Royal College of Psychiatrists

Faculty of Liaison Psychiatry Annual Conference

19-21 May 2021

Conference Booklet

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General Information

Accreditation

This conference is eligible for up to 3.5 CPD hours per day, subject to peer group approval.

Certificates

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

Feedback

A detailed online feedback form can be found by visiting

Day 1 - https://www.surveymonkey.co.uk/r/Liaison19May

Day 2 - https://www.surveymonkey.co.uk/r/Liaison20May

Day 3 - https://www.surveymonkey.co.uk/r/Liaison21May

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

Social Media

If you wish to tweet about the conference use @rcpsychLiaison #Liaisonconf21

Conference Resources

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

Posters

Please see the following link to view the posters.

Speaker abstracts and biographies.

Wednesday 19 May 2021 - Policy

Welcome from the Chair

Dr Jim Bolton, Chair, Faculty of Liaison Psychiatry

Dr Jim Bolton is a Consultant Liaison Psychiatrist at St Helier Hospital, London. His term of office as Chair of the Royal College of Psychiatrists' Faculty of Liaison Psychiatry will come to an end in June 2021.

Jim has previously held several other roles with the College, including the Associate Registrar for Public Engagement and the Clinical Lead for the Psychiatric Liaison Accreditation Network.

Jim has published on various aspects of liaison psychiatry. He has a wide experience of compiling accessible patient information, including several national patient information leaflets, and assisting the media in the accurate representation of mental illnesses and their treatment. Jim is a lifelong Doctor Who fan and has recently taken up playing the guitar (badly).

Chair

Dr Annabel Price, Chair Elect, Faculty of Liaison Psychiatry

Dr Annabel Price is a consultant liaison psychiatrist in Cambridge and chair elect of the RCPsych Liaison Faculty

Keynote 1: Presidential Priorities

Dr Adrian James, President, Royal College of Psychiatrists

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

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

He was the elected Chair of the South West Division of the Royal College of Psychiatrists (2007-2011) and sat on the College Council in this capacity. In 2010 he was appointed Chair

of the Westminster Parliamentary Liaison Committee of the Royal College of Psychiatrists (attending the three main Party Conferences 2011-14 in this capacity).
He was Clinical Director for Mental Health, Dementia and Neurology, working for NHS England South West (2013-2015, interim from 2012-13). He has also acted as a Reviewer and Clinical Expert for the Healthcare Commission and its successor organisation the Care Quality Commission (CQC).

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

His priorities as President are:

- Establishing a pathway to parity for mental health services
- Equality and diversity
- Sustainability
- Workforce Wellbeing

Adrian is a keen cyclist.

Keynote 2: Mental Health in the Emergency Department
Dr Katherine Henderson, President, Royal College of Emergency Medicine

I will describe the key challenges in Emergency Medicine and Emergency Departments both pre peri and hopefully post pandemic. Our mantra is that we are the safety net of the acute ill, acutely injured, acutely distressed and acutely vulnerable but that we have to stop being seen as the safety net of the health and social care system. I will also discuss where the management of mental health patients works well and where their experience of care can become worse than any other single group of patients. I will discuss moral injury to EM and liaison staff trying to cope in this situation.

Dr Katherine Henderson FRCP FRCEM President of the Royal College of Emergency Medicine and Consultant in Emergency Medicine at Guys & St Thomas' Hospital London.

Session 1

Chair
Professor Tayyeb Tahir, Consultant Liaison Psychiatrist, University Hospital of Wales, Cardiff

Professor Tayyeb Tahir is a consultant liaison psychiatrist, Faculty Lead for Training and Chairs National Service Group with Public Health Wales for Liaison Psychiatry. Tayyeb's research interests include treatment of delirium, medically unexplained symptoms and depression in general hospital. Tahir et al (2010) is the only published placebo controlled RCT for treatment of delirium in a general hospital setting. Apart from numerous publications on delirium, he is co-authored a book chapter on psychopharmacology in liaison psychiatry. He had also set up an occupational mental health service in partnership with Cardiff County

Deprivation of liberty in the acute hospital-what will be the impact of Liberty Protection safeguards

Dr Annabel Price, Chair Elect, Faculty of Liaison Psychiatry

The Human Rights Act 1998 proscribes deprivation of a person's liberty unless there are specific exceptional circumstances.

In England and Wales, new legislation amending the current Mental Capacity Act will replace Deprivation of Liberty Safeguards with Liberty Protection Safeguards (LPS).

This session will explore the development of legislation and practice in deprivation of liberty in the acute hospital and look at how the new legislation is likely to impact on clinical practice including the interface with the Mental Health Act.

Dr Annabel Price is a consultant liaison psychiatrist in Cambridge and chair elect of the RCPsych Liaison Faculty.

Meeting mental health needs in acute hospitals: what the CQC found and one Trust's response.

Professor Mark Cobb, Clinical Director, Sheffield Teaching Hospitals NHS FT

The CQC reported in 2020 the findings of its mental health inspectors from their inspections of acute hospitals. This appears to signal a step change in the way the CQC approach assessing the quality of mental health care in acute Trusts and they set out range of concerns and recommendations to improve practice. In this presentation I will set out what the findings mean to a large acute Trust, explore key elements of a quality improvement programme for mental health, and consider organisational and cultural factors that need addressing to achieve positive outcomes.

Professor Mark Cobb is a Clinical Director at Sheffield Teaching Hospitals NHS Foundation Trust leading a multi-professional directorate of around 600 staff providing a range of inpatient, outpatient and community services including psychology. He is deputy chair of the Trust's Mental Health Committee and the chair of the Trust's Ethics Committee. Mark holds honorary academic posts at Sheffield Hallam University, the University of Sheffield and the University of Liverpool and his research interests include palliative and end of life care, service design, and health-related spirituality. He teaches on undergraduate and postgraduate courses where his interests include the medical humanities and he has published in a wide range of journals and books.

Timeless: The Healthy Aging Brain

Professor Louis Cozolino, Professor of Psychology, Pepperdine University, California

This session will focus on the healthy aging brain from the perspectives of social neuroscience and interpersonal neurobiology. The brain will be described a social organ whose health and longevity is embedded in a matrix of social connectedness. The brains evolution and development as well as its changing skills and abilities throughout the lifespan will be interpreted as a succession of adaptations to changing social roles.

Professor Louis Cozolino specialises in the areas of Psychotherapy, Neuroscience and attachment. He holds degrees in Philosophy, Theology and Clinical Psychology . Dr Cozolino maintains clinical and consulting practices in Los Angeles and New York. He is the author of ten books and the editor of the Interpersonal Neurobiology Series in Mental Health from W.W. Norton.

Thursday 20 May 2021 – Integrated Care

Session 2

Chair
Dr Tania Bugelli, Glan Clwyd Hospital, Bodelwyddan, North Wales

Dr Tania Bugelli works as a liaison psychiatrist in Glan Clwyd Hospital, North Wales where she is also the Associate Medical Director for Quality and Safety. She is chair of the faculty of liaison psychiatry Wales.

Journey to Seni's Law – a conversation
Ajibola Lewis and Raju Bhatt, Justice for Seni

Ajibola Lewis is Seni's Mother – a proud Mother of 3 children and 2 grandsons. Aji is a former teacher and lawyer who now spends her time campaigning for accountability and justice in the many cases concerning deaths in state custody across the UK.

Aji also works alongside her family to embed The Mental Health Units (Use of Force) Act 2018, or Seni's Law, in all mental health units across the country and to bring more awareness to mental health and human rights violations happening here in the UK. .

Aji currently works with multiple organisations including South London and Maudsley NHS Trust , The Restraint Reduction Network National Steering group, BILD, The Royal College of Psychiatrists and Manchester Metropolitan University to eliminate the unnecessary use of restraint and restrictive practices both on a local and national level

Raju Bhatt is one of the founding partners of Bhatt Murphy, a team of lawyers based in London who work together to make a contribution to the protection of civil liberties in the UK. He works with members of the public who seek accountability from the state and its officers, focusing upon the treatment of individuals in the criminal justice system in particular.

He has a unique history of work with families who have lost their loved ones through death in custody, especially as a result of the use of force, and he has been responsible for many significant developments in this and related areas of his legal practice over more than three decades.

His experience in relation to deaths in custody and other contentious circumstances has been recognised on various fronts. In 2020, he was appointed as one of two Assessors to

work with Lord Bracadale on the Sheku Bayoh Inquiry which was announced by the Scottish Government in 2019. In 2015, he was appointed to the Reference Group on the Independent Review of Deaths and Serious Incidents in Police Custody by Dame Elish Angiolini who reported to the Home Secretary in 2017. In 2010, he was appointed to the Hillsborough Independent Panel which reported to the Home Secretary in September 2012. In 2009, he was appointed special adviser to the Joint Committee on Human Rights in relation to its parliamentary scrutiny of the bill that came to pass as the Coroners and Justice Act 2009.

Compassionate safety planning after self-harm

Dr Alys Cole-King, Clinical Director, 4MentalHealth

Compassionate risk mitigation and safety planning

Historically, a major element of professional training, especially in psychiatry, has been focused on the assessment and management of risk of suicidal behaviour. There is overwhelming research evidence, however, that the occurrence and timing of suicide cannot be accurately predicted at the individual level. What about recognising the importance of a compassionate response, understanding the impact of stigma, listening to the lived experience of people in deep distress, instilling hope, and helping people to find ways to navigate distress more safely?

Fifty percent of people who self-harm do not seek medical treatment. Only 50% of patients who do present to Emergency Departments (EDs) receive NICE guidelines compliant treatment or a psychosocial assessment, and many NHS staff feel ill-equipped to treat patients with self-harm/suicidal thoughts. Consequently, there is a huge unmet need in this large population who have a 50-100 times elevated risk of suicide compared to the general population and are at an increased risk of all-cause mortality.

Suicide is not inevitable. We need a new narrative which moves away from describing, measuring and predicting risk, towards a compassionate response which emphasises the importance of personalised interventions, safeguarding and safety planning. Suicide reduction interventions include reducing access to the means of suicide, and increasing hopefulness, help-seeking and reasons for living. Therapeutic assessment and safety planning for patients after self-harm should be a potential opportunity to intervene. Currently, however, we are missing thousands of these potential opportunities.

A paradigm shift is required: from ineffective attempts to predict risk as a means of allocating care (or not) to the adoption of a holistic, personalised risk mitigation and safety planning approach which is collaborative and truly person-centred.

Learning objectives:

- Explore the importance of a compassionate response to people in suicidal distress or who have self-harmed
- Understand the background to safety planning and the value of bolstering coping strategies, emotional and social support and minimising or removing access to means for people who self-harm or experience suicidal thoughts
- Know how to co-produce a Safety Plan
- Provide an overview of StayingSafe.net, including development, piloting, early evaluation and next steps

Dr Alys Cole-King is the first person from the UK to be awarded the Ringel Service Award from the International Association for Suicide Prevention. She was named one of the most influential women in medicine by the Medical Women's Journal and has been profiled in The Guardian, The Lancet and The Psychiatrist in recognition of her work with policy makers, medical royal colleges, people with lived experience, academics and charities.

