioural Medicine at the University of Alabama School of Medicine (Tuscaloosa Regional Campus). He is a Distinguished Fellow of American Psychiatric Association and the recepient of numerous awards.He has published extensively in the fields of child, adolescent psychiatry, global mental health and telemedicine.He is also Adjunct Professor at the Northern Ontario School of Medicine and Annual Visiting Professor in Psychiatry at the University of Cape Coast School of Medical Sciences, Ghana.

Plenary 4
Chair: Dr Clare Morgans

Dr Clare Morgans is a Consultant Adult Psychiatrist, working in Early Intervention & Psychosis Community Services in County Durham, as part of Tees, Esk & Wear Valleys NHS Foundation Trust. She is an ADME in Undergraduate Education, the Clinical Lead & Honorary Lecturer for Newcastle University Medical Students. Dr Morgans is a newly appointed member of the GAP Faculty Executive Committee. She has been a CASC Examiner & is passionate about Medical Education matters. Dr Morgans has an endorsement in Addiction Psychiatry and used to work in this field, now focusing on collaboration with 3rd sector colleagues. She is also interested in trauma focused/ informed care and improving co-production/ shared decision making with service users.

50 Years of the Misuse of Drugs Act: how can reform create a better future?
Dr James Nicholls

The UK Misuse of Drugs Act (1971) is now fifty years old. Over that time drug markets, cultures, economies and harms have changed enormously. As drug-related deaths increase, there are growing calls for reform of the legislation to allow novel interventions and to establish drug policy based on health promotion rather than criminalisation. This paper will set out some of the key arguments for reform, and consider how a discussion on drug policy can move from the margins to the mainstream.

Dr James Nicholls is Chief Executive Officer of Transform Drug Policy Foundation. He has worked in drug and alcohol research and policy for over twenty years, including as Director of Research for Alcohol Research UK and member of the Public Health England Alcohol Leadership Board.

The Wrong Type of Trauma? Black people and the diagnosis of the personality disorder
Dr Anne Aiyegbusi

Dr Anne Aiyegbusi is Director, Consultant Nurse & Psychotherapist - Psychological Approaches CIC.

Friday 15 October

Welcome to Day 2 and reflections from Day 1

AGM plus prizes
Dr Billy Boland, Dr Asif Bachlani, Dr Jonathan Scott, Dr Andrea Tocca, Dr Priya Natarajan, Rosanna Flury

Dr Billy Boland took over the role of Medical Director at South West London and St George's MH NHS Trust in March 2021.

Billy brings a wealth of experience to the role. He previously worked as Deputy Medical Director at Hertfordshire Partnership University NHS Foundation Trust, where he was also a Consultant in community psychiatry. Billy is an Honorary Senior Lecturer (Clinical) at the University of Hertfordshire. He was elected to the Royal College of Psychiatry General Adult Faculty Executive Committee in 2013 and took over as Chair in 2019. Billy is also on the Advisory Board of the Money and Mental Health Policy Unit. Billy first trained as a Consultant Psychiatrist here at the South West London and St. George's Mental Health Trust and is delighted to be coming back.

Dr Asif Bachlani is the Clinical Director for Priory Group Acute and PICU Network of Hospitals and an inpatient Consultant Psychiatrist. Asif is also the Hospital Medical Director for Priory Hospital Woking and Oxford Wellbeing Centre.

Asif has always had an interest in providing highest quality care for patients and has used 'data' in order to develop patient pathways in order to meet the needs and unmet needs of the local population. Asif has led on development of patient pathways including the NELFT Acute Care Pathway, North East London Transition Pathway, Physical Health pathway for people with SMI and Kingston Personality Disorder Pathway.

Due to his interest in mental health outcomes, Asif was also the NHS London Co-Clinical Lead for Mental Health Outcomes for 2 years, between 2017-19 where he authored NHS London training modules on Introduction to HoNOS and How to analyse HoNOS. Asif has also held various clinical and managerial positions in NHS Trusts including Associate Medical Director, Trust Lead for Mental Health Outcomes and Chief Clinical Information Officer.

Asif passionately believes in the value of data for clinicians and organised the 1st ever clinician focused data events for the South London Partnership and the Pan-London benchmarking conference in 2018. Asif organised the inaugural RCPsych Better Data, Better Care conference in 2019 for the General Adult Faculty as well as a series of BDBC webinars and was the Chair of the organising committee for RCPsych 2021 conference.

Dr Andrea Tocca works as Consultant Psychiatrist and Associate Medical Director for the Cumbria, Northumberland Tyne, and Wear NHS Foundation Trust. He has migrated in UK in 2005 with his wife and two children. He trained in Italy as General Adult Psychiatrist. He has a special interest in Philosophy and Psychotherapy as well as in Medical Leadership. In his free time, he also fly birds of prey and cultivate his passion about learning and teaching about Movies and Psychiatry.

Rosanna Flury is the Policy Engagement Manager at the RCPsych.

Plenary 5
Chair: Dr Billy Boland

General Adult Psychiatry around the world:

Australia
Dr Agnew Alexander

Dr Agnew Alexander is a senior Psychiatrist specialising in General Adult Psychiatry with special interest in complex mood disorders, anxiety disorders, ADHD, personality disorders and addictive disorders.

Dr Alexander completed his training and obtained MRCPsych in the UK before moving to Australia in 2006. He has subsequently obtained FRANZCP (Australia and New Zealand) in 2009 and FRCPsych (UK) in 2015. He was conferred IFAPA (USA) in 2018 for his contribution to psychiatry.

In addition to his extensive clinical experience, he has held many senior positions in the public and private sectors including Acting Deputy Director of Psychiatry (Gold Coast Mental Health Service), Clinical Director of Mental Health (Gold Coast Health). He is the Chair of the binational Faculty of Adult Psychiatry and is the previous Chair of RANZCP Queensland Branch. He is current serving member of the Mental Health Review Tribunal for Queensland. He is a Reserve officer with the Australian Army.

Throughout his career, Dr Alexander has been involved in mental health education, training and advocacy. He is actively involved in the training and assessment of medical students, registrars and consultant psychiatrists. Dr Alexander is currently Assistant Professor at Bond University and Senior Lecturer at Griffith University on the Gold Coast and serves on various committees of RANZCP for training and assessment.

An Overview of Mental Health in Malawi
Dr Jen Ahrens and Dr Alex Zumazuma

Malawi is landlocked country of 18 million in East Africa, with roughly half the population under the age of 18year and the majority living as subsistence farmers. We aim to provide an overview of the provision for mental health care in Malawi by outlining the roles of the three Malawian psychiatrists currently working there and some of the impact that the COVID19 pandemic has had on their work.

Dr Alex Zumazuma is an Assistant Lecturer in the Department of Mental Health, Kamuzu College of Health Sciences and a psychiatry registrar undertaking the MMed in Mental Health. He has completed his basic training in Malawi and 2years in higher training at the University of Cape Town before returning this year to complete his final assessments.

Dr Jen Ahrens is an NHS psychiatrist in Tower Hamlets, a trustee of SMMHEP (Scotland Malawi Mental Health Education Project) and worked in Malawi as Head of Department of Mental Health at the College of Medicine from 2012-2105.

Overview and update on Community Transformation
Kiran Bhangu

Kiran Bhangu is a Programme Manager – Adult Mental Health, Mental Health Team | Operations & Information | NHS England and NHS Improvement.

Plenary 6
Chair: Dr Indira Vinjamuri

Dr Indira Vinjamuri is a general adult psychiatrist working within a crisis resolution home treatment team in Liverpool. She is the director of medical education at Mersey Care NHS FT and is the chair of the specialist advisory committee for the general adult faculty at RCPsych.

Mental Health Insight Covid Impact & UK Benchmarking Results 2021
Stephen Watkins

Stephen Watkins is Director of the NHS Benchmarking Network

Clinicians and Data – Analysis 1.01
Dr Asif Bachlani

- How to start on data analysis journey
- What data sets are available for clinicians to use to understand needs of local population.
- How to use NHS benchmarking data to get understanding of issues of adult trust services
- How to use data to get services commissioned
- Key enablers to support service development

Data science in mental health research: current challenges and emerging opportunities
Professor Robert Stewart

'Big data' are an increasing feature of the world today and are presenting new research opportunities where they relate to mental health. The focus of this presentation will be on the huge data resources accumulating in electronic health records as one example of this phenomenon. Now that we are beginning to address some of the early challenges around extracting the most clinically relevant information (particularly from text fields, given the extensive use of narrative in mental health service records), we need to find ways to translate this into the learning health system that could be realized not too far down the line. It's not an easy journey, and not helped by a tendency for innovations to be over-promised; however, neither is it a future we can ignore.

Robert Stewart is Professor of Psychiatric Epidemiology and Clinical Informatics at King's College London and works as a consultant old age psychiatrist at the South London and Maudsley NHS Trust. He has been academic lead for the Clinical Record Interactive Search (CRIS) data resource at SLaM since it was developed in 2007-8 as an innovative model for enabling research use of de-identified electronic health records data within a robust, patient-led governance framework. CRIS has supported over 250 research publications to date and has been widely replicated as a resource. Rob co-leads the DATAMIND mental health hub at HDR UK which seeks to develop and promote mental health data science in the UK.

Plenary 7
Chair: Dr Priya Natarajan

In conversation with Professor Linda Gask
Professor Linda Gask

Professor Linda Gask retired from clinical practice in 2013 after working a psychiatrist in the UK National Health Service in the North-West of England and an academic at the University of Manchester.

She is still affiliated to the Centre for Primary Care at the University of Manchester where she is now Emerita Professor of Primary Care Psychiatry. She also helped to establish the STORM suicide prevention initiative, is a non-executive director of Six Degrees Social Enterprise which provides psychological therapy services in Salford, and serves as Chair of the Blide Trust, a mental health voluntary organisation in Orkney.

She has worked as an advisor to WHO and has been on the Board of the World Psychiatric Association.

She has written about her personal experience of depression- as a professional and patient. She was a 2017 recipient of the Royal College of Psychiatrists President's Medal and last year was appointed as the Presidential Lead for Primary Care and community assets.

She now lives in Orkney but returned to work virtually during COVID to provide clinical supervision to Greater Manchester Bereavement Support Service.

Oral Presentations
Chair: Dr Andrea Tocca

An audit of the quality of risk assessments being documented into the Clinical Summary Portal (CSP)
Dr George Coates

Background
The CSP risk assessment was introduced in September 2019 as an initial phase of the CSP roll out. It is a simplified tool for documentation which encourages a formulation approach with more meaningful understanding of the patients' risk profile, in line with NICE guidance.

A succinct re-write of the previous risk assessment was required. Thereafter, editing only is required if there is significant change in the propensity to risk. The current situation is recorded in other parts of the CSP.

Results
53 sets of notes were assessed from 5 teams.

Quality of transcription - mean score 2.24 (range 1-5, SD 1.14). The median was 2, suggesting that the quality is poor, or between poor and fair.

Quality of the understanding of the nature of the risk – across 8 domains the mean scores ranged from 1.8-2.48. The median score was 2 (poor) for every domain.

Quality of the assessment of current risk– across 3 domains the mean scores ranged from 2.10-2.49, median of 2 for each domain, max SD 1.07.

Staff continue to enter their risk assessment in a timeline form (75%). Staff are not using a functionality called "Significant risk events", a section for the 'headline' risk events.

Conclusions
Staff are not transcribing the information from old to new risk summary, leading to poor quality of the new risk summaries. Despite an extensive training programme, the risk assessment remains a list of events.

Dr George Coates is currently an ST5 in General Adult Psychiatry, within the North West London deanery. Dr Coates also completed his core training in this location, having done his foundation years in the East Midlands. He grew up in East Yorkshire, between York and Hull. Within psychiatry Dr Coates is interested in PICUs and in how the information we gather and consider is documented and made available for others.

COVID vs. Capacity – A retrospective audit of capacity assessment documentation
Dr David Davies

Through retrospective audits of capacity assessment documentation on clerking and in the first ward round at Lambeth Hospital, it was possible to further evaluate the impact of the COVID-19 pandemic. Dr David Davies will present data showing a statistically significant decrease in documentation and discuss potential implications for clinical practice.

Dr David Davies is a Core Trainee 3 doctor in the South East Thames deanery including South London and Maudsley NHS Trust.

Analysis of Penetrating Neck Injuries (PNIs) at a South London Trauma Centre before and after the first national lockdown
Dr Gabriela Di Scenza

Introduction
Whilst globally GBH and gunshot wounds account for the majority of Penetrating Neck Injuries (PNIs), Deliberate Self Harm (DSH) and other accidents are responsible for a significant proportion of PNIs in the United Kingdom. It was speculated at the beginning of the pandemic that lockdown and its resultant effects would have a negative impact upon people's mental and physical wellbeing. We sought to compare differences in presentation of PNIs before and after the pandemic in St George's University Hospital, a major London trauma centre.

Method
A hospital database search was undertaken searching for all admissions with ICD-10 diagnostic criteria for all types of PNI. A further hand search of digital department handover records was reviewed. We recorded data on patient demographics, mechanism of injury, management, and outcomes.

Results
A total of 62 PNIs were identified from February 2019 to April 2021. The total incidence of recorded PNIs increased by 48.0% post lockdown (n=25 pre-lockdown to n=37 post-lockdown). A rise in DSH pre and post pandemic was noted. A previous 2009-2011 audit of PNIs in our trust revealed 48.0% were attributed to DSH, we noted a similar rate in our 2019/2021 audit with 40.7% of PNIs pre-lockdown, however this increased to 66.6% of PNIs post-lockdown, a total increase of 177.8%.

Conclusion
Before the pandemic only one patient with a pre-existing psychiatric condition was identified compared to 16 after. Subsequently, there was increased demand for inpatient mental health treatment post-injury reflecting an additional impact on mental health services experienced post-lockdown.

Dr Gabriela Di Scenza is a recent graduate of St George's University of London and Foundation Doctor at Poole General Hospital. She recently carried out an audit at St George's Hospital, Tooting studying the presentations of patients to the emergency department with Penetrating Neck Injuries and hopes to contribute to improvements in the quality of care that patients receive.

Implementation of a Multidisciplinary One Stop Assessment and Intervention Clinic (MOSAIC) within a Home Treatment Team

Dr Tobias Rowland

Aims and hypothesis

This Quality Improvement (QI) project aimed to; reduce the proportion of people referred to the Home Treatment Team (HTT) following their initial assessment, reduce the length of stay of those who were referred, reduce the waiting time for a medical review for patients under the HTT. A multidisciplinary approach to assessment would improve the overall quality of assessment and treatment of patients in crisis.

Background

Home Treatment Accreditation Standards states that the initial assessment of patients should include multidisciplinary team (MDT) assessment of needs, but involving different professionals often occurs over days to weeks. There may be a waiting time before a medical review depending on urgency and staff availability, which can delay an MDT formulation and commencement of appropriate treatment.

Methods

A new clinic 'MOSAIC' (Multidisciplinary One Stop Assessment and Intervention Clinic) was established within the HTT. Patients seen for an initial assessment were assessed by a nurse, and then returned to the waiting area for fifteen minutes while their case was discussed within an MDT meeting consisting of a psychiatrist, psychologist, clinical lead and support workers. Following the discussion and agreement of a biopsychosocial formulation and treatment plan, a psychiatrist and/or support worker could return to discuss the plan and treatment options with the patient, completing appropriate referrals or starting medical treatment if required.

Results

Baseline data were collected from 3 months prior to the start of MOSAIC, and for the first 100 patients seen under the new MOSAIC structure. The proportion of patients taken on by HTT reduced from 53% to 35%. The average length of stay remained the same between both groups at 29.7 days, although the proportion of patients with a 'long stay' (>42 days) reduced from 23% to 14% and the average number of contacts per treatment episode reduced from 15.7 to 12.4. The average waiting time for medical review reduced from 6.2 days to 0.1 days. Positive feedback was received from both staff and patients from anonymous feedback questionnaires.

Conclusions

MOSAIC is an efficient organisation of resources to improve the assessment process for patients referred to HTT, by involving an MDT in decision making from earliest opportunity. This improved efficiency by reducing the proportion of patients taken on by HTT, reducing the number of contacts during the episode and reducing the waiting time for medical reviews. The feedback indicated the clinic was well received by staff and patients alike.

Dr Tobias Rowland graduated medicine from Imperial College London in 2014 and completed his Foundation Training in London. Dr Rowland entered psychiatry training in 2016 in the West Midlands Deanery and completed an Academic Clinical Fellowship including an MSc in Health Research from University of Warwick in 2019. Dr Rowland is currently starting his ST6 year of General Adult Psychiatry higher specialist training in the West Midlands. He is interested in translational research that has practical implication for patients and clinicians to improve the quality and efficiency of mental health services.

Plenary 8
Chair: Dr Oliver Dale

Dr Oliver Dale is the Academic Secretary for the General Adult Psychiatry Faculty and is a Clinical Lead, H&F Community and Recovery Mental Health Services; Consultant Psychiatrist, South H&F Mental Health Integrated Network Team (MINT)Chair, Cassel Hospital Charitable Trust.

Community mental health care for people with complex emotional needs/a "personality disorder" diagnosis: how it is now and what needs to change
Professor Sonia Johnson

Professor Sonia Johnson will be presenting the results of a programme of rapid research, including reviews and qualitative study, commissioned from the NIHR Mental Health Policy Research Unit to provide policy makers with an evidence base on good practice for people with complex emotional needs (their preferred working term to describe service needs of people who may have a "personality disorder" diagnosis).

Evidence in this area strikingly lags behind that for other longer term mental health conditions. Current challenges for service delivery include stigma and highly inconsistent quality of care outside specialist services, fragmented systems of care which do not offer long-term therapeutic relationships, and lack of evidence to underpin service design. A range of specialist therapies tend to result in improvements for those who can engage in them, and have been the focus of most research in this area. However, there is little evidence on how to meet the social needs that service users prioritise, or on treatment outcomes for people with comorbidities, and younger and older people. Trauma is increasingly seen as very salient, but there is again a lack of evidence specific to this context on how to manage it.

Professor Sonia Johnson is an academic psychiatrist, currently Professor of Social and Community Psychiatry at University College London and Consultant Psychiatrist in Camden and Islington NHS Foundation Trust. She is currently Director of the NIHR Mental Health Policy Research Unit for England, and leads the UKRI Loneliness and Social Isolation Network. She is also Director of the MSc programme in the UCL Division of Psychiatry.

Recent Updates on Obsessive Compulsive Disorder
Dr Himanshu Tyagi

- Inform the audience about the latest scientific evidence behind OCD, its etiology, diagnosis, treatment and current controversies and challenges.
- Inform them of the basic neurobiology behind OCD and its pharmacological and psychological treatment.
- Discuss the impact of pharmacological and psychological interventions from a neurobiological point of view.
- Best examples of clinical practice from point of view.
- Neurobiologically focused on newer treatments like neuromodulation.