As Clinical Director at 4 Mental Health, Alys continues to lead the development of the Connecting with People training modules and SAFETool (an assessment and safety planning framework to promote consistency, enhance communication and link research to clinical practice). 4 Mental Health's Connecting with People training is delivered across many sectors: healthcare, education, third sector, community and secure services, including in the UK, Australia, Jersey and Ireland. Through 4 Mental Health, Alys has led the development of several free self-help resources, including StayingSafe.net, an innovative digital solution to share compassion, hope and equip people to make a Safety Plan, and WellbeingAndCoping.net, a website which guides people through making their own Wellbeing Plan. She has an interest in promoting ways to build wellbeing and resilience and foster compassion for ourselves and others.

Alys undertook a year-long research project using psychological autopsy methods to investigate patients who attempted suicide or engaged in self-harm whilst under the care of mental health services. A primary author of numerous papers, book chapters, webinars,

BMJ Best Practice, BMJ podcasts and self-help resources on suicide and self-harm prevention, Alys has also contributed to several national and international e-learning modules, including for the BMJ. Alys is a reviewer for several journals and leads international campaigns via social media and works with film, radio and newspapers to ensure a safe and compassionate public health suicide prevention message.

Eating Disorder in Children and Adolescents – an update

Dr Kiran Chitale, Consultant Child and Adolescent Psychiatrist, Ellern Mede

Dr Kiran Chitale is an award-winning consultant child and adolescent psychiatrist specialising in eating disorders (ED). She joined Ellern Mede in 2018, leaving her previous role as Clinical Service Lead for Eating Disorders at an NHS Trust. Dr Chitale is also an elected Royal College of Psychiatry board member in the Eating Disorders Faculty where she continues to serve in medical education. Earlier in her career, Dr Chitale was a consultant obstetrician and gynaecologist. She also is qualified in systemic family therapy. Ellern Mede is delighted to employ Dr Chitale as our main outpatient consultant operating across four sites in London.

Session 3

Chair

Dr Sarah Eales, Expert Representative for Liaison Psychiatry

Sarah Eales qualified as a mental health nurse in 1994 and has worked within the field of Liaison Mental Health Care for twenty-one years, as a researcher, clinician and academic, completing a PhD on the Service User Experience of Liaison Mental Health Care in 2013. Sarah Edited the Liaison Nursing Competencies and leads on updates.

As a Senior Lecturer in Mental Health at City University London and Bournemouth University Sarah has led Pre-registration Mental Health Nursing programmes and across field curriculum design. Recent research includes integrated care core competencies and health care professional resilience and retention. Sarah is currently the Lead Matron for Mental Health at University Southampton NHS Trust. Sarah is a member of the Faculty of Liaison Psychiatry Executive Committee and the Chair of the Psychiatric Liaison Accreditation Network Accreditation Committee. Twitter: @SarahEales

The FReSH START Study

Professor Else Guthrie, Professor of Psychological Medicine, University of Leeds

FReSH START is a randomized controlled trial to assess the efficacy and cost-effectiveness of psychological treatment for people who multiply self-harm. The trial is due to start in October 2021 and involves 12 sites across England with a target recruitment number of 630. The psychological treatment will be delivered by liaison mental health nurses and will be one of three interventions: CBT, ACT or PIT. A sister trial called SAFE-PIT is due to start in January 2022 for people with acute self- harm (non-multiple) and will compare brief PIT plus usual care with usual care alone. SAFE-PIT will also be conducted across 12 sites and aims to recruit over 700 participants.

Data will be presented from a feasibility study which is just completing which has examined the ability to recruit participants, train liaison nursing staff to deliver the therapy (s) and collect appropriate data.

The presentation will mainly focus on the clinical aspects of the studies and the relevance for liaison settings.

Else Guthrie is Professor of Psychological Medicine at the University of Leeds. She is a former Chair of the Liaison Faculty and is both an experienced clinician and academic. Her main areas of interest are: persistent physical symptoms; self-harm; and physical and psychological co-morbidity. She is currently updating the liaison textbook, Seminars in Liaison Psychiatry with Prof Allan House and Dr Rachel Thomasson.

Session 4

Chair

Dr Deepa Deo is a Consultant in Liaison Psychiatry for Working Age Adults in Surrey and Borders Partnership NHS Foundation Trust. She is Associate Medical Director for the Specialist Services division, and also Working Age Adult Community services.

A feasibility study exploring systemic low-grade inflammation and epigenetic factors in CD/FND

Professor Christina van der Feltz-Cornelis, Chair of Psychiatry and Epidemiology, University of York

In this lecture, prof. Christina van der Feltz-Cornelis will present findings from a feasibility study exploring systemic low-grade inflammation in Conversion Disorder/Functional

Neurological disorder with motor symptoms. This study was conducted in 2019 before the COVID outbreak in Yorkshire, as a collaboration between the University of York and TEWV NHS Trust. Conversion disorder/functional neurological disorder (CD/FND) occurs often in neurological settings and can lead to long-term distress, disability and demand on health care services. Systemic low-grade inflammation might play a role, however, the pathogenic mechanism is still unknown. We intended to find proof of concept regarding a possible role for cytokines, microRNA, cortisol levels and neurocognitive symptoms in patients with motor CD/FND. This feasibility study was conducted in the clinical setting. Findings and the possible implications for research will be discussed.

Professor Christina van der Feltz-Cornelis, psychiatrist-psychotherapist and epidemiologist, joined the University of York as 60th Anniversary Chair of Psychiatry and Epidemiology in 2018. She is a world-renowned mental health researcher whose research draws on her clinical background; she was awarded a Cum Laude at her MD graduation at the School of Medicine Amsterdam in 1988. She registered as psychiatrist and psychotherapist in 1992 and as an epidemiologist in 1996. Christina completed her doctorate (PhD 2002) on Psychiatric consultation for patients with somatoform disorder in general practice and was awarded an endowed chair in Social Psychiatry by Tilburg University in 2010. Christina is a member of the Mental Health and Addictions Research Group in the Department of Health Sciences, and holds a joint appointment with the Hull York Medical School (HYMS). Christina is a registered psychiatrist in the UK and joined as an honorary consultant psychiatrist with Tees Esk and Wear Valley (TEWV) (2018).

'A Year in Pyjamas'

Dr Jim Bolton, Chair of the Faculty of Liaison Psychiatry

In his annual review of the work of the Faculty of Liaison Psychiatry, Jim will look back at our experiences of the pandemic and forward to potential long-term learning and changes in practice.

In his review of the past year, Jim will discuss the role of the Faulty in providing guidance for services, the importance of online communication, the provision of alternatives to the emergency department for mental health assessments, and COVID-related clinical presentations.

Looking to the future, Jim will discuss the role of Liaison Psychiatry in the care of patients with post COVID-19 syndrome, and consider the learning about staff well-being, mental health crisis care and online working.

COVID has been widely recognized as having physical, psychological and social implications for the whole population. Will this lead to a wider recognition of the need for biopsychosocial healthcare and robust Liaison Psychiatry services?

Dr Jim Bolton is a Consultant Liaison Psychiatrist at St Helier Hospital, London. His term of office as Chair of the Royal College of Psychiatrists' Faculty of Liaison Psychiatry will come to an end in June 2021.

Jim has previously held several other roles with the College, including the Associate Registrar for Public Engagement and the Clinical Lead for the Psychiatric Liaison Accreditation Network.
Jim has published on various aspects of liaison psychiatry. He has a wide experience of compiling accessible patient information, including several national patient information leaflets, and assisting the media in the accurate representation of mental illnesses and their treatment. Jim is a lifelong Doctor Who fan and has recently taken up playing the guitar (badly).

21 May 2021 – Covid-19

Session 5

Chair

Dr Peter Aitken, Consultant in Psychological Medicine, Medical Director and executive lead for suicide prevention at Devon Partnership NHS Trust, and Honorary Associate Professor, University of Exeter Medical School.

Dr Peter Aitken MRCGP FRCPsych is Consultant in Psychological Medicine, Medical Director and executive lead for suicide prevention at Devon Partnership NHS Trust, and Honorary Associate Professor, University of Exeter Medical School. He is a trustee at the Lions Barber Collective, chair of the RNLI's Medical Committee, mental health adviser to the National Association of Primary Care and member of the steering group for Zero Suicide Alliance. Peter is past chair of the Faculty of Liaison Psychiatry at the Royal College of Psychiatrists and Psychiatrist of the Year in 2016. He has published in suicide prevention

Compassionate leadership in tough times

Prerana Issar, Chief People Officer, NHS

Prerana Issar is the first NHS Chief People Officer.

Since joining the NHS in April 2019, Prerana has created and published the first ever NHS People Plan, covering 1.4 million staff. The aim of the People Plan is to "to have more people, working differently, in a compassionate and inclusive culture", to help deliver the NHS long term plan. Since March 2020, Prerana has led the national workforce function for the Covid-19 response for the NHS.

Prior to joining the NHS Prerana was Director for Public-Private Partnerships at the United Nations and prior to that she was the Chief Human Resources Officer for the United Nations World Food Programme (she is very proud her ex-colleagues were awarded the Nobel Peace Prize for 2020). During this time Prerana led the development of the United Nation's first strategic human capital approach, as well as the reform of many key policies. Her work took her to many of the world's war zones and areas of conflict, as she does her work in service of the front line.

Before the United Nations, Prerana worked for over 15 years at Unilever Plc, starting with them in India and then for several years was in global roles at Unilever's headquarters in London. Her last role in Unilever was Vice-President HR for the Global Foods business.

Prerana gets her strong service ethos from her parents who were both in the Indian Administrative Service in the Government of India for close to 40 years. A proud mother to a teenage son and daughter, she says they keep her grounded with timely performance feedback on a variety of topics. One of the happiest days of her life was when her daughter was born at the Royal Free hospital in London, giving her first-hand experience of the NHS staff who every day deliver outstanding care to patients.

Improving the psychiatric care of the medically ill: what can we learn from the USA?
Professor Michael Sharpe, President, American Academy of Consultation-Liaison Psychiatry

Most of us have devoted our careers to improving the psychiatric care of the medically ill. Improving the care of individual patients can be both relatively easy and rewarding. However improving the care of a whole population of medically patients can be hard and frustrating.

This difficulty results in part from the historical separation of the doctors caring for the mentally ill from those working in the rest of medicine more than a hundred years ago. Our modern attempts to overcome this separation have been largely limited to providing psychiatric consultations on a small number of patients and giving advice about their care. However, we have only modest evidence that such services improve outcomes for the medically ill populations they purport to serve. A recent systematic review of the randomized trials of inpatient liaison psychiatry services found no good evidence that they improve outcomes.

Health care in the USA has struggled with the same challenges and has produced two innovative service models. The first is collaborative care for medical outpatients. The second is proactive and integrated psychiatry for medical inpatients. Things that we can we learn from these new service designs are: (1) We need to identify all in need – not just those referred; (2) We need ongoing involvement in medical care – not just consultation and advice; (3) To get funding for such new service models we need evidence that they are effective and cost effective – not just arguments.