Dr Himanshu Tyagi is a medical psychotherapist and clinical academic neuropsychiatrist in the field of obsessive-compulsive and related disorders. He coordinated the first UK trial investigating Deep Brain Stimulation (DBS) in severe and treatment refractory obsessive-compulsive disorder (OCD) between 2012-2016 at UCL Queen Square Institute of Neurology. He holds a CCT in Psychotherapy (CBT), a PhD in neuroscience from UCL and was the recipient of Higher Psychiatric Trainee of the Year award from the Royal College of Psychiatrists, UK in 2012 and British Neuropsychiatric Association's Alwyn Lishman prize in 2017. He is also a co-founder and vice chair of the Royal College of Psychiatrists network for Obsessive-Compulsive and Related Disorders (OCARD). At present he runs a specialist

national clinic for OCD comorbid with Tourette syndrome at the National Hospital for Neurology and Neurosurgery, Queen Square and leads one of two specialist inpatient OCD services in England which is based in North London. He is also a co-investigator on the upcoming Op-TICS trial, looking at deep brain stimulation in patients with severe Tourette Syndrome. He routinely tweets about the latest OCD research and clinical practice tips at @himanshutyagi

Closing Plenary
Dr Billy Boland, Dr Oliver Dale, Dr Abdi Sanati, Dr Priya Natarajan, Dr Andrea Tocca

Poster exhibition

(by category, alphabetically by surname)

Education & Training

1. Case Report: Managing Psychosis, Alcohol Withdrawal and Refeeding Syndrome in an Acute Psychiatric Ward

Dr Oluwadamilola Ajayi*, Specialty Doctor, BEH MH NHS Trust, Dr Rachel Levett, CT2, CNWL NHS Trust*

Background

Refeeding Syndrome is a potentially lethal shift in fluid and electrolyte imbalance that results when malnourished patients are refed. A common but often missed complication of eating disorders, refeeding syndrome occurs in other psychiatric disorders and may present with treatment challenges. Initiating antipsychotic medications in patients with psychosis can worsen the risk of refeeding syndrome.

Methods

Summary: A 36 year old woman was admitted with persecutory delusions and aggressive behaviour. She had previously been diagnosed with persistent delusional disorder and was known to abuse alcohol. Nutritional status was poor; Body Mass Index at admission was 17.9. Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar) score was 22. Electrocardiogram tracing showed sinus rhythm and a corrected QT interval of 475ms. Admission blood tests showed low haemoglobin level (82 g/l), thrombocytopenia, mild hypophosphatemia, mild hypokalaemia and deranged liver enzymes. She was commenced on alcohol detoxification. Antipsychotic medication regularly used on previous admissions was withheld despite her agitated behaviour. She requested and was given Ensure in addition to her regular meals. Over the next 48 hours, in addition to ongoing delusional beliefs, she exhibited confusion, irritability, dizziness and generalised weakness. Repeat blood work showed severe hypophosphatemia, hypomagnesemia and hypokalaemia. Refeeding syndrome was suspected and a referral made to an acute hospital for further management.

Results

Despite some initial resistance, this patient was eventually accepted for treatment in the acute hospital setting. She had electrolyte replacement with intravenous phosphate, magnesium and potassium. She also had an intravenous iron infusion in view of iron deficiency anaemia. She had a dietician review recommending weekly weight and nutrition monitoring. She returned to the ward where oral vitamin supplements continued. Her delusional beliefs, agitation and aggression spontaneously resolved.

Conclusions and next steps

Patients with alcohol dependence, eating disorders and uncontrolled diabetes are at risk of refeeding syndrome. Prescribing psychotropic medications must be actively avoided as they can contribute to the complications of refeeding syndrome which includes arrhythmias, hypotension and seizures. Electrolytes may be deranged or normal at admission; serial monitoring is required to detect emerging imbalances. Refeeding following malnutrition or starvation in an acute psychiatric inpatient setting would benefit from the input of a dietician.

2. Experiential Analysis of Contemporary Films with Themes on Black Mental Health, Racism and Racial Trauma

***Dr Olufemi Talabi**, CT2, Essex Partnership University Trust , Ms Oluwafunminiireayomi Shonibare, Medical Student, University of Southampton, Dr Abisola Ogundalu, Consultant, Cheshire and Wirral Partnership NHS Trust, Dr Olukemi Akanle, Consultant, Central and North West London NHS Foundation Trust, Dr Mosun Fapohunda, Consultant, Hertfordshire Partnership NHS Foundation Trust, Dr Toyin Omojuwa, Consultant, Oxleas NHS Foundation Trust, Dr Mona-Lisa Kwentoh, Tees, Esk and Wear Valleys NHS Foundation Trust, Dr Rasheedat Ibrahim, Essex Partnership University Trust , Dr Rasheedah Bankole, Lancashire and South Cumbria NHS Foundation Trust, Dr Isioma Nwokolo, Dorset Healthcare University Foundation Trust, Dr Akeem Sule Consultant, Essex Partnership University Trust, Wolfson College, Cambridge University*

Aims and Hypothesis

To discuss films and documentaries about black lives and racial trauma with a view to finding recurring themes about black mental health and our lived experiences of racism and racial trauma.

Background

The last year has seen racism and racial trauma at the forefront of culture and the media. In the wake of George Floyd's murder and the ensuing prominence of the Black Lives Matter movement, discourse on racism and its legacy has become ubiquitous. The COVID-19 pandemic had a disproportionately negative impact on black lives, further propelling the experience of marginalised populations into the
limelight. The issue of black mental health became urgent as the discussion shifted to the impact of social isolation and misinformation.
The Association of Black Psychiatrists, UK (ABP-UK) was birthed from this imbroglio in 2020. As we sought to educate ourselves about the black narrative and find words to articulate our experiences, a film club emerged. It is common knowledge that film is useful in teaching psychiatry, law and medical sociology.
The film club comprises doctors at all levels and medical students affiliated with ABP-UK. We aim to look at how racism and racial trauma inform black mental health and how the media may inform black mental health.

Methods

Movies and documentaries from across the globe featuring the intersection of racial trauma and black mental health are selected. The feature for the month is watched individually, with a film club discussion occurring virtually once a month. Discussions are centred on the plot, characters, mental health correlations, and themes relative to our own lived experiences. We then note major or recurring themes.

Results

To date, we have watched "Thirteenth", a documentary by Ava DuVernay, and two movies, "Da Five Bloods" by Spike Lee and "Red, White and Blue" by Steve McQueen. The first two screenings originated from the United States and the last from the UK. The emerging critical themes from the screenings and our lived experiences are institutional or systemic racism, differential attainment, vicarious trauma, stigma, and the law.

Conclusions

Key themes underpin black mental health and racial trauma in the UK and the United States. If studied further, these themes could potentially be targeted to improve the lived black experience and, in turn, black mental health. Cinema remains an impactful tool in understanding social discourse.

Quality Improvement

3. Is mobile ECG the way forward to improve the cardiovascular monitoring in community psychiatry?

Dr Darshana Arakkal, *CT2 trainee, West London NHS Trust, Judit Palankai, Physical Health Nurse, EIS, West London NHS Trust, Dr Jose Maret, Consultant, Hammersmith & Fulham EIS, West London NHS Trust*

Aims and Hypothesis

We aim to improve the cardiovascular monitoring of the patients under the Hammersmith & Fulham Early Intervention Services (EIS) by 5% in 3 months and 20% every year by implementing interventions to promote the general physical health.

Background

It is well established that severe mental illness contributes to a reduced life expectancy of up to 20 years. The various contributory factors include increased risk of cardiovascular disease and metabolic syndromes associated with the use of atypical antipsychotics, smoking, substance misuse and inadequate physical health monitoring. We have a robust physical health monitoring system in place which uses high visibility prompts to increase the adherence to guidelines for physical health monitoring.

Methods

A QIP was developed which was registered with the LifeQI project. Retrospective data of 122 patients under the EIS were collated by manual search of the database over a period of 2017 - 2020. The primary care of each patient was contacted to identify the ECG monitoring with them. Following the discussion of the results at the CIG (Clinical Improvement Group) meeting, a driver diagram was developed with the probable interventions to improve the ECG monitoring and resulted in the process of piloting the use of mobile ECG to improve the cardiovascular monitoring of our service users.

Results

A baseline audit identified that there is reduced adherence to national and trust guidelines for ECG monitoring in patients on antipsychotics under the Hammersmith & Fulham EIS. Fragmentation of care between the mental health and various primary care services was identified as the major barrier to regular physical health monitoring which was further impacted by the pandemic. In 2018 and 2019, 50% of our patients had annual ECG whereas in 2020, it was reduced further to 24%. 11% of the ECGs were completed by the primary care whereas 46% by EIS.

Conclusions and next steps

Barriers to routine health monitoring were identified and the fragmentation and disintegration of care with primary care services was identified as the major deterrent in following the national guidelines for the physical health monitoring. This QIP suggest that further validation with the completion of PDSA cycle needs to be performed to evaluate if the implemented use of KardiaMobile ECG may improve the cardio-metabolic monitoring in patients on anti-psychotics in the community and is being currently rolled as a pilot project.

4. Virtual social interaction for trainees- a QI project

Dr Sruthi Easwaran Iyer, *CT2, Mersey Care NHS Foundation Trust, Dr Indira Vinjamuri, Director of Medical Education, Mersey Care NHS Foundation Trust*

Aims and Hypothesis

To evaluate whether a virtual space provided for trainees helped with social isolation at work during the pandemic.

Background

COVID 19 was classified as a pandemic in March 2020 by the World Health Organisation. As the government implemented legal restrictions on group meetings due to the pandemic, teaching was moved to a virtual platform. This resulted in trainees having no/limited social contact with the peers.

Methods

To help trainees have some social contact, the Medical Education Team started a quality improvement project focusing on helping trainees with social isolation. The virtual meeting time for teaching was extended for trainees to interact after teaching so that they could provide support to each other. This quality improvement was carried out between February 2021 and July 2021. Two surveys were sent to junior doctors of different grades within Mersey Care NHS Foundation Trust , one during the start of the semester and one after 3 months to evaluate.

Results

The initial survey showed that ninety percent of the trainees who responded felt more isolated since the start of pandemic. There was a mixed response with regards to the virtual space provided after teaching to meet peers. Trainees were not sure how likely they were to benefit from the virtual meeting space. The survey at three months suggested that most trainees could not use the virtual space provided due to clinical commitments. The remaining trainees however felt that they either felt zoned out after teaching due to increased screen time or meeting trainees virtually felt impersonal and they would rather wait to meet face to face when the restrictions would ease.

Conclusions and next steps

The survey indicated that although trainees felt isolated due to the pandemic, a virtual platform was not ideal for them to interact with peers. This was attributed to work commitments and effects of increased screen time. Personal interaction was preferred to virtual meetings.

Recommendation: Trainees value meeting face to face and work needs to be done to facilitate this and perhaps try hybrid teaching models.

5. Covid 19 vaccine uptake in PICU

***Dr Sharmistha Ghosh**, ST5, Leeds and York Partnership Foundation Trust, Dr David Leung, Consultant, Leeds and York Partnership Foundation Trust*

Aims and Hypothesis

The project aims to investigate if there is correlation between Brief Psychiatric Rating Scale (BPRS) scores and covid-19 vaccine acceptance/refusal among the patients on the Psychiatric Intensive Care Unit (PICU) in Leeds UK. We hypothesised that vaccine uptake amongst PICU patients would be inversely proportional to BPRS score.

Background

Since the national introduction of the covid-19 vaccine it is noted that acceptance by patients on PICU is low. This is concerning given the increased physical comorbidity of our patient population. We were unclear if vaccine refusal correlated with severity of symptoms of mental disorder. We wondered if acceptance of vaccine at a later date by a patient who had previously refused reflected improvement of their mental health.

Methods

We used the BPRS to determine the severity of the symptoms that the patient was experiencing at the time that they were offered the covid-19 vaccine. This scale was administered to the patients at the point of offering vaccination and scores were recorded. For the purpose of this project, we included all patients admitted to PICU who had not yet consented to their vaccine. We excluded patients who were deemed too behaviourally disturbed to engage in 1:1 assessments, eg patients needing nursing in seclusion or eye sight observation as discussion would have been difficult at this point . We offered the vaccine as part of the patient's treatment plan and recorded their response to the offer of vaccine (acceptance or refusal) and if any reason was cited for their decision. This was done over a 3 month period.

Results

Among the 19 vaccine doses offered, 5 were accepted, 1 patient was indecisive about acceptance and 13 vaccination offers were refused. It was noted that for the first 6, BPRS scores ranged between 20 and 25. For the 13 vaccine refusals scores ranged from 28 to 49. We had the opportunity to offer the vaccine to 2 of the 13 patients who had previously refused when their mental health had improved. In both cases, the patients accepted the vaccine and the BPRS score at this time had lowered.

Conclusions and next steps

It was found that patients with a higher BPRS score (those in the range of 28 to 49) refused vaccination in all cases, with lower scoring patients accepting vaccination or being ambivalent to vaccination. Vaccination uptake was thus found to be inversely proportional to BPRS score, as was hypothesised.

6. "PD & Me": What mental health services need to know about personality disorder

***Dr Adrian Hayes**, ST8 Medical Psychotherapy and General Adult Psychiatry, AWP NHS Trust, Stephanie Hares, Senior Lived Experience Practitioner, AWP NHS Trust, Tori Otero, Lived Experience Lead, Beyond Barriers CIC*

Introduction

People diagnosed with a Personality Disorder can be maligned and disliked within mental health services.

Their experiences in services can be re-traumatising, re-enacting difficult relationship styles from their past.

We aimed to give a voice to people with this diagnosis, to share their experiences, be heard, and make recommendations for change. The project was fully coproduced from funding application though to dissemination.

Methods

We ran face to face and online workshops for people with a PD diagnosis, or related to parts of the diagnosis. In semi-structured focus groups, they described their experiences and the effects of these.

They went on to feed back individually and in groups using creative means. We convened a feedback session for staff to hear and see their work.

Results

Nineteen current or recent service users took part either in workshops or fed back.

A total of 72 staff attended the feedback session, including psychiatrists, psychologists, board members,

care coordinators, police, GPs, hospital liaison, and AMHPs. At this event there were 12 contributions of

presentations, videos, collage, artwork and poetry.

Workshop Themes

- I am treated differently by services because of my diagnosis of PD
- I need staff to know more about the condition and how it affects me
- Services are not available when I need them
- What is important? Individual care, consistency, understanding of trauma, listening, and connection

Discussion and Next Steps

Feedback about the project was uniformly positive from service users and staff. Service users reported feeling heard and having a purpose, whilst staff described the material as powerful and moving. Contributors continue to work on projects including producing a leaflet 'What my Care Coordinator needs to know about Personality Disorder', artwork will be published in the Trust art magazine, and the group has been asked to contribute to further work by the Executive Board as well as research priorities and future service developments.

7. Understanding patient experience of virtual contact during the covid-19 pandemic - A pilot quality improvement project

***Dr Shannon Hilton**, CT2, SLaM NHS Trust, Dr Lisa Conlan, Consultant Psychiatrist, SLaM NHS Trust*

Aims and Hypothesis

This pilot quality improvement (QI) project sought to gather views of patients cared for by a mood and personality community team on the use of virtual appointments during the covid-19 pandemic. We hypothesised that most patients would have strong opinions either for or against the use of virtual appointments.

Background

Since March 2020, many NHS departments have moved from in-person to virtual appointments as a result of the ongoing covid-19 pandemic. Current working arrangements are required to protect the health of patients and staff, by minimising social contact from appointments and travel. Whilst telemedicine has existed in some NHS clinics pre-covid, it is generally underused and not part of routine practice. The pandemic therefore gives us a unique opportunity to ask about patients' experiences when forced to operate virtually by circumstance.

Methods

A short (9 item) questionnaire was designed to capture data on type of contact received, patient experience of this (assessed by a 5-point Likert scale), preference for future contact and free text space for qualitative feedback. The questionnaire was sent via email to 65 patients currently on the community team caseload, selected on the basis they had been seen by colleagues collaborating on the project in the previous six months and had access to an email account.

Results

We received 14 responses from the 65 patients contacted, representing 13% of the total caseload. Patients who received video-call appointments more frequently reported liking this method of communication than disliking it with either care co-ordinator or doctor (52% vs 36%). For future communication, mostly patients would choose not to have video calls, although a substantial number would like to be offered the choice and a minority would like to be offered them (44% vs 37% vs 19%). The main theme of qualitative data emphasised people's experience of mental health symptoms impacting on the acceptability of appointment type, with arguments offered both for and against virtual communication. Patients, including those expressing a preference for in-person meetings, understood the need for virtual appointments during the pandemic. There was little mention of virtual communication being more convenient for patients.

Conclusions and next steps

Patients have a wide range of views on virtual communication both during and after the pandemic with many feeling strongly for or against it. These results highlight that patients in our mood and personality disorder service value in-person communication and want to be offered a choice in their care post-pandemic.

8. Developing a new Drug and Alcohol Liaison Service in the Royal Edinburgh Hospital

Dr Rebecca Lawrence*, Consultant Addictions Psychiatrist, NHS Lothian, Dr Rosemary Gordon, ST4 General Adult Psychiatry, NHS Lothian, Dr Ben Meadowcroft, ST4 Generał Adult Psychiatry, NHS Lothian*

Aims and Hypothesis

The aim was to set up and evaluate a liaison service to psychiatric in-patients with co-morbid drug or alcohol problems. The service aimed to ensure safe prescribing (including the provision of take-home Naloxone), offer specialist assessment if required, ensure appropriate follow up and offer training opportunities for Junior Doctors. This was supported by NICE guidelines and was a response to the rise in drug deaths in Scotland.

Background

The Royal Edinburgh Hospital (REH) is a psychiatric hospital in Edinburgh and consists of General Adult Psychiatry (GAP), Psychiatry of Older Adults (POA), Intellectual Disability, Rehabilitation and Forensic wards. The Ritson Clinic is the drug and alcohol in-patient ward at the REH. A reduction in Ritson Clinic beds due to Covid-19 provided an opportunity to create the service.

Methods

A Standard Operating Procedure was created which defined the objectives, standards and referral process. The team consisted of Consultants, Junior Doctors, Charge Nurses, Secretarial and Pharmacy staff in the Ritson Clinic. An email address and poster were shared. Referrals were made by phone or email. Same-day telephone advice was offered during working hours, and face to face patient reviews arranged within 48 hours if required. Referrals were recorded in a database, including information on ward, diagnosis, drugs/alcohol, advice or intervention. Feedback was gathered via a satisfaction survey of in-patient doctors.

Results

60 referrals were received between 28th September 2020 and the 8th June 2021. 47 came from GAP, 9 from Rehabilitation, 3 from POA and 1 from Forensic Psychiatry. 17 were alcohol related and 40 were drug related. Feedback was received from 10 doctors in the REH. 8 rated the likelihood of referring as 5/5. All 6 doctors who had previously referred to the service rated its usefulness as 5/5. The service was described as ‘vital’, ‘hugely important’ and ‘excellent’.

Conclusions and next steps

There is a need for a drug and alcohol liaison service within the REH. This new service has met this need and been positively received. In addition to improving patient care, the service has provided further training opportunities for junior doctors. The next steps are to continue to develop the service and increase awareness within the REH.

9. Food For Thought: Highlighting the Importance of Weight and Nutrition in Patients under the Early Intervention in Psychosis Service in Sheffield

Dr Pranav Mahajan*, ST6, Sheffield Health and Social Care NHS Foundation Trust, Dr Hina Ali, CT1, Sheffield Health and Social Care NHS Foundation Trust, Dr Reem Abed, Consultant, Sheffield Health and Social Care NHS Foundation Trust*

Aims and Hypothesis

Evaluate staff understanding regarding weight gain and nutrition in service users (SUs) under the Early Intervention Service (EIS) in Sheffield

Background

People with serious mental illness are at higher risk of developing cardiovascular and metabolic disease. This contributes to a 20-year lower life expectancy in those with Schizophrenia or Bipolar Affective Disorder. NHS England state this disparity contributes to 12,000 extra deaths per year. Weight gain and metabolic effects are driven by the effects of medication, relative inactivity (illness or medication driven), poor diet and nutrition. Weight gain also contributes to difficulty with self-image and self-esteem, leading to negative cognitions and poor adherence with treatment. In the 2020-21 National Clinical Audit of Psychosis, 47% of SUs required intervention due to their BMI.

Methods

In May 2021, a survey was given to all staff in the Sheffield EIS team asking them about their understanding of weight gain and nutrition in SUs and evaluating their confidence in discussing these issues with SUs.

Results

Q1: I feel confident giving nutritional advice. 78% agree, 22% disagree. Q2: I feel comfortable asking about weight. 94% agree, 4% disagree. Q3: What dietary advice do you give? 74% more fruit and vegetables, 34% low fat diet, 34% low carb diet, 8% low calorie intake, 8% less snacking, 4% anti-diet approach. Q4: Weight gain is an inevitable consequence of antipsychotics. 34% agree, 65% disagree. Q5: What are the barriers to offering advice around nutrition? 78% lack of training, 52% lack of time, 8% not a priority, 39% lack of confidence.

Conclusions and next steps

A fifth of respondents lacked confidence in giving nutritional advice and this was a significant barrier to providing advice along with lack of training and time. When advice was offered, it was inconsistent leading to conflicting ideas. Interestingly, a third of staff members felt weight gain was inevitable in those taking antipsychotics. To address the findings of lack of confidence, training and inconsistent advice, staff were given a tutorial regarding weight and nutrition with a junior doctor and a person with lived experience of weight loss. 100% of attendees found the session useful. This was further presented to the trust grand round, in which 100% of respondents fedback that the content was good/very good and 94% rated the educational value the same. This project highlighted the importance of staff competence and confidence in addressing weight gain and encouraged staff to make nutritional advice a key intervention in their treatment plans.

10. Improving physical health management on an inpatient adult psychiatry ward

Dr Ebrahim Adnan Patel*, FY2, Sheffield Health and Social Care Trust, Dr Nicoletta Lekka, Consultant, Sheffield Health and Social Care Trust, Dr Ketan Dhital, Sheffield Health and Social Care Trust*

Aims and Hypothesis

To evaluate physical health management on an acute adult inpatient psychiatry ward and increase uptake of physical health reviews. To ensure all patients receive a weekly physical health review alongside mental health reviews and to improve documentation.

Background

Severe mental illness and initiation of antipsychotics results in significant physical health burden for acute inpatients. Physical health reviews should routinely be conducted however can be overlooked due to other clinical/mental health needs.

Methods

The first cycle involved offering voluntary 'physical health clinics' held by junior doctors to identify and manage both acute and chronic physical health issues. Review notes were clearly titled 'Physical health review'. Electronic notes were reviewed both retrospectively and prospectively. The second cycle consisted of brief (<20 minutes) mandatory weekly physical health reviews for patients held either face to face or via board round with nurses. Patients were excluded if their LOS was <7 days.

Results

Before introduction of optional physical health clinics, only 20 physical health reviews and 7 urgent reviews over a 6-week period were performed (n=41). After introduction of the clinics, 42 patients underwent 25 clinic reviews, with 9 urgent visits and 29 visits outside of 'clinics' of which half were for 2 patients. For the second cycle, in the 4 weeks prior (n=17), only 12 physical health reviews out of a possible 46 had been performed (26.1%), 17 physical health issues were identified and mean time since a physical health review was 17.8 days. After 4 weeks (n=9), 29/36 (80.5%) reviews were performed, and 2 patients refused face to face reviews. Mean time since review was <7 days and 42 physical health issues were identified. One visit occurred outside of the allotted review. After both cycles documentation for reviews were 100%.

Conclusions and next steps

Results from this audit and improvement project suggest that mandatory weekly physical health reviews can identify more physical health problems, ensure most patients receive a weekly review, mitigate non-engagement through board rounds and better manage staff time through fewer ad hoc reviews when compared to an optional 'clinic' model. The team has now settled on weekly reviews led by junior doctors and a physician associate, as well as MDT discussion of any complex health issues. A guide document for holding these reviews was made, and staff are reminded on induction to perform weekly reviews and ensure clear documentation.

11. Deep dive audit of Absent Without Leave ('AWOL') incidents

***Dr Leonardo Pinto Outes**, CT2, KMPT, Dr Andreea Steiu, CT3, KMPT Dr Lucia Laskowski, CT3, KMPT, Dr Vijay Delaffon, Consultant Psychiatrist, KMPT*

Aims and Hypothesis

The primary aim of the quality improvement project was to audit compliance with the Absent Without Leave ('AWOL') Policy in Kent and Medway NHS and Social Care Partnership Trust ('the Trust'). The secondary aims were to recognise areas of poor compliance, identify barriers to prevent AWOL incidents, and outline a model to reducing their number.

Background

'AWOL' has specific meaning for patients detained under a section of the Mental Health Act 1983. The Trust's AWOL Policy ('the Policy') outlines the procedures to be adopted for locating and returning absconding patients.

Methods

Patients meeting the inclusion criteria of having been AWOL between 04/04/2020 and 26/10/2020 were identified from the Trust's electronic incident reporting system ('DATIX') records. The sample comprised of 108 cases of AWOL across 68 patients. Six standards and 12 additional variables were outlined from the policy. The data was collected from DATIX records and Electronic Patient Records.

Results

The police were informed immediately for 75% of the patients with moderate/high risk, and 88.9% within 2 hours when low risk. 75.9% of patients were reviewed by nurse or doctor upon return. 68% of the patients were reviewed in a multi-disciplinary team meeting or ward review the next working day. 74% had the incident discussed at the following ward review for clinical decision making. 67.6% of the patients had their risk assessments/management plans updated following the incident. The Serious Incident Process was implemented in 13.9% of the cases. 72.1% of AWOL patients were between 19 and 40 years old, 89.7% were smokers, with an equal ratio of males and females. 63% of the incidents happened within the first month of admission, and 72.2% were not the patient's first absconsion. 38.2% of patients had a psychotic illness as primary diagnosis, and 72.2% were on general observation prior to being AWOL. Only 46.3% had absconding care planned for.

Conclusions and next steps

Compliance with policy has been suboptimal. The results will be discussed in consultants meeting, and circulated to the wards for awareness of areas of poor compliance. A template form for risk assessment for doctors will be improved to include AWOL risk as well as a template for post AWOL assessment by nurse or doctor. The policy will be reviewed accordingly. We will also incorporate the nicotine replacement therapy prescribing as a variable for the next cycle for patients with smoking status.

12. Is Richmond Home Treatment Team compliant with the Trust Policy on Medicines Reconciliation?

Dr Leonardo Pinto Outes, *CT2, SWLSTG MH NHS Trust, Dr Sasha Francis, Consultant Psychiatrist, SWLSTG MH NHS Trust*

Aims and Hypothesis

The quality improvement project was designed to enhance compliance of the Richmond Home Treatment Team ('RHTT') with St George's and South West London NHS Mental Health Trust's Policy on Medicines Reconciliation ('the Policy').

Background

George's and South West London Mental Health NHS Trust's Policy on Medicines Reconciliation ('the Policy'). Background: Medicines reconciliation is the process of liaising with a patient and other systems to ensure complete and accurate documentation of their medication. This is normally carried out at initial assessment ('INA') when a patient is new or transferred between services. This process involves identifying a list of medicines which the patient is currently prescribed and comparing this with their current prescription, documenting any changes and inconsistencies, generating an accurate list of medicines. The goal is to reduce the risk of harm to patients.

Methods

37 patients met the inclusion criteria (being in the caseload of HTT on 27/05/2021). We elicited seven standards from the Policy. Data was collected retrospectively from patient electronic records ('RiO'), Electronic Health Information Exchange ('HIE viewer', a shared GP interface), and Summary Care Record ('SCR').

Results

97.3% of the patients had their medicines reconciliation completed at INA. Of these, 77.8% were recorded only on progress notes, while 22.2% were recorded on both Gatekeeping Assessment Form ('GKA') and progress notes. 54.1% of patients had the names/doses of all medicines taken/prescribed accurately documented. In contrast, 37.8% of patients had inaccuracies or omissions of names/doses of either mental or physical health medicines. 8.1% did not have any medications prescribed, and this was accurately documented for all patients. 51.4% of patients had allergies or severe adverse reactions to medicines documented. Similarly, 56.8% had any evidence of discussion about consent to access SCR documented. The adherence to medication was documented for 4.9%. The majority (83.8%) had no data source documented.

Conclusions and next steps

The findings show a suboptimal recording of medicines reconciliation in the INA, especially regarding accuracy of names/doses of medications, documentation of data sources, and allergy status. These findings have been discussed in governance meeting and disseminated to the team managers of RHTT and the Acute Care group, highlighting the Policy along with the recommendation of the INA template/GKA form for medicines reconciliation to be amended with all standards clearly outlined. Most referrals in the Trust are now triaged by a different team, with the majority of INAs carried out by them before transfer to RHTT caseload. A re-audit will be conducted in August 2021.

13. Implementation of MOSAIC (Multidisciplinary One Stop Assessment and Intervention Clinic) within a Home Treatment Team

Dr Tobias Rowland*, ST6, Coventry and Warwickshire Partnership Trust, Dr Sanjay Khurmi, Consultant Psychiatrist, Coventry and Warwickshire Partnership Trust*

Aims and hypothesis:

This Quality Improvement (QI) project aimed to; reduce the proportion of people referred to the Home Treatment Team (HTT) following their initial assessment, reduce the length of stay of those who were referred, reduce the waiting time for a medical review for patients under the HTT. A multidisciplinary approach to assessment would improve the overall quality of assessment and treatment of patients in crisis.

Background:

Home Treatment Accreditation Standards states that the initial assessment of patients should include multidisciplinary team (MDT) assessment of needs, but involving different professionals often occurs over days to weeks. There may be a waiting time before a medical review depending on urgency and staff availability, which can delay an MDT formulation and commencement of appropriate treatment.

Methods:

A new clinic 'MOSAIC' (Multidisciplinary One Stop Assessment and Intervention Clinic) was established within the HTT. Patients seen for an initial assessment were assessed by a nurse, and then returned to the waiting area for fifteen minutes while their case was discussed within an MDT meeting consisting of a psychiatrist, psychologist, clinical lead and support workers. Following the discussion and agreement of a biopsychosocial formulation and treatment plan, a psychiatrist and/or support worker could return to discuss the plan and treatment options with the patient, completing appropriate referrals or starting medical treatment if required.

Results:

Baseline data were collected from 3 months prior to the start of MOSAIC, and for the first 100 patients seen under the new MOSAIC structure. The proportion of patients taken on by HTT reduced from 53% to 35%. The average length of stay remained the same between both groups at 29.7 days, although the proportion of patients with a 'long stay' (>42 days) reduced from 23% to 14% and the average number of contacts per treatment episode reduced from 15.7 to 12.4. The average waiting time for medical review reduced from 6.2 days to 0.1 days. Positive feedback was received from both staff and patients from anonymous feedback questionnaires.

Conclusions:

MOSAIC is an efficient organisation of resources to improve the assessment process for patients referred to HTT, by involving an MDT in decision making from earliest opportunity. This improved efficiency by reducing the proportion of patients taken on by HTT, reducing the number of contacts during the episode and reducing the waiting time for medical reviews. The feedback indicated the clinic was well received by staff and patients alike.

14. Impact of isolation from COVID swabbing upon admission of acute female in-patients

***Dr Sarah Saeed**, CT2, Leeds and York NHS Trust, Dr Barbara McHarg, Consultant Psychiatrist, Leeds and York NHS Trust, Dr Nadadhur Dasarathi, Specialty Doctor, Leeds and York NHS Trust, Dr Sian Jones, FY2, Leeds and York NHS Trust*

Aims and hypothesis

To streamline swabbing procedures for acute in-patients to reduce isolation duration and minimize the impact of isolation on patients.

Background

Patients within an acute female in-patient ward were observed struggling with adherence to isolation guidelines following their COVID swab upon admission. This was corroborated by the days of isolation being directly proportional to the level of negative mental health impact on service users.

Methods

To assess the severity of impact on patient's mental health staff assessed all patients admitted to the ward. Patients were excluded if they were isolating for 14 days due to a recent contact with COVID positive patient or if they did not consent to COVID-swabbing.

Patients were categorized based on the following groups:

- Mild Impact: Minimal changes in mental state / presentation upon admission, coping well with isolation measures, compliant to restrictions and medications, no changes in management plans.
- Moderate Impact: Moderate changes in mental state / presentation, intermittent compliance to restriction / isolation measures and requiring some changes in management plans like increased prescription of anxiolytics, sedatives, laxatives.
- Severe Impact: Considerable change in mental state / presentation, non-complaint to restriction / isolation measures, increase in level of observations, requiring rapid tranquilization or restraint.

Results

In total 48 patients admitted between December 2020 and February 2021 were assessed.

1. The average number of days of isolation was 1.6 days for people with negative swabs. The longest isolation time for a pending admission swab result was SIX DAYS.
2. 58% of patients were impacted negatively due to isolation based on the data collected.
3. All patients isolating for 3 or more days were impacted negatively with 75% falling into the severe category. 65% of patients who only had to isolate for up to 1 day had no impact on their mental health.

Conclusions

The increased duration of isolation is associated with a greater severity of impact. Patients isolating for 3 or more days had a greater negative impact on their mental health.

Next steps

- Given the results, all patients swabbed should isolate for less than 2 days
- Rapid Point of Care Covid-19 Diagnostic Testing machines should be introduced on psychiatric wards to offer instant results and minimise isolation times.

15. Connecting the continents - TelePsychiatry in the NHS

***Dr Madhavan Seshadri**, Locum Consultant Psychiatrist, Hereford Medical Group Neighbourhood Mental Health Team & Community Eating Disorders Team, Herefordshire and Worcestershire Health and Care NHS Trust, Dr Sue Lamerton, Locum Consultant Psychiatrist, Hereford Medical Group Neighbourhood Mental Health Team, Herefordshire and Worcestershire Health and Care NHS Trust, Dr Barnaby Major, Associate Medical Director, Herefordshire and Worcestershire Health and Care NHS Trust*

Introduction

Over the years NHS providers have repeatedly been forced to adapt to meet the changing demands of the populations they serve and the contexts within which they function. With the COVID pandemic many services as well as patients have suffered. Herefordshire and Worcestershire Health & Care NHS Trust like elsewhere, rapidly moved to teleconsultations over a variety of formats and platforms. Psychiatric services in the NHS predominantly function in a multidisciplinary model and audio-visual telecommunication platforms have enabled this to continue in teams alongside the need to maintain social distancing. Most MDT staff working within the United Kingdom are based in the UK.

The first author of this article previously worked as a substantive consultant in Herefordshire for six years. He since relocated to India during the CoVID pandemic. With international borders closed he subsequently rejoined the trust but as a trust locum consultant psychiatrist; however this time working entirely remotely from his base in Chennai (Southern India).

Setting the service

In this poster the authors discuss their experience of setting up a locum consultant post in psychiatry entirely remotely, from of outside the UK, including the medico-legal, information governance, risk, safety, quality and patient experience processes and considerations.

Initial Experience

The first author has been working remotely for more than three months with neighbourhood mental health services as well as an eating disorder service in Herefordshire. He has provided more than 100 consultations; more than 90 of these through telephone software installed on the laptop (Cisco Jabber); the remaining were video consultations. He has also actively participated in MDTs, managerial meetings contributing to service development, SI review processes, peer group and CPD activities. He discusses the challenges faced, advantages, limitations and initial patient and colleague feedback.

Guidelines and Resources

The authors have discussed guidelines and useful reference documents from the GMC, Royal College of Psychiatrists, medico-legal organisations as well as other national bodies.

16. Questionnaire to assess attitudes of patients on level of involvement of medical students during psychiatric consultations

Dr Matthew Short, F2, North-East London Foundation Trust, Dr Miriam Mallet, CT3, North *East London Foundation Trust, Dr Jonathan Keay, Fellow in Medical Education, North East London Foundation Trust, Dr Peter Carter, Consultant Psychiatrist, North East London Foundation Trust*

Aims and Hypothesis

To assess if patients felt that it was important that medical students gained first-hand experience of psychiatric consultations. To evaluate whether patients would be happy to have student involvement in their care and which modalities of involvement would be agreeable to them. We hypothesised that patients do recognise the importance of students gaining this experience and consequently that most would be happy to have students attend the consultations physically. Further, we hypothesised that patients would be amenable to having students present in consultations virtually or over the telephone, which at present is the way many psychiatric consultations are being held.

Background

Currently, the degree of first-hand psychiatric exposure for medical students within North East London Foundation Trust is limited due a reduction in face-to-face appointments. Services have stated that they cannot take on students in person due to social distancing. Consequently, students are likely to have reduced contact with mental health patients. This may hinder their learning and lessen the chances of pursuing a career in psychiatry.

Methods

A ten-question questionnaire was created with each question having a 5-point Likert scale, with an additional comments section at the end. Questionnaires were handed out to patients at the Jane Atkinson centre in Waltham Forest. Patients were selected if they were attending for a mental health service appointment. The results from the questionnaires were inputted into a spreadsheet and the data was evaluated.

Results

28 responses were collected. 93% of respondents either Agreed or Strongly Agreed that it is important for medical students to gain first-hand experience of psychiatric consultations. There was a preference for in-person attendance (in consultation room or home) over virtual attendance on either telephone or video messaging, but the majority were happy with all options of attendance. There was also a preference for a lower number of students present on a telephone or video call – A majority did not want more than two students listening in at a time. 86% of respondents either agreed or strongly agreed that they would be happy with students asking questions during consultations.