Liaison psychiatry in the UK has an opportunity to step up and improve the psychiatric care of a much greater proportion of the medically ill. The lessons from the USA help us to have the confidence and determination to integrate more closely with medicine and to demonstrate the added value of doing this in research.

Professor Michael Sharpe MA MD FRCP FRCPsych is Professor of Psychological Medicine at the University of Oxford. His career long aim is to better integrate psychiatry into other areas of medicine to improve patient care and outcomes. He has published landmark trials of integrated care including the PACE trial of treatment for chronic fatigue syndrome and three SMaRT oncology trials of depression management in cancer patients. He is currently leading the HOME trial of integrated proactive psychiatry for older medical inpatients. He established the Integrated Psychological Medicine Centre at Oxford University Hospitals NHS FT and currently advises the Trust Board on integrated care.

His international roles include serving as President and Board member of the Academy of Consultation Liaison Psychiatry (ACLP) in the USA, and as Vice-President of the European Association of Psychosomatic Medicine (EAPM).

Session 6

Chair
Dr Alice Ashby, West London NHS Trust

Dr Alice Ashby is a Consultant Liaison Psychiatrist and Clinical Director for the Psychological Medicine service line at West London NHS Trust (managing Liaison, Perinatal and IAPT for H&F, Ealing and Hounslow, and Neuropsychology and Clinical Health Psychology across parts of NW London). I have a Masters in Medical Ethics and Law and a Postgraduate Certificate in Medical Education. I have worked in various liaison psychiatry services across London, and am an elected member of the RCPsych Liaison Faculty Executive Committee.

Neuropsychiatry of Covid 19 – Clinical Syndromes
Dr Tim Nicholson, Consultant Neuropsychiatrist, Maudsley Hospital

Dr Tim Nicholson is a Clinical Lecturer at the Institute of Psychiatry Psychology & Neuroscience (IoPPN), King's College London. He is also an Honorary consultant Neuropsychiatrist at the South London and Maudsley NHS Foundation Trust. He runs a specialist clinic for Functional Neurological Disorder (FND) at the Maudsley Hospital.

Tim trained briefly in neurology at the National Hospital for Neurology & Neurosurgery at Queen square before training fully in psychiatry and then neuropsychiatry at the Maudsley Hospital / IoPPN in South London. He did his PhD, funded by the UK Medical Research Council (MRC), in FND looking at the role of stressful life events that might precipitate episodes of paralysis and used other methods such as neuroimaging (both structural and functional MRI scans) and neuropsychological testing to investigate the possible mechanisms of FND. He continues to be interested in the biological basis of FND symptoms and neuropschiatric disorders more broadly, especially autoimmune causes of psychiatric symptoms.

He is currently funded by the UK National Institute of Health Research (NIHR) running a series of randomised controlled trials (RCTs) of transcranial magnetic stimulation (TMS) for FND causing limb paralysis/weakness, with linked studies investigating how TMS might work. He is also involved in developing and standardising outcome measures for FND both for use in research & clinical practice and has set up an international collaboration of 40 researchers from 15 countries (the first such large scale international research collaboration of any sort for FND) to work together on this project

Neuropsychiatry of COVID-19: further presentations and putative mechanisms

Dr Tom Pollak, NIHR Clinical Lecturer, ST General Adult Psychiatrist King's College London , South London and Maudsley NHS Foundation Trust

Dr Thomas Pollak, PhD MRCPsych is a NIHR Clinical Lecturer at the Institute of Psychiatry, Psychology and Neuroscience at King's College London, UK, and a general adult psychiatrist at South London and Maudsley NHS Foundation Trust. His specialist clinical interest is in neuropsychiatry. He has set up and co-runs a joint multidisciplinary clinic dedicated to the assessment and management of patients with confirmed or suspected autoimmune encephalitis and other central nervous system autoimmune disorders, at King's College Hospital, London, and a newly-opened 'long COVID' clinic. With colleagues at King's Health Partners he is embarking on a programme of research into autoimmune neuropsychiatry and the neuropsychiatry of infections, with the aim of improving clinical recognition and outcomes for patients. He has trained in psychology (BA; Corpus Christi College, University of Oxford), medicine (MBBS; King's College London), clinical psychiatry (MRCPsych; Royal College of Psychiatrists) and clinical neurology (MSc; University College London). In 2015 he was awarded a Wellcome Trust Clinical Research Fellowship to look at the neuroimmunological basis of psychiatric disease, with a particular focus on the autoantibodies known to cause autoimmune encephalitis. In his current work, he is using neuroimaging and neuroimmunological methods to characterise the significance of

autoantibodies to neuronal surface antigens in early psychosis. His other research interests include the role of infections in psychiatry, glutamatergic abnormalities in psychosis and organic presentat ons in clinical neuropsychiatry. He sits on the Scientific Advisory Panel of the Encephalitis Society.

Post Covid 19 Syndrome – "Management in Practice
Professor Martin Marshall, Chair, Royal College of GP Council

Professor Martin Marshall is Chair of the Royal College of General Practitioners and a GP in Newham, East London. He is also Professor of Healthcare Improvement at UCL in the Department of Primary Care and Population Health. Previously he was Programme Director for Population Health and Primary Care at UCLPartners (2014-2019), Director of Research & Development at the Health Foundation (2007-2012), Deputy Chief Medical Officer for England and Director General in the Department of Health (2006-2007), Professor of General Practice at the University of Manchester (2000-2006) and a Harkness Fellow in Healthcare Policy.

He is a Fellow of the Royal College of Physicians of London and of the Faculty of Public Health Medicine and was a non-executive director of the Care Quality Commission until 2012. He has advised governments in Singapore, Egypt, Canada and New Zealand, has over 230 publications in the field of quality improvement and health service redesign and his primary academic interest is in maximising the impact of research on practice. In 2005 he was awarded a CBE in the Queen's Birthday Honours for Services to Health Care.

A co-founder and driving force of the Rethinking Medicine movement, Martin has a passionate commitment to the values of the NHS, patient care and ensuring the GP voice is central in a time of great change. When he's not working he likes being outside, preferably on a mountain or a coastal path with his wife Sue and their puppy.

Poster abstracts (alphabetical by surname)

1. Polypharmacy and Potentially Inappropriate Medications (PIMs) in older adults referred to a Liaison Psychiatry service.

Dr Anietie Akpan, ST6, OPMHS, West London NHS Trust Dr Omolade Longe, ST6, OPMHS, West London NHS Trust

Aims and Hypothesis

Medications are not routinely reviewed or rationalised in the elderly, often contributing to preventable harm. We sought to estimate the prevalence of polypharmacy and potentially inappropriate medications, anticholinergics in particular, in patients (65 years and older) referred to the St Mary's Hospital Liaison Psychiatry Department over a 3-month period

Background

The older adult is more likely to be prescribed a lot of medications (polypharmacy) on account of multi-morbidity and being under the care of several specialists. Adverse drug events and reactions account for a significant number of acute hospital presentations in this population group with increased risks of delirium, lasting cognitive impairment, falls and death.

Method

Between 01/06/2019 and 31/08/2019 all referral forms (from in-patient wards and A&E) for patients aged 65+ were screened for medications currently prescribed and administered. The medications were confirmed via the St. Mary's Hospital electronic records, pharmacists' completed Medicines Reconciliation and GP Summary Care Records. Polypharmacy was defined as patients prescribed 5 or more medications. Drugs with anticholinergic properties were considered as an example of Potentially Inappropriate Medication (PIMs) using the Anticholinergic Burden Scale. 77 patients were referred in the time period. 9 were excluded due to incomplete/unreconciled medication information.

Results

77.94% (n = 53) were prescribed 5 or more medications 38.24% (n = 26) were prescribed over 10 medications. 10.29% (n = 7) prescribed over 15 medications. 69% of (n = 47) prescribed an anticholinergic. 42.65% (n = 29) prescribed more than 1 anticholinergic.

Conclusion and next steps

Polypharmacy and potentially inappropriate prescribing remain widespread within the older adult population. On-going training and pharmacovigilance are needed across

services providing care to the elderly to mitigate adverse and compounded sequelae stemming from polypharmacy and potentially inappropriate medications.

2. Dangerous Liaisons – Malaria, Psychiatrists, and Tropical Medicine physicians in England in the early 1920s

Dr Graham Ash, Honorary Archivist, The Royal College of Psychiatrists

Aims and Hypothesis

Wagner-Jauregg developed malarial therapy for general paralysis in Vienna during the First World War (FWW). How did psychiatrists in England implement this unusual treatment?

Background

General paralysis accounted for a high percentage of admissions to mental hospitals in England in the early 20th century. Known to be related to neurosyphilis, it was a progressive neuro-psychiatric disorder that almost invariably had a fatal outcome. No effective treatments were available.

Method

Historical research based on Journal articles and the MD thesis of Dr Alastair Robertson Grant. Retrospectively, 50 patients underwent active treatment and 6 received a comparator. Fisher's exact test statistics calculated using www.socscistatistics.com

Results

The first patients in England were inoculated with malaria in July 1922 at the Liverpool School of Tropical Medicine (LSTM) in a collaboration between Grant, Deputy Medical superintendent at Whittingham asylum near Preston, Lancashire, and Professors Warrington Yorke and JWW Stephens at LSTM. Grant had served in the Royal Army Medical Corps in the Middle East in 1918-19 and it is improbable that he did not have experience of treating servicemen with malaria. Nevertheless, a source of malarial parasites had to be found, and LSTM, within easy reach, had become a major centre for research into malaria and anti-malarial chemotherapy during the FWW. Grant subsequently published a series of 50 patients who underwent malarial therapy, whilst Yorke studied early malaria and the effects of antimalarials in the same patient group. Malarial therapy was considered to have a good outcome by Grant (7 recovered, 43 remitted or death), whereas a retrospective comparison of his results against his smaller series of patients treated with the non-specific pyretic, phlogetan, (1 recovered, 5 remitted or death), suggests no benefit (Fisher's exact test statistic, 1, not significant at $p < .05$).

Conclusion

The contemporary ethical and legal frameworks of the 1920s allowed the introduction into widespread use of a psychiatric treatment, then considered highly effective, that would now be considered highly contentious. The early development of malarial therapy in England provides an unusual historical paradigm offering opportunity for reflection on the vulnerability of people lacking mental capacity, and the efficacy and safety of psychiatric treatments today. Liaison between psychiatrists and physicians is now of increased importance with recognition of the impacts of Covid-19 on mental health care.

3.Psychiatric sequelae of potentially lethal pandemic illness, understanding the needs and timely treatment of our most vulnerable patients – a case report.

Dr Natalie Ashburner, Locum Specialty Doctor, East London Foundation Trust Dr Ruwanka Perera, Consultant Liaison Psychiatrist, East London Foundation Trust

Aims and Hypothesis

To add to the evidence base around the neuropsychiatric sequelae of Covid-19 and to provide a case report that highlights the challenges in distinguishing the symptoms of Covid-19 from a depressive disorder and the management of patients with these coexisting illnesses.