Conclusions and next steps

As predicted, the majority of patients polled were in agreement that it was important for medical students to gain first-hand experience of psychiatric consultations, and were happy to have students ask questions. There was a preference for cameras to be on and microphones to be unmuted if students were attending virtually, presumably due to transparency.

17. Audit and Re-audit Assessing Compliance with Trust Guidelines for Antipsychotic Monitoring on Oakwood War

***Dr Sabina Smith**, CT3, Cumbria, Northumberland, Tyne and Wear, Dr George Severs, CT2, Cumbria, Northumberland, Tyne and Wear, Project Supervisor, Dr Roger Cable, Consultant Older Age Psychiatrist, Cumbria, Northumberland, Tyne and Wear*

Aims and Hypothesis

Audit and re-audit assessing compliance with antipsychotic monitoring guidelines on an acute elderly ward and interventions to improve compliance. On re-audit, the intervention developed during the first audit had been discontinued, so hypotheses for both were the same. This was that compliance would be sub-optimal, especially for follow-up as compared to baseline investigations.

Background

Monitoring for antipsychotics is a vital component of the safe prescription of antipsychotics, particularly in the more vulnerable elderly population

Methods

Retrospective data was taken over two 12 month periods. The initial audit assessed against guidelines agreed with a trust pharmacist: the re-audit used newly developed trust guidelines. For both audits, the acceptable margin was set at +/- 2 weeks for completing admission investigations and antipsychotic baseline and follow-up investigations. Due dates for monitoring were determined using the start date of antipsychotic prescription, but we only assessed compliance for investigations due whilst an inpatient.

Results

Audit: Results were analysed as successful or failed sets of investigations per patient. 44 out of the 55 patients admitted in the period were prescribed antipsychotics. 23% of new admissions didn't have a full set of admission investigations completed. For patients prescribed antipsychotics, 25% didn't have the baseline investigations set completed, 50% didn't have follow-up investigations set(s) completed. Re-audit: Results were analysed as overall numbers of successful and failed investigations. 16 out of the 18 patients admitted in the period were prescribed antipsychotics. 10% of the admission investigations weren't completed. For patients prescribed antipsychotics, 40% of baseline investigations weren't completed, 39% of follow-up investigations weren't completed.

Conclusions and next steps

Both audits results support that the lack of a formal monitoring system leads to poor compliance with antipsychotic monitoring guidelines. More specific comparison between the audits is difficult given different methods of results analysis. Performance was worse on follow-up versus baseline testing in the first audit, but not in the re-audit. After the first audit a patient list on a whiteboard with dates for monitoring was implemented. Unfortunately, this was discontinued after SHO changeover. Due to patient safety concerns, the re-audit was 'broken' and intervention implemented before the end of the study period. To ensure continuity, an antipsychotic monitoring section was incorporated into the 'Weekly Health Summary', a document updated mandatorily weekly. Results post-intervention were excluded from the audit. A re-audit to assess this intervention is required, though the rate of failed investigations decreased from 39% to 14% post-intervention.

18. Mind the Gap: Improving Psychiatric Patient Discharge Summaries for a Safe Step from Hospital to Community

***Dr Alison Thornton**, FY3, SHSC NHS Trust, Dr Anne Wisdom, ST4, SHSC NHS Trust*

Aims and Hypothesis

The aim of this project was to improve the quality of the discharge summaries in accordance with Professional Records Standards Body (PRSB) guidance. It was conducted in a Sheffield Health and Social Care NHS Foundation Trust inpatient unit.

Background

To ensure the safe and effective care of patients following their discharge from inpatient psychiatric units, it is essential that accurate discharge information is conveyed to the wider team in a timely manner. Feedback from community teams indicated this was not the case, potentially jeopardising the safe transfer of care between inpatient and community services.

Methods

An audit was conducted in December 2020 which reviewed ten electronic discharge summaries against PRSB standards. The audit revealed several areas of non-compliance including lack of documented diagnoses, allergy status and medication changes. It also identified a lack of consistency regarding which staff members, medical or nursing, were responsible for completing each section of the summary. A quality improvement project was initiated to improve the standard of the discharge summaries. A collaborative approach was adopted with full involvement of the nursing team who agreed that changes were required. The project involved creating a discharge template, clarifying areas of responsibility with nursing colleagues and identifying processes to ensure that senior medical colleagues recorded patient diagnoses, which were then pre-populated onto the discharge template.

Results

The audit in December 2020 had an overall compliance of 73% with PRSB standards. It revealed that only 20% of summaries had a diagnosis documented, 20% included documentation relating to discontinued medications and 0% had an allergy status documented. The re-audit in April 2021 reviewed ten electronic discharge summaries and noted improved compliance across all areas, with an overall improved compliance of 91%. The summaries were 100% compliant with documented allergy status and 90% compliant with documented diagnoses. Discontinued medication was noted in 30% of summaries and this is an area that could be improved in a further cycle.

Conclusions and next steps

The initial audit highlighted that discharge summaries were not compliant with PRSB standards. This project set out to address deficits and ensure adherence to standards, aiming to improve communication between the inpatient ward and community services to the benefit of ongoing patient care. The results and conclusions arising from the re-audit have noted significant improvements in compliance with standards and a further audit cycle may be beneficial to ensure continued compliance.

19. Developing a mentoring programme for higher trainees in psychiatry

Dr Lauren Unsworth*, ST5, LYPFT, Dr Sarah Orr, ST4, LYPFT, Dr Sara Davies, Consultant Psychiatrist and Training Programme Director for HEE Yorkshire and Humber*

Aims and Hypothesis

The aim of this project was to establish a new mentoring programme within the North, West and East Yorkshire Higher Training Scheme. It was intended that mentors would offer new trainees an informal source of support and guidance as they move into higher training and that the programme would provide benefits for both mentors and mentees.

Background

Mentoring is a partnership in which a more experienced mentor provides support and guidance to someone less experienced who is in a similar role to themselves. Mentoring plays an important role in supporting doctors and helping them to develop and The Royal College of Psychiatrists encourages mentoring at all stages of a psychiatrist's career, particularly at times of transition to a new role. Prior to 2020, there was no mentoring programme in place for higher trainees joining the North, West and East Yorkshire Higher Training Scheme.

Methods

A pilot took place with one higher trainee who joined the scheme in February 2020, who was mentored by a current higher trainee. Following positive feedback from this trial, and with further interest from other trainees, the mentoring programme was introduced across the scheme. Current higher trainees were asked to volunteer as mentors. They were matched with new ST4 mentees based on their experiences and interests – for instance, the subspecialty they were training in, the location they were working or being an international medical graduate.

Results

In August 2020, 8 trainees were matched with mentors. Feedback from mentors and mentees was gathered in December 2020. 6 responses were received from mentors and 6 from mentees. Mentors all said that the programme was valuable for new trainees. They identified benefits of being a mentor including developing experience in medical education, getting joy from supporting others and being able to pass on knowledge. All mentees reported that they had found having a mentor very useful. Particular benefits highlighted included smoothing the transition to higher training, having someone to share concerns with and receiving practical advice. In February 2020, a further 4 new trainees were matched with mentors. The process of matching trainees starting in August 2021 is currently underway.

Conclusions and next steps

The mentoring programme has been a successful addition to the North, West and East Yorkshire Higher Training Scheme, with benefits identified for both mentors and mentees. The programme is continuing, with a higher trainee now in the role of coordinating the programme.

20. Improving the medical handover in the acute mental health setting

Dr Ashleigh Vennard*, ST4, Belfast HSCT, Dr Meta Magee, ST6, Belfast HSCT, Dr Rachel Morrow, Consultant Psychiatrist, Belfast HSCT*

Aims and Hypothesis

Within the Belfast Health and Social Care Trust (BHSCT) there is no established method for medical handover, resulting in a disjointed and inconsistent system.

SMART aim: The goal was that 80% of psychiatry SHOs within the BHSCT rate the psychiatric medical handover as "good" or "excellent" by six months.

Background

Psychiatry junior doctors in BHSCT work across multiple sites spanning a large geographic area. Out of hours there are two SHOs, each covering either the inpatient unit or peripheral sites. As a result, junior doctors are frequently working in areas they are unfamiliar with and handing over to staff with whom they don't normally work. Without a structured handover process at an allocated time, this resulted in a disorganized handover of giving information to staff without being entirely clear where they worked and resulted in low confidence in tasks being acted on appropriately, with a high risk of omissions.

An effective, thorough, and systematised handover process should ultimately improve patient safety.

Methods

PDSA-1

- Introduced a template covering all areas to be discussed at handover
- Protected time was allocated to ensure all relevant staff were able to attend and receive/give necessary information
- Arranged senior medical cover to be present at handover

PDSA-2

- Contact details for peripheral sites being covered out of hours were included in the template to allow easier handover to peripheral sites
- Arranged for the SHO finishing night duty to join the morning handover meeting for the busiest peripheral site
- On-site whiteboard added for jobs to be documented for the weekend rather than relying on this being handed over between multiple staff

A questionnaire was designed to obtain the view of relevant junior doctors at baseline and after each cycle.

Results

Response rate 21/29 for the baseline questionnaire and following PDSA1.

Junior doctor's ratings of all of handover improved significantly.

The proportion of those rating the handover as "good" or "excellent" increased from 4.7% (1/21) to 67% (14/21). Other areas also significantly improved such as rating the handover process as well structured, and the confidence of junior doctors that jobs handed over will be appropriately actioned. PDSA2 questionnaire following August changeover and there was a poorer response rate (9/28) but most parameters continued to improve.

Conclusions & next steps

Although we have not yet reached our aim of 80% SHO rating the handover as "good" or "excellent", outcomes were significantly improved, particularly after the initial interventions.

The poorer response to the questionnaire following changeover stresses the importance of persisting with improvements. The handover process will be given more emphasis during the induction for new doctors.

We aim to create a digital, live version of the handover document to be accessible by all relevant staff via a shared drive. This will improve consistency of use as well as ensure patient data is more secure.

21. Implementing a new handover standard and using the 'SBAR' technique to improve quality of handover in psychiatry

***Dr Kirsty Ward**, CT1, NAViGO Health and Social Care CIC*

Aims & Hypothesis

To improve quality and safety of an on-call email handover system in by holding teaching sessions, introducing set handover criteria and using the SBAR (Situation, Background, Assessment, and Recommendation) handover technique.

Background

Poor quality handover can be at the root of clinical errors. The SBAR handover is increasingly used in acute medical specialities but this may also provide a useful framework in psychiatry.

In a multi-site psychiatric trust, daily written email handovers sent within a shared email chain were used to handover tasks to the on-call doctor. These emails varied in content and quality.

Methods

Handover emails were assessed against set criteria at three points; at baseline, after education and implementation of a new standard, and at three months follow-up to determine whether compliance had changed long term. Emails were assessed for a three week period at each point.

The compliance criteria was as follows: Full patient name, location, date of birth, reason for handover, task required, clinician details and ensuring the email was sent at an appropriate time. From this an average overall compliance percentage could be calculated.

Clinician's opinions regarding the handover quality were obtained via a survey using numerical rating scales from 1-10 (strongly disagree to strongly agree).

Results

Some areas of compliance at baseline were poor with only 80.6% using the patient's full name and 41.7% using a patient identification number. Average compliance at baseline was 69.3% versus 77.6% post education and implementation of a new standard. This dropped to 73.0% at follow-up. The use of two patient identifiers was 47.2% at baseline and improved to 92.5% but dropped to 70.0% at follow-up.

The uptake and correct use of the SBAR handover style was measured. Post education and standardisation this was used fully 29.0% of the time and this dropped to 7.4% at follow up. This was despite 87.5% of clinicians voting to continue with the SBAR after the implementation period and 100% choosing to continue at follow-up.

Clinician opinion of handover also increased from an average score of 7.94 at baseline to 8.51 but dropped to 8.31 at follow up.

Conclusions

The findings suggest that the implementation of a set criteria and use of handover frameworks can improve handover quality. However, without regular re-education the quality and adherence can fall.

Research

22. A remote new world - psychiatrist reflections on using remote consultations for community mental health care during COVID-19: a qualitative interview study

Ms Ayesha Ali, *Medical Student, Imperial College London, Ms Urvi Bihani, Medical Student, Imperial College London, Mr Alan Hasanic, Medical Student, St George's University of London, Ms Aya Khasati, Medical Student, Imperial College London, Ms Keerthi Muthukumar, Medical Student, Imperial College London, Mr Raja Ohri, Medical Student, King's College London, Mr Yusuf Sheikh, Medical Student, King's College London*

Aims and Hypothesis

This study aimed to identify the benefits and challenges experienced by general adult psychiatrists when using video and/or telephone consultations for diagnosis and follow-up in NHS community settings during the COVID-19 pandemic. The authors hypothesised that remote consultations (RC) presented clear benefits and challenges to psychiatrists, with video providing greater value for mental health consultations due to availability of visual cues and greater rapport between clinicians and patients. However, both interventions would remain inferior compared to face-to-face.

Background

Psychiatrists today are caught in the crossfire of two pandemics: the incumbent COVID-19 pandemic, and an emerging mental health crisis. The former has led to an unprecedented shift towards the use of remote consultations for mental health consultations in the NHS. This disruption has led to a clear need to explore the strengths and weaknesses of such consultations and whether they hold a place in a post-COVID-19 world.

Methods

Semi-structured interviews were conducted with 11 psychiatrists working within NHS community settings, with experience delivering video and telephone consultations. A thematic analysis of transcripts then followed, with the benefits and challenges of both interventions being compared to face-to-face consultations.

Results

Telephone and video were reported as suitable for mild mental health conditions (mild depression/anxiety) and follow-up consultations. Benefits over face-to-face consultations included greater efficiency and convenience for patients, greater access to collateral histories and insight into patients' home environments. However, RC was reported as less suitable for initial consultations and more severe mental health conditions such as psychosis and eating disorders. Technical issues were frequent, particularly with video. Psychiatrists also struggled with the non-visual nature of telephone consultations and hindered information gathering associated with this.

Conclusions and next steps

This study has provided valuable insights into the attitudes of psychiatrists working in the UK during the COVID-19 pandemic. To deliver a digital-first future for the NHS, greater investment and exploration into remote technologies is needed, particularly for mental health consultations in the context of severe NHS pressures. Though face-to-face consultations remain the gold standard for mental health, video and telephone can provide a convenient and efficient way of communicating with patients, particularly during follow-up and with less severe forms of illness.

23. Attitudes of medical students to electroconvulsive therapy

***Dr Patrick Clements**, ST4, Queen's University Belfast, School of Medicine, Dentistry and Biomedical Sciences & Belfast Health and Social Care Trust, Dr Aidan Turkington, Consultant Psychiatrist, Queen's University Belfast, School of Medicine, Dentistry and Biomedical Sciences & Belfast Health and Social Care Trust*

Aims and Hypothesis

This study explores the different attitudes among fourth year medical students in Queen's University Belfast to Electroconvulsive Therapy (ECT) and investigates whether these are influenced by teaching and exposure to ECT during their undergraduate psychiatry placement. In particular we sought to determine firstly, correlates of baseline attitudes to ECT and secondly, whether specific forms of ECT teaching improved attitudes to ECT during their placement.

Background

ECT is an important treatment for many psychiatric disorders. However, its use has declined in recent years. This is considered, in part, to be due to inadequate education and training of health care professionals.

Methods

Participants completed a questionnaire at the beginning of their psychiatry placement and another questionnaire in the second half of their placement. The first questionnaire captured background information and baseline attitudes. The second questionnaire recorded the educational and clinical experience gained on ECT during placement (for example lectures, tutorials, informal teaching, observing ECT and interacting with ECT patients), in addition to attitudes to ECT at this timepoint. Attitudes to ECT were assessed on a 5-point Likert scale. A positive attitude to ECT was defined as scoring agree/strongly agree on a 5-point Likert scale to the statement "I would recommend ECT for a patient if clinically indicated".

Results

187 students were interviewed at both time points. At the outset of the psychiatry placement 66% of students reported a positive attitude to ECT. Positive attitude was associated with age: 72% of students under 24 had a positive attitude to ECT vs 58% of students 24 and over ($\chi 2=3.5$; $P<0.05$). Of students who had previously attended a lecture on ECT (n=117) 83% had a positive attitude to ECT vs 42% of those who had not previously attended a lecture ($\chi 2=33.5$; $P<0.001$). Attitudes to ECT significantly improved during the placement (66% vs 94% positive; $t=7.97$; $P<0.001$). Students who attended a lecture on ECT during the psychiatry placement were more likely to have a positive shift in attitude (67% vs 49%; $F=6.0$; $P=0.01$). No other specific teaching modality was associated with a positive shift in attitude.

Conclusions and next steps

We conclude that undertaking a Psychiatry placement and particularly having a lecture on ECT significantly improves attitudes of medical students to ECT. It is therefore important that lectures on ECT are included in the medical undergraduate curriculum to allow students to be accurately informed about this essential treatment for a number of psychiatric disorders.

24. Management of mental illness in people with epilepsy in sub-Saharan Africa

Miss Chloe Gilkinson, *Queen's University Belfast, School of Medicine, Dentistry and Biomedical Sciences, Belfast, UK, Tolu Olaniyan, Pretola Global Health Consulting Limited, ILAE UK, Isle Of Wight, UK, Rohit Shankar, University of Plymouth, Peninsula School of Medicine, Plymouth, UK, Michael Kinney, Queen's University Belfast, School of Medicine, Dentistry and Biomedical Sciences, Belfast, UK*

Aims and hypothesis

This study addressed healthcare providers attitudes toward epilepsy and comorbid mental illness, as well as the management practices and barriers to adequate holistic care in sub-Saharan Africa, the main objective being to draw international attention to the identified gaps in the treatment.

Background

Epilepsy is a common and serious neurological disorder in sub-Saharan Africa (SSA). There exists a significant “treatment gap” as diagnosis and therapeutic access is poor, possibly due to relative scarcity of neurologists. Psychological distress is highly comorbid with epilepsy. Similarly, deficiencies exist in psychiatric care of people with epilepsy. Increasingly, improving quality of life is being recognised as an essential goal of epilepsy treatment.

Methods

A cross-sectional survey using the STROBE guidance was conducted among healthcare providers who were attending a virtual epilepsy training programme provided by Pretola Global Health & Consulting Ltd. The survey was circulated using an exponential and non-discriminatory snowballing technique. A descriptive analysis was performed, and data presented as percentages.