Background

There is now a growing evidence base around the multiple presentations of the novel Covid-19 virus and the longer-term consequences of infection. This case report highlights association between symptoms of depression and covid-19, possible neuropsychiatric presentation of covid-19, increase in risk of infection in those with mental illness and the need for integrated care between Liaison Psychiatry and physical health services when treating complex physical and mental illness.

Method

This is an observational case report of a 49 year old man with no known history of mental illness, who experienced a gradual decline in both his mental and physical health over a period of 9 months during the Covid-19 pandemic. He was admitted to the general hospital with severe self-neglect, malnutrition and osteomyelitis. After initially improving in both physical and mental state, this patient deteriorated rapidly after contracting Covid-19 despite initially seeming asymptomatic of the virus.

Result

The key dilemma in this case was distinguishing and disentangling the symptoms of depression with the symptoms of physical illness and which should be prioritised in terms of treatment. There was much consideration and some debate over the use of a legal framework for treatment and close liaison between psychiatry and the general medical team was essential. Good quality nursing care, a focus on nutrition and a compassionate holistic approach were the key factors in the supportive treatment of this patient who continues to improve in both his physical health and mental health through this collaborative approach.

Conclusion

Emerging evidence demonstrates a link between Covid-19 and mental illness with an increased rate of infection in those with previous psychiatric disorder. There is also a significant overlap in the symptoms of depression and the symptoms of Covid-19 and the presence of one may worsen the other. This case study has demonstrated some of the barriers that clinicians may face in liaison psychiatry while treating patients with both conditions simultaneously and the possible approaches to overcoming these.

4.The Core 24 Liaison Psychiatry service model in a multisite NHS Trust: analysis of referral patterns and outcomes.

Dr Ganesananthan Balasubramaniam GPST1 Registrar. SWYT NHS FT Dr Manouri Senaratne, Consultant Liaison Psychiatrist SWYT NHS FT Carol Deary, ANP, SWYT NHS FT Sarah Stather, ANP, SWYT NHS FT Dan Dearden, ANP, SWYT NHS FT Emma Lloyd, Psychiatric Liaison Practitioner, SWYT NHS FT Becky Brammer, Psychiatric Liaison Practitioner, SWYT NHS FT Phiri Grey, Psychiatric Liaison Practitioner, SWYT NHS FT Simon Fielding, Psychiatric Liaison Practitioner, SWYT NHS FT

Aims and Hypothesis

To gain an understanding of the demands placed upon our Core 24 Liaison Psychiatry service (LPS) at a multisite NHS hospital.

Background

Core 24 is a service delivery model where a hospital with a 24/7 Emergency Department is supported by a 24/7 LPS. NHS England aims for at least half of LPS to follow the Core 24 model by the end of 2021. Our Mental Health NHS Foundation Trust serves two Emergency Departments, a 24-hour urgent Treatment Centre and three hospital sites with three regional centres under one acute care trust. We wanted to assess how our Core 24 LPS is utilised by the hospital teams by analysing referral patterns and outcomes.

Method

We performed a retrospective analysis of referrals and outcomes from April to December 2019 inclusive. Referrals were identified through an electronic log, and data were collected from the electronic patient record. All patients referred and aged 18 years and over were included within the analysis. Data were analysed using Microsoft Excel.

Results

Our LPS had 2,758 referrals in the 9-month period. Referral demographics: 2,448 (88.8%) were working age (18-64 years), whilst 309 (11.2%) were of older (65+ years). 1,449 (52.8%) were referred during hours of 7am to 5pm; 1,297 (47.2%) were between 5pm to 7am. Referral sources: 2,022 (73.3%) were from the Emergency Departments, 734 (26.6%) were from inpatient wards. Referral reasons: 1,710 (62.0%) were with concerns about suicidality (defined as presence of suicidal thoughts with or without a deliberate self-harm (DSH) act). 938 (54.9%) of this subgroup had attempted a DSH act. Of those with an attempted DSH act, 814 (86.7%) were related to drug overdose. Following assessment, 1,264 (45.8%) were discharged to GP led care and 703 (25.5%) were referred on to other secondary mental

health services. 168 (6.1%) required admission to a mental health unit of which 61(36.3%) were detained under the Mental Health Act.

Conclusion

Our Core 24 LPS has a high throughput, with over 300 referrals per month. The specialist mental health assessments provide appropriate and timely support to patients who receive integrated mental health care. It is also beneficial to the local healthcare providers, as patients are directed to services that can best help them and the burden on acute care trusts, inpatient mental health services and GPs is reduced.

5.Online delivery of a liaison psychiatry summer school during Covid-19

Dr Georgios Basdanis, ST6, South London and Maudsley NHS Foundation Trust; Dr Greg Shields, Consultant Psychiatrist, Maudsley Learning; Dr Ranjith Gopinath, Consultant Psychiatrist, South London and Maudsley NHS Foundation Trust

Aims and Hypothesis

We delivered a 5-day summer school, albeit later in the year, online in 2020 during the Covid-19 pandemic. Our aim is to assess whether satisfaction amongst participants remained similar to the course delivered face-to-face in 2019.

Background

The course was originally scheduled to be delivered face-to-face in June 2020. Given the ongoing Covid-19 restrictions, a decision was made to deliver it online in November-December. The course was delivered via Zoom, given added capabilities for interactivity, such as polling and breakout rooms.

Method

To assess attendee satisfaction, online questionnaires were provided at the beginning of each day. The attendees were encouraged to complete these after each session. They were asked to rate each session and were asked in a free text box whether there was anything especially good or bad and anything which could be improved.

Results

On day 1, 97% of attendees rated the sessions as either excellent or good, compared to 88% in 2019. On day 2, 100% rated the sessions as either excellent or good, compared to 95% in 2019. On day 3 (simulation day), 97.5% rated the day as either excellent or good, compared to 96.5% in 2019. On day 4, 98.7% rated the day as either excellent or good, compared to 94.5% in 2019. 88% rated day 5 as either excellent or good; there is no data from 2019 to which to compare this, as the sessions were extended resulting in an overall longer course. Open text feedback was overall positive. Specifically about the online delivery one participant found the online experience less nerve wracking, as they felt more comfortable behind a screen and another commented on the fact that online delivery helped their concentration and they felt less distracted. On the negative side a participant thought that the online delivery felt slightly different and artificial while another highlighted connectivity issues which resulted in a delay in audio.

Conclusion

Although the 2019 and 2020 cohorts are not directly comparable, based on the above results the online delivery of the course was well received. Online delivery meant that people did not have to travel, which could enable people to attend who otherwise would have been unable to do so. Online delivery of courses appears to be a viable alternative and should be considered for future courses after Covid-19 restrictions are lifted.

6.Service development of a psychiatric emergency unit within the Emergency Department

Dr Georgios Basdanis, ST6, South London and Maudsley NHS Foundation Trust; Dr Alexandra Shaw, FY2, Guy's and St Thomas' Hospital NHS Foundation Trust; Dr Oliver Tamblyn, FY2, Guy's and St Thomas' Hospital NHS Foundation Trust; Dr Areeb Zar, FY1, Guy's and St Thomas' Hospital NHS Foundation Trust; Dr Gopinath Ranjith, Consultant Psychiatrist, South London and Maudsley NHS Foundation Trust; Dr Cormac Fenton, Consultant Psychiatrist, South London and Maudsley NHS Foundation Trust

Aims and Hypothesis

To estimate the demand for a psychiatric emergency unit within the Emergency Department (ED) at St Thomas' Hospital and describe practical considerations in establishing a Standard Operating Procedure for the unit.

Background

EDs remain the main point of access for patients experiencing psychiatric emergencies although the busy environment is not always conducive to their management. A purpose designed facility to cater to patients without ongoing emergency medical needs could ensure care in a safe, dignified and private setting. We piloted such a unit in February 2021, initially with 2 beds, with a view to increasing the capacity to 6 beds in May.

Method

Initially we audited the number of patients referred by ED to liaison psychiatry in September 2020 and January 2021 to estimate the number of patients who could have been managed in such a unit. We held weekly meetings with senior staff in psychiatry and ED to establish the staffing, prescribing and physical health pathways. We are holding daily PDSA cycle meetings with acute hospital staff to establish what is working well and what needs to be improved.

Results

Out of 308 patients referred to liaison psychiatry in September 2020, 148 (48%) would have met the admission criteria to the unit. Similarly in January 2021, 140 out of 308 patients would have been admitted (45%). Since opening, between 08 February and 08 March 2021, 43 patients out of 265 (16%) were transferred to the unit. It was agreed that patients in the unit will remain on the ED clock and it will be considered as part of the ED for purposes of the Mental Health Act. It was agreed that the psychiatry team would be responsible for prescribing and the unit will close to new admissions in the absence of junior doctor cover as a result of rota gaps. Medically unwell patients will be referred to acute medicine.

Conclusion

Potentially about half the number of patients presenting to ED with a mental health emergency could be managed in a psychiatry emergency unit within the emergency floor. The actual number of patients transferred was much smaller, possibly reflecting the smaller bed numbers and the lack of familiarity during the pilot phase. There are practical challenges when trying to move from an ED liaison model to a psychiatry emergency unit model that need to be balanced against opportunities to provide care in a quiet and therapeutic setting.

7.Clarity of Referrals to the Liaison Psychiatry Team from Medico-surgical teams

Dr Claire Boothman (co-lead author) FY2 & Dr Katherine Thompson (co-lead author) FY2
Croydon University Hospital, South London and Maudsley NHS trust

Aims and Hypothesis

To evaluate the quality of referrals to the Liaison Psychiatry Team from both medical and surgical teams in Croydon University Hospital (CUH).

Background

To triage referrals appropriately, time was spent clarifying reasons for referrals, and therefore delays in reviews.

Method

We reviewed all referrals made to the Working Age Liaison Psychiatry service at CUH using the hospital computer system for the month of December 2020. Using the existing referral proforma as the standard we audited all 55 referrals and analysed which of the 14 sections had been completed using a checklist. We aimed to clarify whether a clear referral reason had been documented.

Results

Of the 55 referrals audited only 58% had a reason for referral documented and 49% had documented the patients past medical history. However, other fields such as referrer bleep, patient consent and information on dependants were completed in 100% of referrals. When categorising the reason for referral, 34% of referrals requested a physical review, 7% requested advice and in 59% of referrals it was unclear what the referrer required from the liaison service. In total 81% of referrals were accepted by the service after triage however of these 62% did not have a clear reason for referral documented.

Conclusion

Our audit highlighted that although the majority of referrals were accepted, over 60% were not completed to a standard that informed the liaison team of what was expected of them. Subsequently resulting in further discussions with the referrer which was not time effective. When comparing the current online referral proforma to other specialities at CUH, the liaison proforma had significantly more areas to fill. Once the form had been opened the referrer was unable to return to the patients' notes for further information if needed to complete the referral in full. Based on this data we have revised the referral form in order to improve the quality of referrals received. We have reduced the number of questions by 50% and the reason for referral has been electronically configured in such a way that

populating this section is a prerequisite to be able to click send. Now included is a question explicitly asking about substance use in order to prompt a referral to the Drug and Alcohol Support Service, we will review the effectiveness of this in the future.

8.Referrals before and after COVID-19 – Unprecedented? Or business as usual?