Results

Our survey received responses from 203 healthcare professionals in sub-Saharan African countries. Most (80.0%) recognised a bi-directional relationship between mental illness and epilepsy. However, only a small proportion reported that they screen for (14.4%) or provide education on the risk of developing mental illness (12.4%) in epilepsy populations. The majority would value further training (74.1%) and improvements to be made in current management practices within their local healthcare settings (93.5%). The major themes identified as challenges to the management of mental health this population were a lack of confidence in how to assess for mental illness; lack of awareness that there is a heightened risk of mental illness in patients with epilepsy; and limited access to psychological services.

Conclusions

This study highlights the need for improving routine assessment and treatment of mental health disorders in this population. Healthcare providers responded that they require further training relating to the recognition and management of psychiatric comorbidities in people with epilepsy. During the pandemic, the development of bespoke virtual educational initiatives to tackle the identified gaps in management are urgently needed.

25. A case study of unique dissociative experiences following a traumatic event.

Dr Muhammad Faisal Amir Malik, *PGY1 Psychiatry, Institute of Psychiatry, Rawalpindi Medical University*

Aims and Hypothesis

To report a case with dissociative fugue and Ganserian symptoms in peri-traumatic dissociation.

Background

Dissociative experiences commonly arise following trauma. Ganser syndrome is a rare psychiatric presentation that is defined by the presence of 'approximate' or 'Ganserian' answers. Additionally, other features such as dissociation, pseudohallucinations, and clouding of consciousness are also often, but not always, present. While cases from South Asia have been reported, none is from Pakistan.

Methods

A case study.

Results

A 20-years old male stopped responding to his family members and developed confused, disconnected behavior following physical abuse by his neighbors. He refused to recognize his family members. During this time, he once announced intentions to hang himself and ran to his room but was intercepted by the family members. He left his home and went to another city without any plausible reason. His family found him after he told his number to a stranger. On initial mental state examination (MSE), signs of self-neglect were seen. He was repeating sentences and engaging in disconnected activities. Interestingly, he became engaged in the interview when asked questions of addition, to which he returned approximate answers (10+10=5, 1+1=100). The approximate answers were given in the categories of addition of numbers, naming colors, and recognizing pieces of furniture and the pictures of animals. When a question was repeated, he gave the same wrong answer. The next day, he gave approximate answers in the same approximate categories but different from before (1+1=3). After reattribution, he recovered spontaneously. He recalled the details of his traumatic experience fully, however his memory of the subsequent days was patchy. He also described hearing female shrieks but said that he knew they weren't real but could hear them as if they were. He was discharged after problem solving and stress-coping. Premorbidly, he had mild intellectual disability and dependent traits. No history of previous dissociative experiences was elicited.

Conclusions and next steps

The case is important as it describes an uncommon presentation following traumatic experience and is a first contribution to the literature of Ganser's syndrome from Pakistan.

26. Moral Incongruence, spiritual distress, and guilt associated with depression: a study of 2 cases

***Dr Bahjat Najeeb**, PGY2 Psychiatry, Institute of Psychiatry, Rawalpindi Medical University, Rawalpindi, Dr Muhammad Faisal Amir Malik, PGY1 Psychiatry, Institute of Psychiatry, Rawalpindi Medical University, Rawalpindi*

Aims and Hypothesis

We present two cases of young, educated males with major depressive disorder and prominent themes of guilt and spiritual distress. We explore the relationship between moral incongruence, spiritual distress, and feelings of guilt with major depressive episodes.

Background

More attention needs to be paid to the psychological and societal factors which precipitate, prolong, and cause relapse of depression in high achieving young individuals.

Methods

A case study of two high achieving students. The severity of depressive episode was measured using the Hamilton Depression Scale (HAM-D). Themes of guilt and shame were measured measuring State of Guilt and Shame Scale (SSGS).

Results

Case 1: A 25 years-old-male with one month history of excessive weeping, social withdrawal, decreased oral intake, and decreased verbal communication. On mental state examination (MSE), psychomotor retardation and mutism was seen. His HAM-D score was 28 (very severe). He was started on tablet sertraline 50 mg/day and tablet olanzapine 5 mg/day. On further exploration, he expressed distress due to feelings of excessive guilt and shame due to moral incongruence secondary to internet pornography use (IPU). His SSGS score was high on both shame and guilt domains (14/25, 20/25, respectively). He was discharged after a cycle of 6 electroconvulsive therapies (ECTs), psychotherapy, and psychoeducation of patient and family. Case 2: A 21 years-old-male with four months history of low mood, low energy, weeping spells, decreased oral intake. On MSE, psychomotor retardation and mutism was seen After thorough medical and neurological examination and investigation to rule out organicity, a diagnosis of severe depressive disorder was made. He was started on tablet mirtazapine built up to 30 mg/day and tablet lorazepam 2 mg/day. His score on HAM-D was 24. On further sessions, he opened up regarding stressors pertaining to psychosexual domain, spiritual distress, and feeling of moral incongruence regarding his masturbatory behavior. On SSGS he scored high on both shame and guilt domains (16/25, 21/25, respectively).

Conclusions and next steps

Both cases presented with low mood, psychomotor slowing, and selective mutism. Upon detailed history, spiritual distress and feelings of guilt due to IPU and the resulting self-perceived addiction and moral incongruence were linked to the initiation and progression of major depressive episodes. High expectations from family were also a source of stress. Hence, it's important to keep these factors in mind while managing mental health problems in young individuals.

27. Obsessive-Compulsive Disorder in UK Coroners' Reports

***Lisa Quigley**, MSc Student, UCL Division of Psychiatry, Himanshu Tyagi, MRCPsych, UCL Institute of Psychiatry, UCL Institute of Neurology, UCLH*

Aims and Hypothesis

This study looks at coroners' reports into suicides in England and Scotland in order to: - Explore characteristics of suspected or confirmed cases of OCD in coroners' reports - Identify instances of possible undiagnosed or misdiagnosed OCD - Identify recurring themes - Compare findings with reports from Canada and Australia

Background

Suicidality in obsessive-compulsive has historically been under-reported, despite research pointing to a significant association between OCD and suicidality. Likewise, OCD is frequently undiagnosed or misdiagnosed. Individuals with OCD are thought to be up to ten times more likely to die by suicide, with this risk increasing in the presence of psychiatric comorbidities.

Methods

328 publicly available coroners reports were accessed from England (n=200) and Scotland (n=128). Reports were screened in order to identify individuals who had either a diagnosis of OCD (n=3), a diagnosis of a related condition (n=0), or indications of possible undiagnosed OCD (n=2). Demographic and psychiatric characteristics were extracted. Qualitative thematic analysis was carried out on all five reports. Findings were compared to reports from Canada (n=3) and Australia (n=23).

Results

Psychiatric comorbidities in this small sample (n=5) were examined, with diagnoses of anxiety disorders (n=3), psychotic disorders (n=2) and 'personality disorders' (n=2) the most prevalent. All 5 had attempted suicide in the year prior to their death, and all had expressed thoughts of suicide in the week before they died. Themes from this sample included: a tendency for mental health services to rely on family and friends to provide care; misdiagnosis; mental health service failings; and stigma/discrimination associated with a 'personality disorder' diagnosis. Of the cases where OCD had been diagnosed (n=3), OCD seems to have been a contributing factor to suicide in only one instance. In contrast, in each of the 3 cases where OCD appears likely but was never diagnosed, the coroners' reports clearly document severe distress associated with fear of causing contamination and harm.

Conclusions and next steps

The distress felt prior to suicide was documented most extensively in reports where OCD was strongly indicated but never diagnosed, highlighting the impact of potentially missed, or incorrect diagnosis. All of the reports reveal repeated attempts to seek help. Despite this, many appear to have experienced stigma, mental health service failings and missed opportunities for help in the months preceding their deaths. Stigma was most commonly associated with a 'personality disorder' label or diagnosis.

28. Examining the prevalence of cognitive impairment alongside depression and anxiety symptomatology in Multiple Sclerosis: A systematic review and meta-analysis

Alan Selman, *MSc student in Mental Health Research & Practice, Institute of Mental Health, University of Nottingham, Dr Hina Khan, Neurology ST5, Queen's Medical Centre, Nottingham, Nottinghamshire, Dr Musa Sami, Consultant Psychiatrist & Clinical Associate Professor of Psychiatry University of Nottingham*

(The Authors are grateful for funding from the General Adult Psychiatry Faculty Small Project Grant 2019 which helped with facilitating this project)

Aims and Hypothesis

This study aimed to identify whether there is a difference in Cognitive Function (as measured by executive function, memory, attention and psychomotor processing speed) and depression and anxiety between patients with Multiple Sclerosis and controls.

Background

There is considerable interest in the neuroinflammatory basis for psychiatric disorders. In depression, schizophrenia and dementia neuroinflammatory mechanisms have been proposed which posits that a proportion of these disorders can be explained through neuroinflammation. On the other hand typical neuroinflammatory disorders (such as Multiple Sclerosis) are often managed by neurologists, where both cognitive and neuropsychiatric manifestations are known to be prevalent and under-recognised. Psychiatric comorbidity is common in Multiple Sclerosis. We aimed to undertake a meta-analysis of cognitive, depression and anxiety symptoms in patients with MS versus controls using a commonly used neurocognitive battery (CANTAB).

Methods

We undertook a meta-analysis of all studies on the CANTAB database including groups with MS. We extracted all outcome measures of interest (cognitive score, reaction time, fluency, depression and anxiety) from all identified studies. We categorised these into five domains:

1. Executive Functioning
2. Memory
3. Attention and Psychomotor Speech
4. Emotional and Social Cognition and
5. Depression and Anxiety. We undertook meta-analysis using R (the metafor package) and undertook mixed-modelling meta-analysis to account for both between study and within study variance.

Results

We identified 10 studies with 349 MS patients and 291 controls. Meta-analysis of 134 outcomes revealed a high level of heterogeneity ($Q=523$, $p<0.001$). Taken together all outcomes showed an effect size difference of 0.656 between patients and controls ($p<0.001$). On subgroup analysis this was demonstrated across domains: attention and psychomotor processing (effect size: 0.638, $p=0.004$), memory (effect size: 0.623, $p<0.001$), executive functioning (effect size: 0.703, $p<0.0001$) and depression and anxiety (effect size: 0.499, $p=0.02$). There were no tests of emotional and social cognition.

Conclusions and next steps

There is clear evidence of impairment in patients with MS across domains. These are of moderate to large effect size. Further studies should examine social and emotional cognition.

29. Criminal sanctions for suicidality in the United Kingdom: autoethnography and protocol for a scoping review

Dr Alex Thomson, *Consultant Liaison Psychiatrist, Central and North West London NHS Foundation Trust, Dr Sarah Eales, Lead Matron for Mental Health, University Hospital Southampton NHS Foundation Trust, and Visiting Fellow, Bournemouth University, Dr Emma McAllister, Lived Experience Advisor, UK, Dr Andrew Molodynski, Consultant Psychiatrist, Oxford Health NHS Foundation Trust, and Honorary Senior Clinical Lecturer, Oxford University*

Aims and Hypothesis

1. Evaluate current literature on criminal sanctions for suicidality in terms of number of reports, quality, and strength of evidence
2. Identify the reported benefits and harms of criminal sanctions for suicidality.

Background

In the UK, over 6,000 people die by suicide every year. Many more receive medical attention for self-harm, suicide attempts, and suicidal thoughts. Suicidality is associated with many mental disorders; public health approaches and evidence-based treatment are vital for suicide prevention. Although attempting suicide was decriminalised in the whole UK over 55 years ago, people are still prosecuted and imprisoned for alleged offences related to suicidality where there is no public danger. The apparent rationale is to try and deter suicidality through punishment. The Royal College of Psychiatrists has expressed concern that there is little evidence to support health professionals having a role in such interventions, and substantial risk of harm.

Methods

We report the protocol for a scoping review, and autoethnography by a person who was prosecuted for alleged offences related to suicidality. Published and unpublished reports relating to bail conditions, antisocial behaviour orders, community protection notices, prosecution or imprisonment for alleged offences related to suicidality, self-harm or attempting suicide will be included. Offences of violence to others will be excluded. Reports will be restricted to adults in the UK since 2000. Stakeholder events will be held to refine the protocol. Electronic databases, grey literature, and reference lists will be searched and experts will be approached. Data related to participant characteristics, interventions and clinical outcomes will be extracted. Data will be synthesised using narrative scoping review methods. Informed consent was given for publication of clinical material.

Results

We report a 34-year-old professional with severe obsessive-compulsive disorder, prosecuted for wasting police time, breach of the peace, and reckless and culpable conduct, while unable to access mental health treatment, despite no public danger and having made only one call to police on advice of mental health staff. Prosecution resulted in increased decontamination compulsions causing long-term physical disability, increased suicidal behaviour almost causing death, further withdrawal of mental health services, and loss of career. There was no improvement in any clinical outcome. The scoping review will be conducted during 2021-22.

Conclusions and next steps

Current evidence suggests criminal sanctions for suicidality can cause substantial harm with no evidence of benefit. A full review of evidence is urgently needed to guide health professionals' roles and duties in practice.

Service Evaluation/Audit

30. Survey of Work related stress among staff in a CMHT

Dr Karmabir ACHARYA*, CT1, Devon Partnership NHS Trust, Dr Arun DEVASAHAYAM, consultant psychiatrist, Devon Partnership NHS Trust, Dr Vinesh NARAYAN, consultant psychiatrist, Devon Partnership NHS Trust, Dr Adebayo ABUDU, Trust Grade Doctor, Devon Partnership NHS Trust*

Aims and Hypothesis

We aimed to conduct a survey to evaluate work related stress in the last one year among OPMH Community Mental Health staff in Torbay, Devon. We hypothesised that there will be increased stress in the last year that has been marked by Covid, as indicated by other surveys.

Background

A recent HSE survey indicated that nationally over 15.4 million working days were lost due to stress, accounting for 57% of sickness absence(HSE . Work related stress 2020). NHS Staff survey has showed that almost half of NHS staff in England (44%) have reported feeling unwell from work related stress, the highest rate recorded in the past five years. (BMJ 2021;372:n703)

Methods

We devised a Survey Monkey Questionnaire with 9 questions related to work stress and free text for comments. Previous work-related stress questionnaires were analysed and adapted to the local need. The survey was open to all staff in the team including medical staff, team managers, mental health practitioners, support workers and admin staff.

Results

Questionnaire was sent to 30 staff members out of which 19 (63%) responded. Data collection was done from May to June 2021. All staff members reported having felt stressed at work in the last year with 57% reporting felling `usually' or `always' stressed. 76% reported they were thinking of leaving or changing their job. 90% of staff reported feeling worn out at the end of the day and 42% reported they are always or usually stressed in the morning at the thought of another day at work. 90% felt that their work is emotionally exhausting .12% felt disempowered to make any changes to the issues that were making their work stressful. In the Qualitative date the 3 main prominent themes contributing to work stress were lack of admin support for the team, too much electronic paperwork including copious amount of forms and duplication, and high caseload numbers.

Conclusions and next steps

The survey identified that there is high amount of work-related stress in our team. Although this survey was conducted in a small but busy OPMH community team, we feel it may be applicable to other teams as well. There could be various reasons for the increased stress, and we envisage that the challenges working in a covid environment including the lockdown has contributed to this.

31. The Effect of the first Coronavirus lockdown on psychiatric outpatient attendance, a North Fife survey

Dr Adebola Eromosele Adegbite, *CT2, NHS Fife, Dr George Howson, Consultant Psychiatrist, NHS Fife*

Aims and Hypothesis

The purpose of this study is to establish if virtual/remote consulting has affected patient attendance rate.

Background

There has been a significant change in outpatient psychiatric consultations, thereby leading to challenges we face in delivering safe and effective care to patients. The existing literature on remote/virtual consultations during the COVID pandemic are on the rise but quite sparse.

Methods

The data was collected using the "2020 stats sheets" for inpatient appointments within North Fife consultants from January to October 2020. This project was registered with the NHS Fife clinical effectiveness team in January 2021.

Results

This survey showed a clear reduction in clinic appointments made during lockdown compared to pre-lockdown and a slight observable improvement in attendance rates during the lockdown. There was no statistical significance by comparing attendance rates between video and telephone consultations.

Conclusions and next steps

The large sample size over this period suggests that the results are reliable and valid, we can therefore say virtual/telephone consultation does not affect attendance. It should be noted that the attendance rate may be a good indicator but we should also consider patient/clinician satisfaction, communication quality/effectiveness and other factors which could influence patient's compliance to outpatient follow up. It is important to acknowledge the lack of a control group and the COVID-19 pandemic were major cofounding factors. Mental health services should continue the use of virtual consultation post-pandemic and possibly integrate it with in person consultations (hybrid), this may help with attendance rate of patients with difficulty attending face-to-face appointments.

32. "I love and want my befriender back and miss them!"

Sahar Ahmadi, *Student, SE5, King's College London University, Megan Smith, Student, SE5, King's College London University, Aderinsola Adebowale, Student, SE5, King's College London University, Dr Mary Docherty, South London and Maudsley NHS Foundation Trust & Department of Psychological Medicine, Hugh Baillie, South London and Maudsley NHS Foundation Trust & Department of Psychological Medicine, Luke Gosset, South London and Maudsley NHS Foundation Trust & Department of Psychological Medicine*

Aims and Hypothesis

To assess the feasibility and acceptability of the delivery of a weekly befriending service which incorporates CBT techniques (e.g. behavioral activation & goal setting) to reduce loneliness, self-isolation and low mood in older adults with mild to moderate mental health problems, chronic-obstructive pulmonary disease (COPD) and heart failure.

Background

Due to the COVID-19 pandemic and the enforced shielding rules in the UK, older adults with long-term health conditions with mild/ moderate mental health problems were at a high risk of suffering from loneliness, self-isolation and low mood. There are well-known gaps in services for older adults with mild/moderate mental health problems and co-occurring long term physical health problems therefore this befriending service (blended with CBT techniques) attempts to address the gap.

Methods

53 older adults living with COPD or heart failure consented to receive weekly phone calls every Friday from psychology interns over a 12-month period. Psychology interns were trained and supervised by a CBT therapist, psychiatrist and social support worker to implement CBT techniques (behavioural activation and goal setting) into the programme.

Results

Around 500 calls to 53 clients over a 12-month period were made (2 cycles of 13-weeks). The service: increased social participation (69% were more likely to join social activities); was acceptable (65% of clients remained in the service); was highly valued (100% of clients would recommend the service). Qualitative analysis showed the power of building relationships and talking to people; clients built connections with the befrienders, the calls were enjoyable and looked forward to, the service reduced feelings of loneliness and increased confidence in engaging in other social activities.

Conclusions and next steps

Overall, the telephone-based befriending service that incorporated CBT techniques was well received and effective in reducing loneliness and low mood in older adults with mild to moderate mental health problems, COPD and heart failure. Initial results suggested a preventative effect however we have insufficient power to detect this. Further studies should assess application, methodology and efficacy of this befriending service in preventing patients from entering secondary care.