Dr Karen Borges, FY1, NHS Lothian Dr Katie Marwick, Higher Psychiatry Trainee, NHS Lothian Dr Jude Halford, Consultant Psychiatrist, NHS Lothian

Aims and Hypothesis

Hypothesis: There would be a change in the numbers and nature of referrals to the liaison psychiatry service following lockdown. Aims: 1.To ascertain whether there was a change in numbers of referrals 2.To evaluate the breakdown of case numbers by diagnostic category 3.To further describe the incidence and distribution of common presentations. 4.To compare the incidence of deliberate self-harm (DSH). 5.To determine the percentage of new cases seen each month in 2020 that explicitly cite lockdown as a contributing stressor. 6.To determine the percentage of patients presenting with psychosis or delirium/cognitive impairment that were also COVID-19 positive

Background

A comparison between March – August 2020 and the same period in 2019.

Method

All new cases seen by Liaison Psychiatry at St John's Hospital, Livingston from March to August in 2019 and 2020 were analysed. - Each case was classified into 1 of 10 broad diagnostic categories. For patients with multiple psychiatric diagnoses, labels were based on the primary cause of presentation. - Cases of DSH, and cases with discharge letters that mentioned lockdown as a contributing stressor, were identified. -In presentations of psychosis or delirium/cognitive impairment, records pertaining to two weeks before and after date of presentation, were examined for evidence of COVID-19 +ve test.

Results

241 cases were in 2019 and 201 in 2020. -Notably fewer cases were seen in April 2020. - In 2019 situational crises, personality disorders, addictions and mood disorders (in decreasing frequency) were the most common reasons for presenting in nearly all months. -In 2020 the same pattern persisted except for May where there was a spike in personality disorders and a dip in situational crises. -There was lower incidence of DSH in March and April of 2020 compared to 2019. - In 2020 presentations that explicitly mention lockdown as a contributing stressor peaked at 50% in April and slowly decreased after this. -31 patients were seen in 2020 with either psychosis or delirium/cognitive impairment, none tested positive for COVID-19.

Conclusion

There was no increase in referrals to Liaison Psychiatry at SJH. Differences were observed between the two time periods, namely distribution of cases amongst diagnostic categories and incidence of DSH. Lockdown was noted as a stressor in 32% of 2020 cases. None of the psychosis or delirium/cognitive impairment presentations were COVID-19 positive.

9.Improving the quality of referrals to the Psychiatry Liaison Team in a busy acute hospital

Dr Amanda Brickstock, FY2, NHS Heart of England Trust Dr. Aditya Krishnan, FY1, NHS Heart of England Trust

Aims and Hypothesis

This quality improvement project aims to reduce inappropriate referrals made to the Psychiatry Liaison Team (PLT) and improve staff understanding of mental health services to ensure patients receive the most appropriate care.

Background

Birmingham Heartlands Hospital PLT provide psychiatric input for hospital inpatients when needed. We have both worked with PLT during our F1 year and within other specialities during our foundation training. We have observed the difficulty in both receiving inappropriate PLT referrals and the conflicted interface between psychiatry and other directorates.

Method

Retrospective baseline data of all ward referrals was collected over a 2-week period. Referral reason and outcome data were recorded. Additionally, a 10-point Likert scenario-based assessment was sent to foundation doctors collecting data on referral confidence. Data over 2-week periods was collected after each cycle. The 1st cycle was used to design a poster signposting appropriate mental health services within the trust including alcohol and homelessness alongside capacity assessment and delirium advice. Posters were distributed across all wards. A subsequent cycle involved core teaching to foundation doctors about PLT and getting feedback on service improvement. The third cycle focused on teaching acute medicine (AMU) staff.

Results

Baseline data (n = 78) demonstrated that 38.5% of referrals were seen with no PLT role, or were immediately rejected. Foundation doctors (n = 29) responded to the baseline survey. The most poorly answered scenario was “Patient’s family is worried they may be developing dementia" (n = 0 considering this appropriate to refer to PLT). Results showed that overall, the appropriateness of referrals improved. Data showed a reduction in inappropriate referrals from 38.5% at baseline to 29% at cycle 1, 27.9% at cycle 2 and 16% at cycle 3. Staff mean scores on a 19-item scenario based assessment went from 13.9 at baseline to 16.3 after the 3rd cycle. Our 3rd cycle aimed to teach AMU staff as data showed that 44% of referrals from AMU did not require a PLT role.

Conclusion

These results demonstrate an improved hospital wide understanding of mental health services. We successfully improved the referrals process at our hospital, staff better understand the liaison team role and the poster is in the process of being added to the trust intranet permanently. We hope we have empowered our colleagues to make appropriate referrals and ultimately ensure the best care for our patients.

10.Has COVID-19 impacted young people and families' experience of their care during a presentation to general hospital with a mental health crisis?

Miss Charlotte Casteleyn, Medical Student, University College London

Aims and Hypothesis

The aim was to compare experience of hospital care for the patient and family when an adolescent was admitted with a mental health crisis at the Whittington Hospital. Comparisons were made across 2-time frames (Jan-March and October -November 2020). I hypothesise a less satisfactory experience for adolescents aged 10-17 and their families at the end of 2020 compared to the start of the year, due to COVID-19.

Background

A mental health crisis is an emergency that threatens an individual's physical or emotional wellbeing. COVID-19, creating a lack of routine, closure of schools and social isolation has exacerbated the mental health of many adolescents. In response to COVID-19, during April-September 2020, the paediatric emergency, and acute inpatient departments at the Royal Free and University College Hospital closed. The Whittington Hospital was the only acute paediatric emergency and inpatient site in the "South" of North Central London limiting mental health crisis work in Accident and Emergency departments. As a result of the COVID-19 pandemic, there was increased pressure on the Whittington Hospital paediatric mental health team.

Method

A service evaluation was conducted using questions from the Experience of Service Questionnaire (ESQ). 50 parents were randomly selected whose child, aged 10-17 at the time, was admitted to the Whittington Hospital for a mental health crisis in January-March or October-November 2020. For parents and adolescents, there was an option to complete the survey online or over the phone. 17 respondents (14 parents, 3 adolescents) in the January-March sample and 20 respondents (15 parents, 5 adolescents) in the October-November sample gave consent, participated and their data was analysed.

Results

The Mann-Whitney U Test and the Fisher's exact test was used to calculate any statistical difference for questions 1-13 of the ESQ. No statistically significant difference was found ($p>0.05$) in patient experience between the two-time frames. A thematic analysis was conducted for question 14-15 identifying 6 major themes: access to the service, communication and listening, empathy and support, facilities, waiting times and overall issues. In January-March, there were more complaints regarding lack of access to services

but in October-November there were more complaints surrounding lack of communication.

Conclusion

Results suggest that patient experience was similar but there is evidence of reduced communication in the time of October-November coinciding with increased pressure at the Whittington Hospital suggesting the pandemic impacted patient experience of care during a mental health crisis.

11.“Are they medically fit?” - Clinical Audit on the Physical Assessment of Mental Health Patients in A&E

Dr Ashley Cooper, CT3, GMMH NHS Trust

Aims and hypothesis

Following a number of dangerous ‘near misses’, this audit was conducted to review the practice of triage and physical assessment of patients presenting to A&E with mental health symptoms. The concern, and hypothesis, was that mental health patients were not being adequately physically assessed before referral. The aim was to compare practice against the Royal College of Emergency Medicine (RCEM) guidelines, to identify repeated issues and systemic vulnerabilities which endangered patients through a lack of appropriate assessment.

Background

A&E departments are busy places; with quick triage decisions required to prioritise urgent care to those who need it. This requires the use of predictions based on past experiences and probabilities. However, this runs the risk of patients being categorised by prejudices and stigmas associated with their conditions; particularly in the case of mental health patients and the assumption they are otherwise ‘medically fit’. This is especially of concern when considering that mental health often deteriorates during acute physical illness.

Method

Using the Electronic Patient Record (EPR) system, the notes of 100 patients referred to the Bolton Mental Health Liaison Team (MHLT) from Bolton A&E were reviewed. They were assessed for whether or not the patients had been appropriately physically assessed, according to RCEM guidelines, before being referred to the MHLT. These results were analysed anonymously.

Results

The findings showed that less than half (44%) of all referred patients had physical observations taken at all, and even fewer (37%) received the full, physical assessment before referral. Out of the patients identified as having abnormal physical observations only 58% were acted on. Many patients had no history or triage assessment completed; with triage referrals consisting of only the words “mental health”. Most importantly, the audit identified this lack of adequate physical assessment resulted in a 2% ‘near miss’ rate, including a missed diabetic ketoacidosis and delayed treatment for a missed overdose.

Conclusion

Following this audit and the above result, it is clear that triage and physical assessment of mental health patients attending A&E is inadequate; with resulting risk of severe consequences to patients. It is therefore recommended to co-develop joint guidelines and teaching to guide A&E and MHLT practitioners on the process of completing the physical assessment prior to referral. It is also recommended to repeat this audit throughout other hospital trusts, in order to review the local referral pathways to ensure adequate physical assessment to avoid any 'near misses' or serious incidents.

12. Working towards enhanced care for patients presenting to Plastic Surgery and Burns following self-harm

Crowley G1, Qaqish Y2, Clarke A1, Barton C1, Eldolify M2, Green A1

1. Mental Health Liaison Team, North Bristol NHS Trust, Bristol, UK
2. Plastic Surgery department, North Bristol NHS Trust, Bristol, UK

Aims and Hypothesis

We outline two stages of a collaborative project between the Plastic Surgery/Burns team (PSBT) and Mental Health Liaison Team (MHLT) in a tertiary Burns centre. First, we aimed to describe a cohort of patients who presented to the PSBT team over a 10-month period with injuries following deliberate self-harm (DSH). The primary outcome was the proportion of encounters referred to the MHLT. Secondary outcomes were current input from mental health services, proportion of out of area (OOA) patients, and number of multidisciplinary team (MDT) discussions between the PSBT and MHLT. Current practice was then audited against the National Institute for Health and Care Excellence quality statement: "people who have self-harmed receive a comprehensive psychosocial assessment".

Background

This patient population are likely to have dual physical and mental health needs that require a proactive, collaborative approach. Potential adverse outcomes include those related to the injury itself (e.g., infection, disfigurement), emotions surrounding the injury (e.g., heightened distress, shame, impacts of stigma) and long-term consequences (e.g., multiple surgeries, amputation, repeated DSH, suicide). The National Burn Care Standards specify that clinical guidelines should be used for the management of patients who self-harm, however there is currently no such guideline in this Trust.

Method

The PSBT provided a database of encounters for DSH from 1st January - 31st October 2020, which formed the study population. The database included inpatient, outpatient and Emergency Department encounters. Demographic and mental health-related indicators were compiled following agreement by members of the MHLT and PSBT. Data sources included electronic patient records for the mental health and acute trusts. Microsoft Excel was used to calculate proportions and analyse data.

Results

There were 90 encounters for DSH injuries during the study period, involving 71 patients (female: 46 (65%), male: 25 (35%)). Twenty-nine (32%) encounters were referred to the MHLT,

the majority in the inpatient setting. Five of these (17%) involved an MDT discussion with the MHLT. Of those referred to the MHLT, 10 (40%) were currently under an OOA mental health team. A documented psychosocial assessment was identified for 46 encounters (51%).

Conclusion

These findings will inform the development of Trust guidance on enhanced care for patients presenting to the PSBT following DSH. We recommend an early MDT discussion for every inpatient. This data will inform improvements in communication between the MHLT and OOA mental health teams, facilitating transfer of important clinical information and timely follow-up in patients' localities.

13. Documentation of Delirium Symptoms and Diagnosis in Parkinson's Disease

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Aims and Hypothesis

To evaluate the documentation of symptoms and diagnoses of delirium in medical notes of inpatients with Parkinson's disease (PD). We hypothesized that medical notes reporting will be lower than diagnoses and symptoms recorded in a research setting, and it will be more likely that there will also be no diagnosis. Furthermore, that the most likely form of delirium to be missed will be hypoactive delirium.

Background

Parkinson's disease is a neurological condition defined by the presence of motor symptoms (tremor, rigidity and bradykinesia); non-motor features are common, including memory problems and hallucinations. Delirium is a neuropsychiatric syndrome characterised by altered level of consciousness, confusion and impaired attention, and is a risk factor for developing dementia. Patients with PD may be at increased risk of developing delirium but delirium is commonly missed.

Method

The DETERMINE-PD pilot study assessed 53 patients with PD admitted over a 4-month period; delirium was diagnosed using a standardized assessment. Incident delirium was diagnosed using detailed clinical vignettes complied from participants' medical notes, study assessments in a single research visit and a collateral history from family or informal carers, and a validated consensus method. Inpatient medical notes of those with possible or probable delirium were reviewed for documentation of delirium symptoms and diagnosis. Results were collated in SPSS and statistical analyses performed.

Results

Thirty (56.6%) admissions had possible or probable delirium during their inpatient stay. Delirium symptoms were documented in 24 (75%) admissions. Eleven (37.9%) patients had a delirium diagnosis documented in their medical notes. Older patients were significantly more likely to be diagnosed with delirium (p=0.027). There was no association between previous cognitive impairment and diagnosis of delirium ($\chi 2$=1.0, p=0.79). Time from documentation of symptoms to that of diagnosis ranged from within 24 hours to 7 days (mean 1.6±4.4 days). Of patients with hypoactive delirium only 29% (n=5) had a diagnosis documented, compared with 66% (n=4) in hyperactive delirium, however this was not a significant difference (p= 0.234).

Conclusion

Although delirium is common in PD patients, documentation of delirium is poor. Documentation of symptoms is more common, but frequently failed to lead to a formal diagnosis. These results highlight the need for continued education about delirium symptomatology and diagnosis. Improved documentation of diagnosis could reduce the impact on morbidity and mortality from delirium, and help identify patients at greater risk of dementia. Future work is required to develop education and screening tools on PD and delirium.

14. Improving outbound referrals in liaison setting

Dr Darena Dineva, CT3, East London foundation trust

Aims and Hypothesis

The aim of this QI project was improve current outbound referrals rate and to ensure that all patients are appropriately referred to community mental health teams at the point of being discharged from the general hospital. Also to ensure the above action is appropriately documented on the local electronic patient records. We aim for the following 2 measures to improve at least 30% from previous baseline: Percentage of patients who are appropriately referred to a mental health community team at the point of discharge from the general hospital. Percentage of patients that the referral has been documented appropriately on local mental health electronic records.

Background

There was an incident in September 2019 where it was noted that a referral was missed and as result the team looked into referrals rate in general for the last year and identified that referrals were not being identified, on other occasions not being made after being identified and lastly it was not documented whether the referrals had been made.

Method

QIP team started meeting regularly. Via Driver diagram and process mapping the following change ideas were identified and implemented in the form of PDSA cycles.Electronic patient list for board rounds on excel replacing physical board. Additional box was added on Excel to clarify if ongoing referral is required.Create electronic list “to be referred” on the hospital’s electronic system where there was colour change when the patient was discharged. Daily checking of this list to identify any pending referrals of discharged patients and prompt for that on the Excel board round list. Specific team member is allocated to complete the referral/notifications and update the relevant list on Excel when that is done. Increase team’s awareness via presentations and emails.Copy admin team when sending the referral/notification as a safeguard.

Results

At baseline the average percentage of patients with appropriate referral documented over 11 months before the intervention was 37% and following the intervention rose to average of 88%; for referrals that there was some evidence of referral being done but it hasn’t been documented baseline average for the same period was 76%, in the year following the interventions the average percentage was 98%.

Conclusion

We used quality improvement methodology and implemented a number of change ideas, including more efficient use of patient electronic systems and we are delighted that sustainable improvement was achieved.

15. Clinical Audit of the Timeframe in which Mental Health Act Assessments (MHAA's) take place in the Emergency Department (ED) at the Royal Cornwall Hospital Treliske (RCHT).

Dr Ana Durning CT2, Dr Claudia Murton (Consultant Psychiatrist), Bob Taylor (Team Manager) February 2021

Aims and Hypothesis

We aimed to obtain objective measures and causes of delays to MHAA's carried out in ED at RCHT in order to improve standards.

Background

ED can be a distressing place for vulnerable patients in a mental health crisis. Some long delays were identified for patients awaiting MHAA's to be commenced. Routes taken by patients admitted to ED requiring a MHAA are either via the usual admission process to ED (Liaison Psychiatry request MHAA) or via the Police under Section 136 (Police request MHAA). The standard used in this audit was: 'Evidenced Based Treatment Pathway for Adults' (EBTP): 'Within 4 hours of the patient arriving in ED they must receive a full biopsychosocial assessment or Mental Health Act assessment if appropriate'.

Methods

54 MHAA requests were recorded by Liaison Psychiatry between 01.07.20 and 30.11.20. 33 took place in ED. The remaining took place on RCHT wards or in the 136 suite and were not included. Audit records were completed for each request, with the times that MHAA's were requested and commenced, and any relevant information recorded such as causes of delays. The records were analysed and compared to the 4 hour EBTP standard. MHAA outcomes were separated into those who were detained vs not detained, and those requested by Liaison Psychiatry vs the Police (Section 136).

Results

33 MHAA's took place in ED between 01.07.20 and 30.11.20. 23 MHAA's were requested by Liaison Psychiatry: 8/23 (34.8%) were completed within the 4 hour time stated in the standard; 15/23 (65.2%) were not completed within the target. 10 MHAA's were requested by the Police: 50% completed within 4hrs. 8/33 (24.2%) MHAA's in ED were significantly delayed more than 12 hours. Causes included no second doctor, Approved Mental Health Practitioner (AMHP) or beds available. Of the MHAA's requested by Liaison Psychiatry 60.9% of patients were detained under the Mental Health Act compared to 10% of the S136 patients.

Conclusions

20/33 MHAA's were delayed in ED, 8/33 longer than 12 hours. The majority of patients who underwent a MHAA in ED were not detained. This audit highlights service difficulties which may lead to delays in MHAA's in ED. Given the significant proportion of patients who are not detained and the significant number of delayed MHAA's, we recommend starting MHAA's at the earliest opportunity. It may be appropriate to initiate MHAA's with one doctor and an AMHP if no second doctor is available

16. The Dementia & Delirium Team: A novel multidisciplinary service to promote high quality care for inpatients with confusion

Dr Oliver Fox, IMT2, North Middlesex University Hospital Dr Richard Robson, consultant geriatrician, North Middlesex University Hospital Professor Elizabeth L Sampson, consultant old-age/liaison psychiatrist, North Middlesex University Hospital

Aims and Hypothesis

To establish a new 'Dementia & Delirium (D&D) team' service, using existing resources, at North Middlesex University Hospital (NMUH) and assess its impact on the care of inpatients with dementia, delirium and 'confusion'.

Background

A quarter of UK hospital beds are occupied by people with dementia. Audits show that around 25% of NMUH patients are 'confused' due to dementia, delirium or both. They are vulnerable to adverse events including prolonged admission, disability at discharge and death. The 'D&D team' is a novel multidisciplinary service, aiming to improve diagnosis of dementia and delirium, and ensure high quality care. It involves a weekly multidisciplinary team meeting and ward round by a consultant old-age/liaison psychiatrist, consultant geriatrician (and juniors), and dementia nurse specialist. The team supports the diagnosis, investigation and management of inpatients with 'confusion', using a structured pro-forma based on comprehensive geriatric assessment and principles of best psychiatric care. Patients are referred by teams in all inpatient areas (geriatric, medical and surgical wards, ICU), and electronic patient records are actively searched for cases.

Method

Data was collected for all patients reviewed over six months from the commencement of the service in June 2020. Data was reviewed to assess the most common reasons for referral, average length of hospital admission including length of stay post-review by this team, and the readmission rates within 7 days, 8-14 days, and 15-30 days.

Results

From June 2020 to November 2020, 243 patients were reviewed by the D&D team, and 176 were new referrals (average 41 patients per month). 46% of patients had known dementia and 38% had delirium. Commonest reasons for referral included 'suspected dementia' and aid in managing behavioural and psychological symptoms. Other common referrals were for help with diagnosis and management of delirium in severe or prolonged cases, and aid with decision-making around eating/drinking. Median length of stay was 16 days (range 1-87 days) for these patients. Patients were discharged 7 days (median; range 0-77 days) after

review by the D&D team. 17% of patients reviewed were readmitted within 30 days of discharge (7% within 7 days, 5% within 8-14 days and 5% within 15-30 days).

Conclusion

The D&D team is a popular resource, demonstrating a real need for expert and specialist support for this patient group. Future work will focus on caring outcomes in this group prior to this service's establishment as well as against the general geriatric inpatient cohort.

17. An Audit of the use of Section 5 (2) of the Mental Health Act in the Royal Derby Hospital

Dr Malkeet Gill, Consultant Liaison Psychiatrist, DHCFT

Aims and Hypothesis

To check that the H1 Form is being completed accurately

Background

Section 5(2) of the Mental Health Act 1983 (MHA 1983) authorises the detention of patients with mental health problems for up to seventy-two hours. Form H1 is the official document that has to be completed at the time of MHA 1983 Section 5(2) application for detention of a service user. I have used the hospitals policy on use of section 5 (2) holding power to set audit criteria and standards.

Method

I analysed a sample of 21 H1 forms from 2019 & 2020. I created an Audit proforma looking at the following information: 1. Hospital Details 2.Doctors name 3.Correctly deleted phrases (a) or (b) on the form 4. Patients Name 5.Reason for using holding power 6.Form signed, dated & timed by doctor completing paperwork 7.Appropriate phrase deleted detailing how it will be furnished 8.Form signed, dated & timed by the accepting nurse on behalf of hospital managers 9.Appropriate phrase deleted detailing how it was delivered to them

Results

1.12 of the forms didn't include the full name and address of the hospital. Often the address was missing. 2.16 of the forms didn't clearly specify whom was completing the form by deleting phrase (a) or (b). 3. Of the 19 forms that were signed, dated and timed by the completing doctor, 17 didn't specify how it was furnished to the hospital manager by crossing out the appropriate phrase. 4. 2 of the forms weren't signed, dated and timed by the doctor completing the form. 5. Of the 12 forms that were signed, dated and timed by the receiving nurse, 9 didn't specify how it was received/delivered to them by crossing out the appropriate phrase. 6. 9 of the forms weren't signed, dated and timed by the nurse receiving the paperwork on behalf of the hospital manager.