33. Effects of COVID-19 restrictions on individuals with severe mental illness

Dr Muhammad Mahdi Boolaky, *ST6, Birmingham and Solihull Mental Health NHS Foundation Trust. Ms Eleanor Lowe, Community Psychiatric Nurse, Birmingham and Solihull Mental Health NHS Foundation Trust, Dr Shay-Anne Pantall, ST5, Birmingham and Solihull Mental Health NHS Foundation Trust, Dr Lisa Brownell, Consultant Psychiatrist, Birmingham and Solihull Mental Health NHS Foundation Trust*

Aims and Hypothesis

To evaluate the experience of and attitudes towards COVID restrictions in people with a pre-existing diagnosis of severe mental illness.

Background

Since March 2020, the COVID-19 pandemic has resulted in various restrictions and regulations for all individuals. In England, these have included the wearing of face coverings and social distancing. There has been concern about how these restrictions may impact upon mental wellbeing, and in particular what the impact may be upon those with a pre-existing mental illness. Here, we report the experiences of individuals with severe mental illnesses, who have been attending our clinic throughout the pandemic, for their long acting antipsychotic injections.

Methods

A questionnaire was administered to all individuals receiving long acting antipsychotic medication in a community mental health team depot clinic in May and June 2021. 27 completed questionnaires were returned.

Results

Key findings include:

- 96% service users reported their attendance at depot clinic during the pandemic was a positive experience.
- 93% reported that they always wore a mask at their appointment for their depot injection
- 85% reported that they always wore a mask while shopping
- 81% felt more confident because the staff in the depot clinic were wearing PPE
- Only 15% felt that the general public wearing masks had impacted negatively on their mental health
- 22% felt that the wider COVID restrictions had impacted negatively upon their mental health
- 85% reported that they had fully complied with all COVID restrictions
- 81% had received COVID vaccination
- In addition to the face to face administration of depot medication, 74% had telephone consultations
    - Of these, 85% stated that this was a positive experience
- 48% reported that they would prefer to continue with telephone consultations once COVID restrictions were lifted.

Conclusions and next steps

We were pleased to find that attendance at the clinic and telephone consultations were both experienced positively. We were surprised at the extent to which the service users were comfortable with staff wearing PPE when they visited the hospital and felt able themselves to wear face coverings for their appointments and in other situations, without this impacting adversely upon their mental health. We noted a high uptake of vaccination, in a group of people who may be expected to be more hesitant or struggle to book for vaccination appointments.

34. What did home treatment teams do in the COVID pandemic?

***Dr Muhammad Mahdi Boolaky**, ST6, Birmingham and Solihull Mental Health NHS Foundation Trust, Dr Amy Shaw, CT1, Birmingham and Solihull Mental Health NHS Foundation Trust, Dr Shay-Anne Pantall, ST5, Birmingham and Solihull Mental Health NHS Foundation Trust, Dr Lisa Brownell, Consultant Psychiatrist, Birmingham and Solihull Mental Health NHS Foundation Trust*

Aims and Hypothesis

To evaluate the clinical activity of home treatment teams during the COVID-19 pandemic

Background

From March 2020, the COVID-19 pandemic necessitated a "lockdown" in the UK. All people were required to stay at home, except for very limited purposes, certain businesses and venues were closed, and all gathering of more than two people in public were stopped. All health services were impacted, whether this was because of a need to treat COVID patients, or a need to continue to provide services for other health problems. It was anticipated that the pandemic, and the restrictions, would impact the mental health of the population. Little has been written about the clinical activity of mental health services during this period. Here, we describe the activity of Home Treatment Teams in Birmingham and Solihull at that time.

Methods

Electronic records were examined for all individuals referred to the Birmingham and Solihull's Home Treatment Teams in April 2020 (n=1378).

Results

Key findings include:

- Most (67.8%) referrals came from other mental health services (including psychiatric liaison teams covering the local acute hospitals), although patients were also received from GPs (20.9%), self/carer (4.3%), police and court diversion (1.3%) and social services (0.6%).
- 55% patients were male
- 6% were assessments only and were not taken on for further treatment. 38% were under the care of the home treatment team for between 1 and 6 days, 46% for between 7 and 30 days, 10% were under their care for more than 30 days
- The most common diagnoses were schizophrenia and related psychotic illnesses (38.6%), mood disorders (27.8%) and personality disorders (14.2%)
- Substance misuse disorders were recorded as the primary diagnosis in 4.9% cases, but was also a very common secondary diagnosis (17.1%)

Conclusions and next steps

The home treatment teams received a high number of referrals in this month. We were unsurprised that a large number of individuals were referred via acute hospitals, via the psychiatric liaison teams. Patients generally received intensive home treatment for up to one month, with almost half being discharged within one week. Most patients had significant mental illnesses, but we were surprised by the high levels of diagnosed substance misuse disorders.

35. Assessing the impact of low mood and anxiety at initial presentation to a Long COVID assessment Service

***Dr Emily Bruchez**, Clinical Fellow, Liverpool University Hospitals NHS Foundation Trust, Dr Selim Kimyongur, Clinical Fellow, Liverpool University Hospitals NHS Foundation Trust, Dr Alex Barnes, Clinical Fellow, Liverpool University Hospitals NHS Foundation Trust, Dr Aidan Flatt, Clinical Fellow, Liverpool University Hospitals NHS Foundation Trust, Dr Gabriel Heppenstall-Harris, Clinical Fellow, Liverpool University Hospitals NHS Foundation Trust, Dr Laura Watkins, Consultant, Liverpool University Hospitals NHS Foundation Trust, Dr Nneka Nwosu, Consultant, Liverpool University Hospitals NHS Foundation Trust, Dr Gurinder Tack, Consultant, Liverpool University Hospitals NHS Foundation Trust, Dr Marie Stolbrink, ST7, Liverpool University Hospitals NHS Foundation Trust*

Aims and Hypothesis

We aimed to review if patients presenting to a long COVID assessment service had symptoms of low mood and/or anxiety compared to before their illness.

Background

The COVID pandemic has placed a greater pressure on the United Kingdom's already strained mental health services. The range of symptoms patients with Long COVID develop is growing and include depression and anxiety. There is recognition that the medical community would benefit from a greater understanding of how Long COVID can impact mental health and what we can do to support this. The Long COVID assessment Hub covers counties Cheshire and Merseyside, a combined population of 2.6 million. Once referrals are screened, patients complete a telephone consultation with a clinician.

Methods

Retrospective analysis of patients reviewed in our Long COVD assessment hub between February and April 2021 (332 total). Patients were asked to score their anxiety and depression on a 0-10 scale (0 = no change, 10 = maximal) at the time of review and retrospectively for pre-COVID illness. Patients scoring above a certain threshold in either low mood or anxiety scores would then complete PHQ9 (Patient Health Questionnaire) or GAD7 (Generalised Anxiety Disorder Assessment) for further assessment.

Results

248 (74.7%) reported worsening low mood 251 (75.6%) reported worsening anxiety Patients reported an average pre-COVID anxiety score of 1.6, and 4.7 at time of review with an average increase of 3.0 ($P<0.0001$) Patients reported an average pre-COVID low mood score of 1.4 and 4.5 at time of review with an average increase of 3.0 ($P<0.0001$) 145 patients completed a GAD7 and 112 completed a PHQ9. Of these patients 135 scored ≥ 5 in the GAD7 to meet or exceed criteria for mild anxiety, including 29 mild, 63 moderate and 43 severe. 112 scored ≥ 5 in the PHQ9 to meet or exceed the criteria for mild depression, including 14 mild, 36 moderate, 35 moderately severe and 27 severe. Following clinical assessment 54% of patients with self reported worsening mood and/or anxiety were referred to psychology and 35% directed to IAPT (Improving Access to Psychological Therapies)

Conclusions and next steps

We found that patients reported increased anxiety and low mood during Long COVID illness when compared to prior to developing COVID. Given the uncertainty around the future of Long COVID it may be that extra provisions will be required to ensure the mental health needs of this population can be met.

36. An evaluation of the roll out of a new documentation system, the Clinical Summary Portal (CSP)

***Dr George Coates**, ST5, West London NHS Trust, Dr Jonathan Scott, Chief Clinical Information Officer, West London NHS Trust, Emma Brown, Practice Development Clinician, West London NHS Trust, Dr Evan Picton-Jones, Consultant Psychiatrist, West London NHS Trust, Fiona Mulcahy, Psychiatric Nurse, West London NHS Trust*

Aims and Hypothesis

This baseline project aimed to provide oversight and support to the "go live" process of a new documentation method, intended to facilitate the NHSX strategy of 'digitisation'.

Background

Introduced in September 2019, the Clinical Summary Portal (CSP) is a novel configuration of the Electronic Patient Record (EPR) highlighting a core summary of each patient. Key aspects of the psychiatric history are prominent and there is a particular focus on introducing a standardised formulation. Duplicated and non retrievable narrative is avoided. Success is dependent on all MDT staff editing each section successively.

Methods

Organisational leadership was assessed using the NHS Elect Sustainability Questionnaire. Staff in early adopter teams completed an edited version of the Computer System Usability Questionnaire (CSUQ, Jim Lewis, 1995). This was supplemented by focussed feedback sessions and comments from team leaders.

Results

The Sustainability Questionnaire was completed by the Project Board (n=8) and Steering Group (n=10). Limited Senior and Clinical Leadership was where greatest change could be made. After these were Infrastructure and Staff Behaviour Involvement. The CSUQ (n = 35, from 5 teams) showed 71% had received in person training, 17% no training. Staff with no training felt uncomfortable using the portal. Being simple and easy to learn to use scored highest. Efficiency and being able to complete work quickly were the lowest scoring. Slow navigation, cluttering and unfamiliarity were noted for low efficiency. The comments sections were positive for focus on summary and formulation. The qualitative feedback revealed a reluctance to move away from unstructured narrative and for different staff to build the record over time. Nonetheless, staff commented that they found clinical benefits when other teams had added to the portal.

Conclusions and next steps

Despite staff increasingly recognising the value of the CSP there are many barriers to implementation. This has significant implications for the NHSX digitisation strategy. Further evaluation will now take place following these actions in response to the initial findings:

- Enhanced senior leadership and establishment of 'Task and Finish' groups.
- Improved training through a recorded webinar with many key clinicians.
- Linking the CSP to mandatory risk training and a successful business case to fund a band 8 & 7 post to support this.
- Focused discussions with teams using the CSP based on the usability questionnaire.
- Agreement for a comprehensive roll out to all teams simultaneously.

37. An audit of the quality of risk assessments being documented into the Clinical Summary Portal (CSP)

Dr George Coates, *ST5, West London NHS Trust, Dr Jonathan Scott, Chief Clinical Information Officer, West London NHS Trust, Emma Brown, Clinical Risk Practice Developer, West London NHS Trust, Dr Yena Cho, Core Trainee, West London NHS Trust, Dr Sarah Cheng, Core Trainee, West London NHS Trust*

Background

The CSP risk assessment was introduced in September 2019 as an initial phase of the CSP roll out. It is a simplified tool for documentation which encourages a formulation approach with more meaningful understanding of the patients' risk profile, in line with NICE guidance.

A succinct re-write of the previous risk assessment was required. Thereafter, editing only is required if there is significant change in the propensity to risk. The current situation is recorded in other parts of the CSP.

Results

53 sets of notes were assessed from 5 teams.

Quality of transcription - mean score 2.24 (range 1-5, SD 1.14). The median was 2, suggesting that the quality is poor, or between poor and fair.

Quality of the understanding of the nature of the risk – across 8 domains the mean scores ranged from 1.8-2.48. The median score was 2 (poor) for every domain.

Quality of the assessment of current risk– across 3 domains the mean scores ranged from 2.10-2.49, median of 2 for each domain, max SD 1.07.

Staff continue to enter their risk assessment in a timeline form (75%). Staff are not using a functionality called "Significant risk events", a section for the 'headline' risk events.

Conclusions

Staff are not transcribing the information from old to new risk summary, leading to poor quality of the new risk summaries. Despite an extensive training programme, the risk assessment remains a list of events.

38. Improving Discharge Letter Quality and Production Time: A Two Cycle Audit

Dr Matthew Cordiner, *Consultant General Adult Psychiatrist, NHS Lanarkshire, Dr Leah Jones, Consultant Forensic Psychiatrist, NHS Lanarkshire, Dr Khalid Nawab, Consultant Psychiatrist in Learning Disability and Clinical Director, NHS Lanarkshire*

Aims and Hypothesis

To assess whether discharge letters created following inpatient admission conform to local standards of (1) creation within 10 days and (2) containing an ICD-10 code.

Background

Concerns were raised by the Scottish Public Services Ombudsman about the creation of discharge letters following discharge from Acute Psychiatry Wards within NHS Lanarkshire. The original process involved the psychiatrist responsible for the patient's care dictating a letter using WinScribe software, which was transcribed by the administration team, then returned electronically to the author to verify. Once verified, the letter was uploaded to electronic records and sent to the recipient.

Methods

Wards 1 and 2, Wishaw Hospital, were chosen as being representative of practice in NHS Lanarkshire's Acute Admission Units. 60 discharges immediately before December 1st 2020 were included for each ward. For each discharge, electronic systems were searched for a discharge letter. If a discharge letter was present, details of the dates of discharge/dictation/verification, and presence of ICD-10 code were noted. Discharges were not included if they represented transfers to another unit. Prior to round 2, a new process of notifying consultants that a discharge letter is due was implemented. The inpatient administration team now email the relevant consultant and secretary the day after discharge requesting a discharge letter be completed. All consultants were reminded of the need to include an ICD-10 code.

Results

First Round: 116 discharges were identified, with 103 discharge letters found. 10% had an ICD-10 code, 11% were produced within 10 days, median time to production 27 days (range 1 to 108). 50 letters were verified by trainees, against policy. Second Round: 110 discharges were identified, with 91 discharge letters found. 50% had an ICD-10 code, 50% were produced within 10 days, median time to production 15 days (range 0 to 66). No trainees verified letters.

Conclusions and next steps

Round 2 revealed improvement in most areas, but some showed regression. Volatile staffing levels are likely to contribute to this. Absence of consultants will have negative impact on the time taken to create discharges letters through delays to dictating and verifying letters. It was advised CMHT's have contingency plans for this. Without a major redesign of process, achieving the goal of 100% of discharge letters being produced within 10 days of discharge is optimistic. However, the inclusion of ICD-10 codes has shown a substantial improvement, as has the number of trainees verifying letters. Ongoing monitoring has been implemented.

39. COVID vs. Capacity – A retrospective audit of capacity assessment documentation

***Dr David Davies**, CT3, South London and Maudsley NHS Foundation Trust, Dr Lucia Chaplin, CT3, South London and Maudsley NHS Foundation Trust, Dr Nacharin Phiphopthatsanee, CT3, South London and Maudsley NHS Foundation Trust, Dr Rory Ellwood, CT3, South London and Maudsley NHS Foundation Trust, Dr Jonathan Beckett, Consultant Psychiatrist, South London and Maudsley NHS Foundation Trust*

Aims and Hypothesis

To explore the effect of the COVID-19 pandemic on capacity documentation at clerking and in the first ward round in Lambeth Hospital.

Background

The Care Quality Commission recommends that capacity to consent to psychiatric hospitalisation and treatment should be assessed and documented on and throughout an admission. However, the COVID-19 pandemic (declared on 11th March 2021 by the World Health Organisation) has significantly changed the flow of psychiatric inpatients with many trusts adopting a 'COVID triaging' model. This shift has led to a stronger organisational focus on physical health in mental health settings.

Methods

Data was collected through retrospective audits of all newly admitted patients over two-month periods to three acute general adult psychiatric wards in Lambeth Hospital, UK. Auditors manually reviewed the electronic patient records (as no paper records were used in the hospital) to identify any documentation of capacity either by freetext or through pre-defined consent checklists. In a binary fashion, the presence or absence of capacity documentation was recorded at clerking and in the first ward round. The 'pre-pandemic' cohort (n=73) was made from January and February 2020 audit data whereas the 'during-pandemic' cohort (n=64) used July and August 2020 audit data. These months were chosen as junior clinicians rotate posts in early February and August and therefore the confounding effect of a new clinical environment could be reduced. Previous internal audits have not demonstrated any seasonal changes in capacity documentation. The chi-square test was used to assess statistical association with an alpha of 0.05.

Results

For clerking capacity documentation, 'pre-pandemic,' 71% of patients had capacity documented compared to 52% in the 'during-pandemic' group. This difference was statistically significant [$X2$ (1, $N=137$)=5.6, $p=.018$]. For first ward round capacity documentation, 'pre-pandemic,' 85% of patients had capacity documented compared to 52% in the 'during-pandemic' group. This difference was statistically significant [$X2$ (1, $N=137$)=17.9, $p<.001$].

Conclusions and next steps

During the pandemic, capacity documentation in Lambeth Hospital has reduced significantly and this is one of the first local audits to demonstrate this finding. However, this study does not assess whether capacity assessments themselves have also decreased. The outcome is particularly concerning from ethical and medicolegal viewpoints, particularly given the higher risk of contracting COVID in inpatient settings. This learning has relevance to clinicians working in inpatient settings. Further audits should investigate how this trend could be reversed.

40. Analysis of Penetrating Neck Injuries (PNIs) at a South London Trauma Centre before and after the first national lockdown

Dr Gabriela Di Scenza*, Medical Student, St George's University of London, Miss Katrina Mason, ST7, St George's University Hospitals NHS Foundation Trust, Mr Georgios Oikonomou, Consultant, St George's and Croydon University Hospital NHS Trusts*

Introduction

Whilst globally GBH and gunshot wounds account for the majority of Penetrating Neck Injuries (PNIs), Deliberate Self Harm (DSH) and other accidents are responsible for a significant proportion of PNIs in the United Kingdom. It was speculated at the beginning of the pandemic that lockdown and its resultant effects would have a negative impact upon people's mental and physical wellbeing. We sought to compare differences in presentation of PNIs before and after the pandemic in St George's University Hospital, a major London trauma centre.

Method

A hospital database search was undertaken searching for all admissions with ICD-10 diagnostic criteria for all types of PNI. A further hand search of digital department handover records was reviewed. We recorded data on patient demographics, mechanism of injury, management, and outcomes.

Results

A total of 62 PNIs were identified from February 2019 to April 2021. The total incidence of recorded PNIs increased by 48.0% post lockdown (n=25 pre-lockdown to n=37 post-lockdown). A rise in DSH pre and post pandemic was noted. A previous 2009-2011 audit of PNIs in our trust revealed 48.0% were attributed to DSH, we noted a similar rate in our 2019/2021 audit with 40.7% of PNIs pre-lockdown, however this increased to 66.6% of PNIs post-lockdown, a total increase of 177.8%.

Conclusion

Before the pandemic only one patient with a pre-existing psychiatric condition was identified compared to 16 after. Subsequently, there was increased demand for inpatient mental health treatment post-injury reflecting an additional impact on mental health services experienced post-lockdown.

41. Service evaluation of Rockbox in a mental health inpatient unit

Miss Nicole Freeman, *Medical Student, University of Sheffield, Dr Simon Taylor, Consultant Psychiatrist, Derbyshire Healthcare NHS Foundation Trust*

Aims and Hypothesis

This service evaluation aimed to analyse the baseline levels of physical activity (PA) of mental health inpatients and staff, alongside their attitudes and experiences of Rockbox fitness sessions. It was expected that patients' baseline level of PA would not meet 600 MET-minutes of exercise per week and that Rockbox would have an impact on their attitudes towards PA.

Background

A mental health inpatient unit ran weekly Rockbox sessions over 2 years for both inpatients and staff, because mental health inpatients do less PA than the general population despite PA being beneficial. Rockbox is a fitness session that incorporates boxercise moves with upbeat rock music.

Methods

Fourteen patients and 2 staff members who had taken part in a Rockbox session were given feedback forms, including questions on demographics, PA in the last week, if they felt they did enough exercise, barriers towards exercise, and comments on the session. Each exercise was classified as 'moderate' or 'vigorous' and, based on this, the number of MET-minutes per week was calculated for each patient.

Results

Of the participants who filled out the relevant area of the form, 41.6% (n=5) exceeded 600 MET-minutes per week. The remaining 58.3% (n=7) did not meet 600 MET-minutes per week, with 25% (n=3) of participants including both staff members doing no PA. The mean number of MET-minutes per week was 550 minutes and median 210 minutes. Of the 8 patients who felt they did enough PA, 6 did not meet 600 MET-minutes per week. In this group, lack of confidence was the most common (n=5) barrier. Not enough time was the most common barrier in the 4 participants who did not feel as though they did enough PA. Of the patients who provided additional comments on the session (n=15), all were positive and included patient comments on wanting to try the session again.

Conclusions and next steps

In this cohort, 41.6% participants exceeded 600-MET minutes per week. Lack of confidence was the most common barrier towards PA in those who did not meet this target. A different set of barriers were faced by those who felt they did enough PA in comparison to those who felt they did not. All participants found Rockbox a positive experience and patient comments show that such sessions have the potential to engage them in PA.

42. Reasons for Referral and Outcomes of Neuroimaging in Early Intervention in Psychosis Team

Dr Shreeya Gyawali, *Clinical Fellow, North East London NHS Foundation Trust, Dr Emmanuel Mandalakis, Consultant Psychiatrist, Barking and Dagenham EIP, North East London NHS Foundation Trust*

Aim

To ascertain reasons for neuroimaging referral and outcomes of neuroimaging in patients under Early Intervention Service in Barking and Dagenham (B+D EIP). To assess compliance with NICE guidance

Background

Brain abnormalities in patients presenting with First Episode Psychosis (FEP) have been reported and it is important to exclude any brain occupying lesion or other crude brain pathology masquerading as functional illness. NICE guidelines for neuroimaging in FEP do not recommend CT scan or MRI scan as a routine investigation. The guideline advises neuroimaging only if indicated by certain features in clinical picture without mentioning explicitly clear criteria.

Methods

A retrospective audit of records of all patients in B+D EIP was carried out to identify patients referred for neuroimaging. Patients' progress notes on electronic recording system RIO were scanned using search terms- 'MRI', 'scan', 'imaging'. Data extraction for reasons of referral was done by reading clinical notes. Data analysis was carried out using SPSS version 23.

Results

50 patients (36.2% of EIP caseload) were referred for structural neuro-imaging (head-MRI and/or head-CT scan). 41 individuals (82% of those referred) had been referred for an MRI, 7 individuals (14%) had been referred for a CT and only two individuals (4%) were referred for both CT and MRI.

Few patients had multiple reasons for referral. The commonest reason was presence of neurological signs and symptoms (20.28%), atypical age of onset (14.49%), visual hallucinations (11.59%), bizarre presentation (8.69%), hyperprolactinemia (8.69%). Other reasons were treatment non-response (5.79%), changes in cognitive capacity (5.79%), suspected encephalitis (4.34%), acute onset of symptoms (2.89%), catatonic symptoms (2.89%).

31 patients (62% of referrals) had imaging done.
Of those 31 patients 25 patients (80.6%) did not have significant findings and report was 'normal'. 5 patients (16.1%) had non-specific white matter changes such as "no specific foci of high FLAIR signal", "Slight white matter hyperintensity". Only one patient was found to have "small vessel disease of a mild form in both cerebral hemisphere white matter"

Conclusions

More than a third of cases in B+D EIP had been referred for structural neuroimaging. The reasons for referral were in line with NICE guidelines. The yield of structural neuroimaging was very low and only in one patient there could be potential advice given. The benefit of structural neuroimaging in this group is therefore questionable. Further research is recommended to optimise the yield of structural neuroimaging in psychosis by establishing tighter criteria for referral

No financial sponsorship was received for the above research project

43. Physical health assessment completion of new inpatients

***Dr Jimmy Hung**, CT3, Norfolk and Suffolk Foundation Trust (NSFT), Dr Matthew Nelson, CT1, Norfolk and Suffolk Foundation Trust (NSFT), Dr Jemima Jackson, CT3 (NSFT), Dr Vivek Agarwal, consultant psychiatrist, Norfolk and Suffolk Foundation Trust (NSFT)*

Aims and Hypothesis

To clarify if initial physical examination, admission bloods, electrocardiogram (ECG) and venous thromboembolism (VTE) assessments are completed within 24 hours and documented appropriately on the electronic health record system (Lorenzo).

Background

Severe mental illnesses have been linked consistently to increased mortality where modifiable risk factors are largely responsible. Biochemical derangements and symptoms of physical health conditions can exacerbate and imitate mental illness. Moreover, initial assessment can determine the choice of treatment, e.g. long QT interval on ECG and choice of rapid tranquilisation. Therefore, early investigation can provide appropriate treatment options and an opportunity to provide holistic care to improve health outcomes.

Methods

A retrospective audit of the patient electronic notes (Lorenzo) and blood records from Norfolk and Norwich University Hospital Sunquest ICE desktop system were performed. The initial audit sample included 40 new patients admitted during the four weeks following the start of new trainee doctors on 3rd August 2019. The sample was obtained from a combination of seven adult and old age psychiatric wards. A reaudit was performed for the four weeks following 3rd August 2020 where 53 new patients were admitted from the same wards. Interventions between the two cycles included a Powerpoint presentation to new trainee doctors during their induction and a separate email highlighting the requirement of initial physical health assessment for new patients. All information was collated and percentage compliance calculated with no further statistical analysis.

Results

From the 40 patients newly admitted in August 2019, the following percentage of each investigation were performed within the first 24 hours: Physical examination: 21/40 (53%) Admission bloods: /40 (33%) ECG: 5/40 (13%) VTE assessment: 27/40 (68%) From the 53 patients newly admitted in August 2020, the following percentage of each investigation were performed within the first 24 hours: Physical examination: 38/53 (72%) Admission bloods: 24/53 (45%) ECG: 6/53 (11%) VTE assessment: 38/53 (72%)

Conclusions and next steps

Our interventions appear to have had a positive impact in the majority of physical health assessments in this sample. Aside from the percentage of ECGs performed, which reduced slightly from 13% to 11%, there was an improvement in the remainder of investigations performed for new patients admitted. A future audit is needed to further evaluate the impact of our intervention and whether it has been sustained.

44. An audit of the assessment of and management of alcohol misuse in patients following admission to the general adult inpatient ward setting

***Dr Declan Hyland**, Consultant in General Adult Psychiatry, Clock View Hospital, Liverpool, Mersey Care NHS Foundation Trust, Humayun Ahmad, 5th year medical undergraduate, University of Liverpool, Jack Hood, 5th year medical undergraduate, University of Liverpool, Dr Alice Hill, Foundation Year 2 Trainee, Clock View Hospital, Liverpool, Mersey Care NHS Foundation Trust, Dr Chris Hammond, Foundation Year 2 Trainee, Clock View Hospital, Liverpool, Mersey Care NHS Foundation Trust*

Aims and Hypothesis

To establish whether patients admitted to general adult inpatient wards in Mersey Care NHS Foundation Trust are screened for alcohol use on admission and, for those with harmful or dependent use, whether they are prescribed Chlordiazepoxide (regularly or PRN), as indicated by the patient's Clinical Institute for Withdrawal Assessment of Alcohol (CIWA) score, and having relevant blood tests checked within 24 hours of admission.

Background

Individuals admitted to inpatient psychiatric units are unwillingly subjected to abstinence from alcohol at the point of admission and at risk of acute withdrawal. Assessment and management of acute alcohol withdrawal in the general adult inpatient setting hasn't been audited in Mersey Care NHS Foundation Trust's Local Division since 2018. At that time, only inpatients on three general adult wards were included. This audit incorporated all eight general adult wards, optimising the reliability of the findings.

Methods

A list of the 139 inpatients on the eight general adult wards was obtained. An audit tool was completed for each patient, capturing: demographic data, alcohol use history, previous history of delirium tremens (DTs) , documentation of a CIWA score, prescription of Chlordiazepoxide, Thiamine, Vitamin B Compound Strong and rectal Diazepam, and whether a serum gamma GT level and Magnesium level were checked.

Results

Of the 139 inpatients, 82 were male, 57 were female. 117 of the inpatients were Caucasian. An alcohol history was documented in 62 of the inpatients. The presence or absence of a history of DTs was documented in only 1 inpatient. Only 1 patient had a CIWA score documented within 24 hours of admission. Rates of prescription of Chlordiazepoxide, Thiamine, Vitamin B Compound Strong and rectal Diazepam were low. 14 inpatients had a serum gamma GT level done, with 21 having a serum Magnesium level done. Only 4 inpatients were offered referral to community alcohol services.

Conclusions and next steps

Current practice falls below what should be expected. Modification of the inpatient clerking proforma is required to ensure an adequate alcohol use history is obtained. There is a need for education and awareness training for junior doctors and nursing staff of the importance of checking gamma GT level and serum Magnesium level on admission and early recognition of the need for a CIWA score and prompt initiation of Chlordiazepoxide, Thiamine and Vitamin B Compound Strong, as indicated. Admission to the ward provides an ideal opportunity to offer referral to alcohol services in the community.

45. What can we learn about psychiatric prescribing from an audit of CMHT prescriptions?

***Dr Jacob King**, ST1/ACF, North Kensington and Chelsea CMHT, Dr Omar Mahmoud, ST5, North Kensington and Chelsea CMHT, Ms Phoebe Atieno, Advanced Clinical Practioner, North Kensington and Chelsea CMHT, Dr Jasna Munjiza, Consultant Psychiatrist, North Kensington and Chelsea CMHT*

Aims and Hypothesis

We aimed to complete the first cycle of an open audit into the community prescribing of our CMHT in order to 1. evaluate our prescriptions of benzodiazepines specifically, and 2. identify patterns of prescribing which could be addressed towards optimising GP/regular care provider-led prescribing.

Background

Various models of community psychiatric prescribing exist. In our inner London borough patients' GPs are supported to prescribe on-going medication to ensure continuity of care. However, 'FP10' outpatient prescriptions are used on occasion, particularly in cases of urgency or when initiating antipsychotic medication (in line with shared care agreement in most London boroughs). Several guidelines exist on the prescribing of controlled medications including benzodiazepines and hypnotics in the community psychiatry patient group.

Methods

Paper charts co-recording FP10 dispensing over the 16 month period between August 2019 and November 2020 were reviewed by three authors, (JK, OM, PA). The medication(s), length of prescription, grade of prescriber, were recorded along with the date of prescription.

Results

There were a total of 219 FP10s issued over the 16 months audited, representing 253 prescriptions of individual medications. The mean number of medications prescribed per FP10 was 1.15 (σ = 0.53), with one FP10 containing 6 medications. There was notable variance in the number of prescriptions by month, mean = 14.5, σ = 10.9. The most commonly prescribed medications were promethazine (n=39), olanzapine (n=36), and Zopiclone (n=22). Total prescriptions of benzodiazepines were 16, chiefly clonazepam (n=12). Antipsychotics were the most commonly prescribed class of medications (n=95). There were three (3) non-psychiatric medications prescribed. The number of prescriptions by grade; SHO, SpR, consultant or prescribing pharmacist, varied considerably (91, 75, 39, and 6 respectively).

Conclusions and next steps

Most commonly prescribed group of medications were antipsychotics which can be explained by shared care agreement for prescribing for antipsychotics. On the whole we were encouraged by low prescribing of benzodiazepines and non-psychiatric medications, however higher than expected rates of promethazine scripts open a number of questions about the role community psychiatrists see promethazine playing in the treatment of their patients. Follow-up audit following a team presentation revealing these results will be completed in due course.

46. Management of metabolic syndrome on a psychiatric ward against current NICE guidance

***Dr Cristina Lefter**, SHO, Pennine Care NHS Foundation Trust, Dr Adeola Akinola, Consultant Psychiatrist, Pennine Care NHS Foundation Trust*

Aims and Hypothesis

To gauge whether we are performing physical health assessments for new admissions as per National Institute for Health and Care Excellence (NICE) guidelines. This audit aims to identify if the risks of metabolic syndrome (MS) and cardiovascular disease (CVD) were assessed in patients during their admission and the actions taken in order to identify and avoid certain complications that could lead to a physical health deterioration.

Background

The metabolic syndrome is a term used to describe a combination of medical disorders that increase the risk of CVD and diabetes mellitus (DM). In order to be diagnosed the patient must present at least three of the following five medical conditions: obesity, high level of glycaemia, high blood pressure (BP), dyslipidaemia and low serum high-density lipoprotein (HDL). Convincing evidence shows that individuals suffering from mental health conditions have an increased risk of developing CVD and MS, which can lead to a greater risk of mortality.

Methods

Retrospective data was collected from the patients' files on North Ward, Irwell Unit. This audit involved 21 patients and there were examined their admission notes, blood tests results, physical health forms, treatment, medical history and Q-risk assessment. For the statistics, Microsoft Excel tools were used.

Results

This audit was conducted on a female ward, 45% of them being aged between 18 and 35 years old. Regarding their blood pressure measurements, 14% of the patients have not had it noted and 5% refused it. Normal values of BP were found in 19% of patients. During admission, 57% of the patients have not had ECGs done. The Q-risk was calculated for only 67% of patients, as the rest of them were unable to be assessed due to insufficient information on their physical health forms. The results of this audit show that waist circumference was measured for 5% of the patients. Regarding the body mass index (BMI), 29% of patients were not assessed, 19% had a normal BMI, 29% were overweight and 9% refused weight and height during admission.

Conclusions and next steps

In conclusion, the audit standards were not achieved throughout the initial stages of the audit. The absence of BMI, ECGs, and waist circumference accounts for the majority of the incomplete physical health monitoring. The audit revealed the need for physical health assessment standardization.

47. Monitoring of Plasma Clozapine Levels in the Chiltern Community Mental Health Team Audit

***Dr Claire Palmer**, CT3, Oxford Health NHS Foundation Trust, Ms Louise Revell, Pharmacy Technician, Oxford Health NHS Foundation Trust, Dr Sara Rawal, GP ST2, Oxford Health NHS Foundation Trust*

Aims and Hypothesis

To investigate the frequency of plasma clozapine monitoring and the reason for conducting a level. We then analysed if the results were within the recommended target range, at the recommended time and if any subsequent actions were taken.

Background

Guidelines related to plasma clozapine monitoring and the target range are limited. It is known that certain circumstances, such as a change in smoking levels, infections, suspected toxicity, non-compliance and medication interactions can warrant monitoring. Oxford Health NHS Foundation Trust has considered implementing a policy to complete annual plasma clozapine levels on all patients taking clozapine. This audit helps to ascertain current monitoring practices and what future resources may be needed.

Methods

All plasma clozapine levels from community and inpatients within the Chiltern Community Mental Health Team (CMHT) were included. Levels were taken within a one year period from 1st August 2019 – 31st July 2020, with 99 levels in total. Results were obtained from Analytical Services International laboratory and the clinical notes used to obtain the timing of samples and actions taken.

Results

Under half (45.3%) of patients on clozapine had a plasma clozapine level in the period. 49 (49.5%) levels were higher than the target range, with 28 (28.3%) levels within the range and 22 (22.2%) low levels. Documenting the time of sample and reason for request was sporadic. Continuing or initiating antiepileptic medication, reducing dose and repeating levels were common for high level results. Increasing dose was a common action for low level results, although 27.3% of patients had no documentation of any action taken.

Conclusions and next steps

Given that under half of patients have had a plasma clozapine level taken in the one year period, a significant increase in resources would be required if the trust were to implement a policy of annual plasma clozapine monitoring. Ensuring documentation is recorded for timing of the sample, reason for request and action taken is imperative and could affect patient care. Along with staff education, it is important to consider whether a clozapine clinic in the Chiltern CMHT could help mitigate these factors.

48. Audit Of Documented Assessment of Capacity to Consent to Treatment in Braeburn House Inpatients (Rehabilitation)

Dr Sunita Amarjeet Patil, *Speciality Doctor, GMMH NHS Trust, Dr Minu Sabharwal Chopra, Speciality Doctor, GMMH NHS Trust, Audit supervised by: Dr Imran Ali, Consultant GMMH NHS Trust*

Aims and Hypothesis

1. To review assessment of capacity to consent to treatment for detained inpatients is being adhered to in accordance with the MHA code of practice at Braeburn House, Salford.
2. Assess whether there is a record of an initial discussion with patient in regard to their capacity to consent to treatment.
3. Assess whether a documented follow up discussion occurred, if the patient is not initially deemed to have capacity.
4. Assess whether ''Record of discussion of contents re; treatment plan'' form is completed.

Background

The MHA code of practice states: "To give time to develop a treatment programme suitable for the patient's needs, the Act allows treatment to be given in the initial three-month period starting the day on which any form of medication for mental disorder was first administered to the patient during the current period in the which the patient is liable to be detained under the Act". And at 24.41: "During this time, the patient's consent should still be sought before any medication is administered, wherever practicable. The patient's consent, refusal to consent, or lack of capacity to consent should be recorded in the patient's notes…." And at 25.17: "Where approved clinicians certify the treatment of a patient who consents, they should not rely on the certificate as the only record of their reasons for believing that the patient has consented to treatment. A record of their discussion with the patient including any capacity assessments should be make in the patient's notes as normal".

Methods

1. There are 28 inpatients at Braeburn House, Salford who were detained under MHA Sections.
2. The notes of these patients in the period from 1.5.21- 15.5.21 will be audited.
3. Notes will be searched for the word capacity and entry reviewed.
4. ''Record of discussion of contents'' form completion will be checked.