Conclusion

The audit findings were unexpected and indicate a need for further training on completing this paperwork. There is also a duty of candour to notify the patients in many cases that it is likely their detention using this holding power wasn't legal due to the paperwork not being completed properly

18. Diabetes Care in an Acute Psychiatric Inpatient Setting: a logic model for service delivery

Dr Zoe Goff, CT3, LYPFT Professor Allan House, Professor of Liaison Psychiatry, University of Leeds Professor Elspeth Guthrie, Professor of Liaison Psychiatry, University of Leeds Dr Hannah Weston, GP Registrar, Leeds Training Scheme Dr Laura Mansbridge, FY2, Leeds and Harrogate Training Scheme

Aims and Hypothesis

To develop a logic model that illustrates the steps needed to develop an effective intervention for diabetes management in a psychiatric inpatient setting, as the point of admission to a psychiatric inpatient unit may present as an opportune time for improving diabetes care.

Background

People with severe mental illness have a shortened life expectancy, with cardiovascular disease the main cause. Diabetes is a major risk factor for this.

Method

We undertook (i) a survey of diabetes care among inpatients in a Mental Health Trust in England, comparing care to the National Health Service (NHS) Core National Diabetes Standards (ii) interviews with key clinical staff to understand challenges in delivering good diabetes care (iii) a review of current UK guidance on standards for diabetes care. On the basis of the findings we developed an initial logic model for service delivery.

Results

Among 163 inpatients reviewed, 44 (27%) had a diagnosis of diabetes, and only 3 (7%) had all three National Institute for Health and Care Excellence (NICE) treatment targets within range. Staff identified needs for regular training, better understanding of roles in shared care, and good quality IT support. We developed a logic model that illustrates the steps needed to develop an effective intervention for diabetes management in a psychiatric inpatient setting.

Conclusion

Admission to a psychiatric inpatient setting provides an opportunity in which diabetes care may be optimised. The quality and understanding of diabetes care will need to be enhanced if this opportunity is to be exploited.

19. Assessing the impact of the Integrated Psychological Medicine Service (IPMS) on service utilisation

Dr Sarah Harvey CT3 DPT Supervisor; Dr Joanna Bromley Liaison Psychiatry consultant DPT Megan Hooper Liaison Team Lead DPT Dr Miles Edwards FY1 RD&E Hannah McAndrews Medical student Exeter medical school Joanne Timms Clinical Psychologist DPT

Aims and Hypothesis

An audit to assess the impact of an Integrated Psychological Medicine Service (IPMS) on healthcare utilization pre & post intervention. We hypothesized that an IPMS approach would reduce healthcare utilization.

Background

The IPMS focusses on integrating biopsychosocial assessments into physical healthcare pathways. It has developed in stages as opportunities presented in different specialities leading to a heterogeneous non-standardised service. The key aim is involvement of mental health practitioners, psychologists & psychiatrists in complex patients with comorbidity or functional presentations in combination with the specialty MDT. This audit is the first attempt to gather data across all involved specialities and complete a randomised deep dive into cases.

Method

Referrals into IMPS from July 2019 to June 2020 pulled 129 referrals, of which a 10% randomised sample of 13 patients was selected to analyse. 5 patients had one year of data either side of the duration of the IPMS intervention (excluding 8 patients with incomplete data sets). We analysed; the duration & nature of the IPMS intervention, the number, duration & speciality of inpatient admissions & short stays, outpatient attendances, non-attendances & patient cancellations. Psychosocial information was also gathered. One non-randomised patient was analysed as a comparative case illustration.

Results

Randomised patients; patient 78's utilisation remained static, patient 71 post-referral engaged with health psychology & reduced healthcare utilisation. Patient 7 increased healthcare utilisation post-referral secondary to health complications. Patient 54 did not attend & increased healthcare utilisation post-referral. Patient 106 had increased healthcare utilisation post-referral from a new health condition. The randomised sample identified limitations of using healthcare utilisation as an outcome measure when contrasted to the non-randomised case (which significantly reduced healthcare utilisation post-referral).

Conclusion

Correlation only can be inferred from the data due to sample size, limitations & confounding factors e.g. psycho-social life events, acquired illness. Alternative outcome measurements documented (e.g PHQ9/GAD7) were not reliably recorded across pathways. The results evidenced that single cases can demonstrate highly desirable effects of a biopsychosocial approach but they can also skew data sets if results are pooled due to the small sample size & heterogeneous interventions. With some patients an increase in healthcare utilisation was appropriate for an improved clinical outcome. This audit identified that utilising healthcare utilisation as an outcome measure is a crude tool with significant limitations & the need to agree tailored outcome measures based on the type of intervention to assess the impact of IPMS.

20. The Introduction of regular group reflective practice sessions for junior doctors in a critical care setting during second wave of COVID-19 pandemic.

Dr Elizabeth M Headon, Core Surgical trainee CT1, Lewisham & Greenwich Trust , Dr Itunuayo Ayeni, Consultant Liaison Psychiatrist, Oxleas NHS Foundation Trust , Luke Martin. FY1 in Lewisham & Greenwich trust.

Aims and Hypothesis

Reflective practice is now a core component of medical training, it provides the opportunity for individuals to be able to respond to challenges faced which in turn impacts on the individual's ability to manage stress and emotions and thus wellbeing. We therefore aim to assess the impact and emerging themes of regular group reflective practice sessions on the wellbeing of critical care junior doctors within in London DGH.

Background

The emotional and psychological wellbeing of all healthcare professionals has been significantly impacted on by COVID-19. Aside from the direct impact and disruption to medical training, data suggests that up to 2/3rd of junior doctors are now experiencing depression, anxiety or signs of burnout.

Method

We aimed to create a regular group reflective practice space for 'difficult or challenging cases' to support critical care doctors during the second wave of the COVID pandemic. We offered two weekly sessions to all grade of doctors within a critical care department. The groups were facilitated by a consultant liaison psychiatrist, an accredited balint group leader.

Results

We completed a total of four group sessions; on average four junior doctors attended each session. One session was cancelled due to work load in the department. The sessions were conducted face to face but within a socially distanced manner. Themes that emerged in sessions as well as feedback in questionnaires sent to trainees included: guilt, cynicism, frustration and irritability, prolonged suffering, desensitisation, lack of understanding from other medical specialities and exhaustion. Despite the challenges, many also identified the benefit of being at work during the pandemic. The group found it beneficial to be able to share their experiences and challenges; this was most striking amongst the very junior members of the team.

Conclusion

Low morale and burnout has already been highlighted amongst junior doctors prior to the pandemic. COVID-19 has identified a clear need for additional support to be provided. Group reflective practice provides an avenue to build on this collective activity with the aim of sharing experience and insight during difficult and challenging times. This project suggests that group sessions introduced as part of a wellbeing support package for junior doctors within a critical care setting can be utilised in an effective and productive manner.

21. Psychiatric Morbidity among the Patient of First event Ischemic stroke

Dr Muhammad Sayed Inam, Assistant Professor of Psychiatry, Sylhet MAG Osmani Medical College and Hospital. Sylhet. Bangladesh.

Aims and Hypothesis

To evaluate psychiatric morbidity among the patients of first ever ischemic stroke.

Background

The World Health Organization defines Stroke as ''rapidly developing clinical signs of focal (or global) disturbance of cerebral function, with symptoms lasting 24 hours or longer or leading to death with no apparent cause other than of vascular origin" (World Health Organization,1989). Stroke is classified as being either hemorrhagic or ischemic in nature depending on the underlying pathological process responsible. Several studies have documented that the ischemic sub type accounts for the greater number of stroke cases accounts for up to 85% of all strokes. Ischemic stroke is a subtype of stroke said to occur as a result of interruption of blood supply to the brain due to occlusion of blood vessels caused by thrombosis or embolism or both. Stroke produces a wide range of mental/emotional disorders. Some of the neuropsychiatric disorders associated with stroke include post stroke depression (PSD), bipolar mood disorder, anxiety disorder, apathy without depression, psychotic disorder, pathological affect and catastrophic reaction. Post stroke depression (PSD) is one of the commonest neuropsychiatric complications associated with stroke. Studies from developed countries have reported prevalence rates of 21.6% for major depression and 20.0% for minor depression in acute rehabilitation hospitals and 24.0% and 23.0% respectively in the out patient clinics in which duration of stroke varies between 3 months and 3 years.Studies have shown that neuropsychiatric complications associated with stroke may have negative effect not only on the social functioning and overall quality of life of stroke survivors but also on the recovery of their motor functioning as well.

Method

This cross sectional comparative study was carried out in the Department of Psychiatry, Sylhet MAG Osmani Medical College Hospital, Sylhet during the period from 1st July 2013 to 30th June 2014. Sixty six ischemic stroke patients of first attack between 2 weeks to 2 years of stroke, aged above 18 years irrespective of sex and 66 accompanying healthy person of the patients and other patients without any kind of stroke matching age and sex fulfilling inclusion and exclusion criteria were taken in Group-A and Group-B respectively. Exclusion criteria were patients with transient ischemic attack, hemorrhagic stroke, previous stroke, head injury, known psychiatric disorder, serious cognitive impairment and other chronic diseases that may cause psychiatric morbidity. Diagnosis of ischemic stroke was made in

these patients by the consultant neurologists reviewing the history, clinical examination and accompanying investigations reports specially CT scan of brain. Psychiatric assessment was done using General Health Questionnaire (GHQ12) as screening tool. All GHQ12 positive cases were evaluated using mental state examination and recorded in a MSE sheet. Diagnosis of psychiatric disorders of all respondents was confirmed by psychiatrist according to DSM-5 criteria.

Results

Co-morbid psychiatric disorder was found in 23 (34.8%) patients of ischemic stroke and 9 (13.6%) control subjects. The co-morbid psychiatric disorder was significantly higher in patients of ischemic stroke than that of control subjects ($p=0.004$). Co-morbid specific psychiatric disorders were generalized anxiety disorder in 9 (13.6%) and major depressive disorder in 14 (21.2%) in stroke group; while co-morbid specific psychiatric disorders were generalized anxiety disorder in 2 (3.0%) and major depressive disorder in 7 (10.6%) respondents in control group ($p<0.013$).

Conclusion

Psychiatric disorders in neurological patients like stroke when not treated may persist, and this may have negative effects on social functioning and overall quality of life. It may also negatively affect medication compliance, slow down recovery, increase cost of treatment and lead to increased morbidity and mortality rate. There is therefore the need for further studies of psychiatric morbidity in neurological populations (among inpatients, outpatients, primary care) and community based in Bangladesh and other developing countries in order to allow for cross cultural comparison of rates of disorders and associated factors and also for development of preventive strategies to reduce morbidity and mortality rates and improve quality of life of patients.