Results

There were12 patients (43%) on T2 and 16 patients (57%) on T3. Follow up discussion for patients on T3 was done for 12 patients (75%) (out of 16). Record of discussion re: SOAD plan for patients on T3 – Done for 09 patients (56%)

Conclusions and next steps

1. 75% of patients on T3 have had a follow up discussion about medications. In 25% of patients on T3, no follow-up discussion happened.
2. For 44% of patients who are on T3 and were referred for SOAD opinion, there was no record of discussion about the SOAD treatment plan with the patient.

49. Community Lithium Monitoring during the COVID 19 Pandemic

***Dr Evonne Shek**, Consultant Psychiatrist, Dr Amy Hudson, GPST2 trainee*

Aims and Hypothesis

The National Institute for Health and Clinical Excellence, British National Formulary and local guidance are consistent in their recommendation for monitoring. This includes: serum lithium levels, urea and electrolytes, thyroid function, calcium, body mass index and assessment of side effects and signs of toxicity at each clinical contact. This study sought to establish our local adherence to these recommendations over a six month period corresponding to the first wave of the COVID-19 pandemic. Patients should have their lithium levels checked on a 3 monthly basis and their urea and electrolytes, thyroid function, calcium checked on a six monthly basis. It was anticipated that the pandemic would impact on adherence to these monitoring criteria, however to what degree unknown. Owing to the severity of adverse effects and consequences of toxicity if left unmonitored, the standard remains at 100% of patients taking lithium should have regular monitoring of blood tests.

Background

Lithium is a widely prescribed mood stabiliser which is the gold standard of treatment for Bipolar affective disorder and has also proven beneficial in recurrent depression and self injurious behaviour. Auditing lithium monitoring during the first wave of the pandemic allows further learning and improvement in services with primary and secondary care.

Methods

A retrospective analysis of a cohort of patients at a community mental health team in the west of Scotland was performed between 3rd August 2020 and 3rd June 2021. Patients prescribed lithium were identified following review of clinic letters and cross referenced with nursing records. The most recent date on which a lithium level, renal function, thyroid function and calcium were recorded.

Results

Thirty seven patients were identified as currently being prescribed lithium. In the preceding three months, 64.9% (n=24) had a recorded lithium level. In the preceding six months, 83.4% (n=31) of patients had urea and electrolytes recorded, 75.7% (n=28) had thyroid function recorded and 56.8% (n=21) had a serum corrected calcium recorded

Conclusions and next steps

Local practice during this time frame does not reflect on national lithium monitoring standards. There was variability in the monitoring of different parameters suggesting a number of factors have influenced adherence. Next steps include letters to all the GP practices with results of this first cycle audit and a plan to repeat audit again as pandemic restriction ease this year..

50. Clinical Audit on the Measurement of Antipsychotic Side Effects using rating scales (GASS, LUNSERS, and SESCAM) in community settings

Dr Olusegun Sodiya*, CT2, Tees, Esk and Wear Valleys NHS Foundation Trust, Dr Adewole Adegoke, CT2, Tees, Esk and Wear Valleys NHS Foundation Trust, Dr Geanina Ilinoiu, ST6 Tees, Esk and Wear Valleys NHS Foundation Trust, Dr Clare Morgans, Consultant Psychiatrist, Tees, Esk and Wear Valleys NHS Foundation Trust*

Aims and Hypothesis

This clinical audit aimed to assess if the monitoring of side effects of antipsychotics is complied with using the Trust and National institute of clinical excellence (NICE) guidelines.

Background

One of the determinants of prognosis in schizophrenia is adherence to medications. Several patients during episodes of relapse or while recovering on the ward have stated that experience of adverse side effects were the main reasons for defaulting on their medications. It highlights the significance of a collaborative approach with patients about the benefits and risks of antipsychotics. The recommended monitoring scales are Glasgow antipsychotic side effect scale, Liverpool University Neuroleptic Side Effect Rating Scale, and side effects scale for antipsychotic medication.

Methods

The audit was conducted from March 30th to April 30th, 2021 by using a random sampling technique to select 50 patients on the caseloads of two community mental health teams within South Durham. The data was collected with a tool designed using NICE guidelines on the management of psychosis and, schizophrenia (CG178) and the trust policy document on monitoring of psychotropic medications.

Results

In all the selected patients, no rating scales were used to assess their side effects at three months or after one year of commencement of antipsychotics. However, there was documented review of side effects written as case notes in 96% of patients. The side effects on case notes included; extrapyramidal side effects (EPSE) in 96% of patients, sexual side effects in 72% of patients, and menstrual irregularities (females under 50) in 18% of patients. We also noted that EPSE was the most documented of the side effects.

Conclusions and next steps

This audit showed a significant gap in the measurement of side effects of patients on antipsychotics as none of the recommended rating scales were used in the selected service users. The reviews of side effects were carried out in a random pattern rather than the suggested timeline of three months and one year by the guidelines. We also noted that the documented sexual side effects were not well explored and this may be due to the sensitive nature of the topic. Hence the use of a rating scale could have elicited a better response. Given our findings, there is a need for the Trust and NICE guidelines to be adhered to in the monitoring of side effects of antipsychotics as this is likely to have a positive impact on compliance to medications by service users.

51. An Evaluation of Leicestershire's new Central Access Point, (CAP)

***Dr Thomas Sun**, FY2, LPT NHS Trust, Dr Janan Sathiendran, FY2, UHL NHS Trust, Dr Daniel Kinnair, CONS, LPT NHS Trus,t Rachael Eldessouky, Team Manager - CRHT & CAP, LPT NHS Trust, Saskya Falope, Team Manager - Urgent Care & Access Pathway, LPT NHS Trust, Dr Srinivas Naik, CONS, LPT NHS Trust*

Aims and Hypothesis

The Central Access Point (CAP) was set up in April 2020 covering the whole of Leicester, Leicestershire and Rutland, (approximately one million people). Patient records of all callers to the CAP in January 2021 were assessed.

Background

The CAP consists of two parts:

1. A telephone service allowing patients, their friends and family to phone and seek mental health support. Phone calls are taken by support and recovery workers employed by Turning Point who can signpost to other services or take formal referrals.
2. For professionals calling the CAP, information is gathered from an administrator. This is then discussed within the wider team, and the patient will be called back and offered support and signposting or offered a more detailed triage.

Methods

We examined all of the calls to the CAP in January 2021, totalling 1336 calls, across 1159 patients. Outcomes were identified using SystmOne. Statistics Kingdom's Chi-square test for analysis of significance and effect size.

Results

Preliminary analysis of 452 calls, across 399 patients, sourced referrals from: Primary care (185; 40.93%), Self (130; 28.76%), NHS 111 (51; 11.28%), IAPT (30; 6.60%) and other sources (56; 12.39%). 356 users contacted the CAP once, 35 twice, 6 thrice, and 2 four times during January 2021.

124 (27.4%) did not complete triage. 85 (18.81%) were not contactable after multiple attempts (DNA) and subsequently discharged; 39 (8.63%) declined. Outcomes by 1-month included: re-referral to the CAP (31), GP review (107), CHRT (42), admission (3), self-harm (7) and others.

DNA rates across the four commonest referral sources: Primary care (54; 19.19%), Self (13; 10%), NHS 111 (6; 11.76%), and IAPT (5; 16.67%). 28 (41.79%) of Primary care referral DNAs were routine, with a mean wait time of 29 days. A moderate association between CAP attendance rates and referral sources directly contactable by service users was found ($P<.001$; Cramer's V effect size = 0.29). These included self-referrals, primary care, and NHS 111 referrals.

Conclusions

The CAP provides an innovative pathway for almost 1/3 of service users (both new and known to services) to seek psychiatric support through self-referral. The telephone-based service observed 20% DNA rate, greatly varying between referral sources. Self-referral had significantly reduced DNA rates versus alternatives (Primary care or NHS 111) which existed prior to establishment of the CAP.

52. Diagnostic choices in patients with First Episode Psychosis

Olivia Tierney, *Medical Student, Brighton and Sussex Medical School, Dr James Fallon, Clinical Senior Lecturer and Honorary Consultant Psychiatrist, Brighton and Sussex Medical School*

Aims and Hypothesis

The purpose of this service review was to establish whether there is variation between treating teams in choice of initial diagnosis for those presenting with a First Episode of Psychosis (FEP). We also explored whether diagnosis is reviewed over the first 12 months of treatment by the Early Intervention in Psychosis Service (EIS), who assume management of all patients with FEP in the treatment and recovery period.

Background

It is important that clinicians acknowledge that a single episode of psychosis is not representative of a chronic, progressive illness. Episodic diagnoses may inform care planning as well as offer hope of recovery to patients and their carers. Using the term 'First Episode of Psychosis' (FEP) is viewed as the 'gold-standard' among EIS teams, however the extent to which this is used by all treating teams is unknown.

Methods

Medical records of all patients who had completed at least one year of follow up with EIS in Sussex Partnership Foundation Trust (n=274) were reviewed. The initial diagnosis used was recorded and grouped according to ICD-10 criteria with initiating care team (EIS service, non-EIS community services and inpatient services). Diagnosis used at 12-months was recorded alongside demographic data. Analysis was performed of initial diagnosis by initial care team and diagnosis at 12 months.

Results

There was variation among care teams in use of FEP as the initial diagnostic term (P=0.042). FEP was used most frequently by EIS and non-EIS community teams, comprising 58% and 46% of initial diagnoses respectively. Inpatient teams used FEP less frequently (31%), instead favouring the 'Psychotic Disorder' grouping (35%). Following 12 months of treatment with EIS 74% of caseload had episodic diagnoses compared to 69% at initial diagnosis. 10% of patients had been given a diagnosis of a long-term psychotic or affective condition during their first episode.

Conclusions and next steps

It was positive that diagnoses for patients experiencing a first episode of psychosis were mostly episodic in nature. Specialist EIS services favoured use of FEP in keeping with the ethos of recovery and not moving to lifelong diagnosis at an early stage. This is in keeping with recent evidence around positive recovery rates in FEP. The use of FEP as a diagnosis was less common in inpatient services which perhaps reflects reduced exposure to positive long-term recovery. That 10% of patients were diagnosed with chronic conditions such as schizophrenia at initial presentation indicates that work on promoting the use of FEP as a diagnosis would be valuable.

53. Audit and re-audit of rewriting depot prescription cards in treatment team, Folly Hall

***Dr Chinwe Utomi**, CT2, South West Yorkshire NHS Trust*

Aims and Hypothesis

To evaluate whether depot prescription cards were re-written according to Trust's guideline

Background

The Trust guidelines includes- to check if the dose is within the BNF limit, and if not, is there a high dose antipsychotic form attached - to check if patient has had their bloods and ECG done as per protocol - check if patient has been reviewed by a medic in the past 1 year- and check if side effects of medications is checked and recorded.

Methods

The audit was done using cards re-written between April and June 2020; while the re-audit was carried out using cards rewritten between April and June 2021.Cards were chosen randomly from the shelves and sorted by choosing cards re-written in the specified period of the audit. Sample size was 40 prescription cards. The same sampling method and sample size was used for re-audit. Data gathering was from prescription cards, Systemone and ICE.

Results

Audit result showed 28 out of 40 (70%) had their bloods up to date; 34 out of 40 (85%) had been reviewed by a medic in the last year; 26 out of 40 (65%) had ECG reported; all doses were within BNF limits; and all had side effects check recorded. Recommendation- A chart was designed and displayed in the Treatment Team office as a prompt for the medics re-writing depot prescriptions, with instructions regarding required reviews and appropriate recording. Next due date for bloods and medic review was written at the top of the prescription cards. Emails were also sent out as a reminder. Result of re-audit showed that all patients had their bloods up to date; 35 out of 40 (87%) has had their annual medic review; 30 out of 40 (75%) had their ECG reported; all prescriptions were within BNF limits; and they all had their side effects recorded.

Conclusions and next steps

The recommendations given has proven to be useful and has improved service delivery. This practice will be trialled and recommended to other centres within the trust.

54. The Patient's Guide to Buvidal - A service improvement of a digital repository of patient information for patients taking Buvidal in Wales

Mx Devon Ward, *3rd Year Medical Student, Cardiff University*

Aims and Hypothesis

To create a series of informative videos answering important questions for patients taking Buvidal as part of an 8 week student-selected project.

Background

Buvidal is a prolonged-release injection of Buprenorphine currently being used in Wales to manage allostatic cravings in patients with opioid dependence. Following the success of using videos in patient education in the management of ulcerative colitis, a similar video repository for patients taking Buvidal may be useful in providing holistic support for their recovery journey.

Methods

Participants were chosen using voluntary response and convenience sampling from two participant groups in Cardiff Royal Infirmary: patients taking Buvidal and prescribers. Data was collected regarding the usefulness of the patient information leaflet and their recommendations for a repository of videos. A series of animated videos were created and the same participants gave feedback on the usefulness of the videos.

Results

10 participants took part in this initial trial of the videos. Prescribers placed more importance on lifestyle restrictions when taking Buvidal, whereas patients rated the administration and dosage of Buvidal as more important. 90% of patients preferred animated videos to recordings, and 60% of participants preferred several short videos over one long video. 5 videos were created covering 12 topics that <50% of the participants rated "very important" in the initial questionnaire. The second questionnaire showed an increase in prescriber confidence in 9/12 of topics, whereas 7 for patients. Confidence decreased in both groups in the topics that weren't covered in the videos. 100% of participants preferred the videos to the paper leaflet and 33% of participants wanted more topics to be covered.

Conclusions and next steps

With all participants reporting that these videos were useful, these videos could be beneficial in supporting patients with opioid dependence. This study was encouraging in its initial response to this digital repository, but has drawbacks due to its small sample size, sampling method and lack of comparison to a control. To improve, the group could be chosen using stratified sampling and then split into two groups: one using the paper leaflet, and the other using the paper leaflet and videos to compare recall and understanding. There is a potential view to create similar video series for other medications following a larger scale trial of the video series.

55. Re-audit: Health Education North West (Mersey) Psychiatry core trainees' experiences in undertaking an Audit/Quality improvement project

Dr Aisha Yousaf, *CT3 Psychiatry, Halton Recovery Team, Brooker Centre, Merseycare NHS FT, Dr Indira Vinjamuri, Consultant Psychiatrist CRHT, Consultant lead for crisis services, Deputy Medical Director/Director of Medical Education, Merseycare NHS FT*

Aims and Hypothesis

To improve trainees' experience in understanding the audit requirements. To focus on what support should be provided by trust in undertaking the audit.

Background

Guidance taken from: Royal College of Psychiatrists (RCPsych) Audit/QI competencies. We also took guidance from Health Education England - ST interview expectation and requirement.

Methods

Data was collected from Health Education North West (Mersey) Psychiatry Core Trainees (CT1-CT3) and equivalent (Trust grades, FY3/4). Trusts included: Merseycare, Cheshire and Wirral Partnership, North West Boroughs Health. A survey was generated on Google Forms and questions were asked about trainee's experiences on undertaking an audit/QI project. All responses were collated in the form of charts in Google Forms.

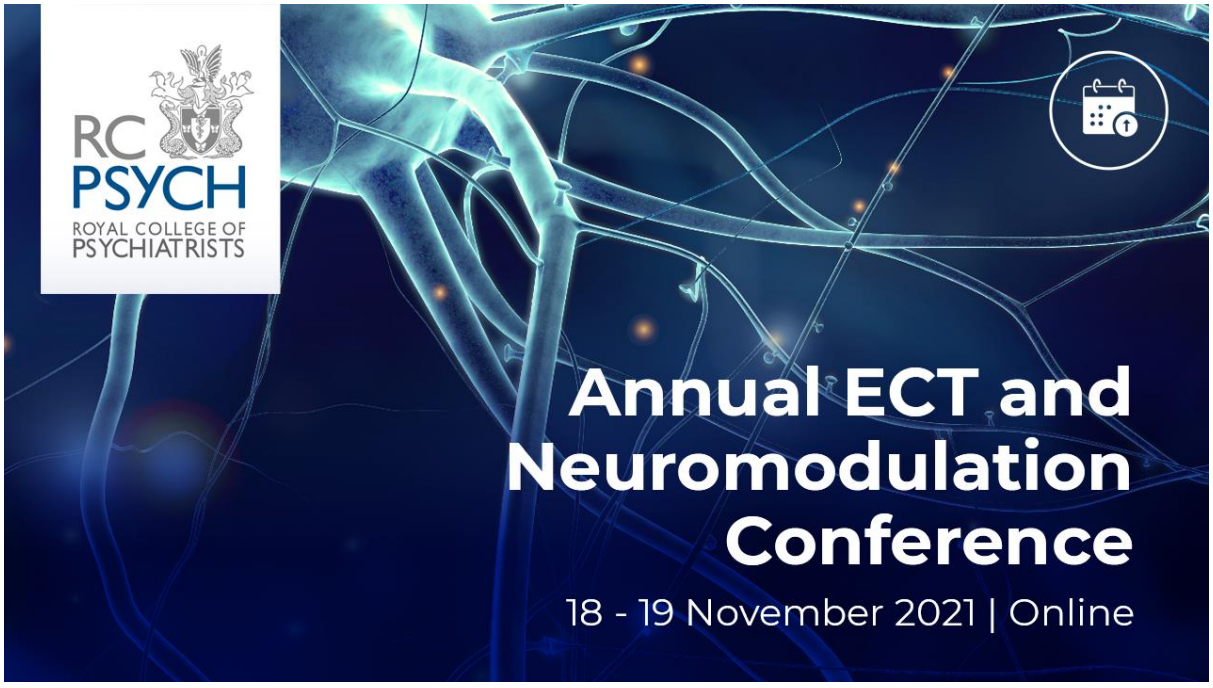
Results

- 80% of trainees were aware of RCPsych audit requirements for undert`king audit in core training years. Recommendation was given to include a session in induction about RCPsych requirement for audit in CT years, 40% of responses are session was included.
- 46% feel supported in helping them towards ST interviews.
- LTFT trust wide did not seem to get much supported when it comes to participating in QI projects.
- 65% people feel they have sufficient time in their job plan to work on audit compared to 61% in original audit.
- 20% managed to complete audit loop compared to 16% in original audit.
- Many trainees are getting chance to present their audits in local meetings. 4 of them managed to present in national conference (compared to only 1 in original audit). 17% did not get a chance to present. The figure stays the same as previous audit (17%).
- 43% trainees think covid has impacted their ability to complete audit.

Conclusions and next steps

- Trusts to include a section on audit especially focussing on core trainees requirements and expectations in junior doctor induction. This should cover requirements set by RCPsych and HEE for ST interviews.
- Every core trainee should be given a chance to present an audit/QI project during their placement.
- Supervisors to actively encourage and guide trainees in choosing QI projects and discuss progression in supervision at least once a month.
- More collaboration between various placements and trusts would make this process easier.
- Re-audit in a year.

Upcoming Events




RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS
Women and Mental Health Special Interest Group Conference 2021
26 November 2021 | Online


RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS
Physical Health Updates 2021
3 & 6 December 2021 | Online