22. Chelsea and Westminster Psychiatry Liaison and British Red Cross Partnership

Dr Natalia Jankowska, FY1, CNWL NHS Trust Dr Laetitia Hawkins-Hooker, FY1, CNWL NHS Trust Clare Rowland, Red Cross Project Lead, British Red Cross Seema Assadullah, Red Cross Support Worker, British Red Cross Dr Hugh Hall, ST6, CNWL NHS Trust Dr Catherine Adams, Consultant Psychiatrist, CNWL NHS Trust Dr Thomas Maclaren, Consultant Psychiatrist, CNWL NHS Trust Lucy Keating, Team Manager, CNWL NHS Trust Katherine Evans, Deputy Team Manager, CNWL NHS Trust

Aims and Hypothesis

In October 2020 Chelsea and Westminster Hospital (C&WH) Psychiatric Liaison Team (PLT) partnered with the British Red Cross (BRC), to enhance social and practical support for patients whilst in hospital, and after their discharge. The aim of the BRC Liaison project is to support patients to live independently, be connected with appropriate community services and to reduce distressing crisis attendances to hospital.

Background

It has been widely identified that Psychiatry Liaison services should strive towards a biopsychosocial model, providing integrated healthcare meeting patient's mental, physical and social needs. The collaboration of the C&WH PLT with the BRC was driven by a recognition of the interrelation of these complex needs.

Method

This is an innovative model where a humanitarian organisation sits within a PLT. Suitable patients are identified during psychiatric assessment and consented for referral to BRC Liaison. The team works collaboratively with the patient to define the areas of need and identify strategies to address these. Between 10/2020 and 01/2021 37 patients were referred to BRC Liaison of which 28 were included in the evaluation. The initial impact of the project has been evaluated through retrospective data collection by review of electronic medical records and the BRC referral system.

Results

The average patient had 23.8 interactions with the BRC team; 47.6% of these were phone calls and 18.9% were face to face appointments.

Conclusion

The initial evaluation of the C&WH PLT and BRC partnership has shown encouraging results. This holistic approach allows for clearly identified, individual needs to be met, increasing community resilience with low levels of repeat presentations to PLT. In London

alone, there are 17 local BRC teams already collaborating with hospitals to support vulnerable patients. With over 20 London Psychiatric Liaison teams, there is a high scalability potential of this project by replicating this model in other London hospitals and nationwide.

23. What does good practice look like? A systematic review of quality standards for gatekeeping assessments for psychiatric admissions.

Dr Jennifer Keal, CT3, CNWL NHS Foundation Trust Dr Chan Nyein, ST5, CNWL NHS Foundation Trust Dr Alex Thomson, Consultant, CNWL NHS Foundation Trust

Aim and Hypothesis

Our aim was to review current literature on gatekeeping assessments in psychiatry in order to identify good practice standards on considering alternatives to hospitalisation.

Background

Response to psychiatric emergencies in the emergency department and on acute medical and surgical wards is a core aspect of unplanned work in liaison psychiatry. Some patients may need transfer to inpatient psychiatry wards; in such cases, it is good practice to consider alternatives to hospitalisation such as intensive home treatment, a practice known as 'gatekeeping'. Across the UK there is variation in pathways, with gatekeeping being conducted by liaison psychiatry staff, home treatment team staff, or by first response teams. There are also variations in the content and form of a gatekeeping assessment. In order to ensure consistency and good practice in acute hospitals, there is a need to develop and introduce quality standards for the content and conduct of gatekeeping assessments in the liaison psychiatry context.

Method

We searched the PubMed database using terms "Gatekeeping" and "Psychiatry and Psychology category". We read abstracts for all papers and retrieved full text of relevant papers to determine if they met our inclusion criteria. We read all papers that were included and summarised the content using narrative synthesis.

Results

Our initial search terms generated 1396 abstracts. After applying inclusion criteria, we were left with 11 papers, of which we were able to access the full text of 9. We read these nine papers in full detail. We found that there is relatively sparse literature on the topic. Broadly gatekeeping is being used to assess patients and determine whether hospital admission is appropriate, or whether they can be better managed by crisis resolution or home treatment teams. The process seems to be determined locally, with no regional or national standardisation on what a gatekeeping assessment should include.

Conclusion

We offer some recommendations for quality standards. We recommend further work to develop consensus quality standards and evaluate their use in practice.

24. Family / carer involvement in care, treatment and discharge planning of patients under the mental health liaison team

Dr Angela Kwan, CT3, Camden & Islington NHS Trust

Aim and Hypothesis

The aim was to improve family and carer involvement in care of patients being assessed by the mental health liaison team (MHLT) at University College London Hospital (UCLH). Target of 80% of family/carers should be involved in discussions and decisions about the patient's care, treatment and discharge planning. Target of 100% of cases in which consent is gained when involving family/carers or adequate reason documented if not. And discharge planning. Target of 100% of cases in which consent is gained when involving family/carers or adequate reason documented if not.

Background

PLAN (Psychiatric Liaison Accreditation Network) Quality Standards used as the standard for this audit: Families/carers, with patient consent, are involved in discussions and decisions about the patient's care, treatment and discharge planning. This standard was of particular interest as this audit was completed during the second wave of COVID-19.

Method

Initial retrospective audit included patients aged over 18 years of age admitted to UCLH who were referred to UCLH MHLT and discharged from the team between 1st – 5th February 2021. This was a sample size of 14 patients during time period audited. Data was collected from patients' electronic case notes (Carenotes & EPIC) and was inputted into and analysed using Microsoft Excel. Action plan included reminding all MHLT staff of this standard and introducing a new heading on the new assessment pro-forma used by the team. The re-audit included the same population of patients but was a retrospective audit of all patients discharged from the team between 22nd – 26th February 2021. This was a sample size of 14 patients during the time period audited. Data was collected, inputted and analysed as per the initial audit.

Results

In 5/12 (42%) in the initial audit compared to 4/11 (36%) in the re-audit involved family/carer in discussions and decisions about the patient's care, treatment and discharge planning. In 4/5 (80%) in the initial audit compared to 3/4 (75%) in the re-audit had documented gaining consent from the patient for involving famiily/carer or documented an adequate reason if

not. In 5/9 (56%) in the initial audit compared to 3/10 (30%) in the re-audit, there was no clear reason for not involving the family/carer.

Conclusion

We should continue efforts on improving involvement of family/carer in discussions and decisions about the patient's care, treatment and discharge planning and improve documentation on whether consent was gained to involve family/carers or the reasons if involving family/carer without consent. Further projects could include discussions by family liaison staff in the acute hospital with family/carers and whether this includes updates on their mental health.

25. Risk Assessment Completion by Whipps Cross Psychiatric Liaison Team – A Quality Improvement Project

Dr Fergus Lewis, CT3, North East London NHS Foundation Trust Dr Andrew Winnett, Consultant Psychiatrist, North East London NHS Foundation Trust

Aim and Hypothesis

To increase the completion of risk assessments to 90-100% within Whipps Cross Liaison Psychiatry Service by August 2020.

Background

The risk assessment pro forma is not always completed following initial assessment of a patient by the Psychiatric Liaison Service. A previous audit completed on the 23/04/2018 showed a risk assessment completion rate of 70% (21/30). Incomplete risk assessments were by both doctors and nurses (4 doctors and 5 nurses).

Method

The project involved a retrospective case note review of 60 electronic consecutive patient records on RIO over two cycles. Patients referred onto the caseload from 12AM 01/04/20 (Cycle one) AND 12AM 29/06/20 (Cycle two) were reviewed. The presence or absence of a risk assessment in the risk folder on RiO was noted, and the corresponding entry in the progress notes was reviewed to assess concordance and whether risk assessment was documented or not. It was also noted whether the risk assessment had been completed by a doctor or a nurse. Interventions were completed following cycle one. These included a survey that was sent out to doctors exploring attitudes to risk assessment and encouraging completion out of hours. A risk assessment poster was also created, directed at liaison staff and out of hours doctors, and a presentation was given to liaison staff.

Results

Cycle one identified a completion rate of 80% (24/30) with incomplete risks assessment mostly by doctors out of hours (5 doctors and 1 nurse). Following interventions the completion rate increased to 90% (27/30). Improvement was seen significantly in out of hours duty doctor practices (2 doctors and 1 nurse).

Conclusion

Objective to increase the completion of risk assessment to 90-100% by August 2020 was met. Both doctors and nurses do not complete it and at times no risk assessment is documented anywhere in the patient's notes, which warrants further training to avoid possible adverse outcomes.

26. Reducing the transfer of patients to A&E from an emergency mental health assessment centre

Dr Rosanna Lyus, FY1, Candi NHS Trust Dr James Dove, consultant, Candi NHS Trust Sifi Bahuleyan, quality improvement coach, Candi NHS Trust

Aim and Hypothesis

To reduce the number of patients being transferred back to A&E departments from an emergency mental health assessment centre

Background

The Mental Health Crisis Assessment Service (MHCAS) at Camden and Islington NHS Foundation Trust is an emergency mental health assessment centre that was formed in response to the COVID-19 pandemic. Patients who present to three acute trusts in mental health crises can be transferred to MHCAS for psychiatric assessment following medical clearance (they can also be conveyed directly to MHCAS by the ambulance service, police or can walk in). Since MHCAS opened, a small number of patients have been transferred back to A&E following medical clearance and transfer to MHCAS from acute trusts. This puts patients at risk and results in a poor patient experience.

Method

Clinical notes were reviewed to obtain data on the reasons for patients being transferred back to A&E and the management they received on their second A&E attendance. Based on these data, quality improvement initiatives were developed using a multi-disciplinary approach. Three changes were made: 1) review of all patients by a doctor before the decision is made to transfer back to A&E 2) direct communication between MHCAS doctor and A&E doctor 3) greater provision of medical management at MHCAS. Change ideas were tested using “Plan-Do-Study-Act” cycles. The time interval between incidents of patients being transferred back to A&E was monitored to measure the impact of the changes.

Results

21 patients that were transferred back to A&E following medical clearance and transfer to MHCAS between 12/04/2020 and 10/02/2021 were identified. A review of clinical notes revealed that of these 21 patients, 5 (23.8%) had no investigations performed, 13 (61.9%) had blood tests and 4 (19.1%) had radiology scans in A&E. 7 (33.3%) patients who returned to A&E had no interventions performed, 3 (14.3%) were admitted and 11 (52.4%) had another type of intervention. Prior to implementation of changes on 10/02/2021 the average interval

between incidents was 7 days. Early data from the month following the changes showed that this had increased to 14 days.

Conclusion

Improved communication and greater provision of medical management at an emergency mental health assessment centre may represent effective strategies for reducing the number of patients being transferred back to A&E. This will ultimately improve patient care.

27. Dopaminergic Imaging in Parkinson's Disease Depression: A Systematic Review

Dr David McKernon, Registrar, Monash Health, Melbourne, Australia and Institute of Psychiatry, Psychology and Neuroscience, King's College London, UK Miss Louise Lord, Senior Pharmacist and PhD candidate, Centre for Medicine Use and Safety, Faculty of Pharmacy and Pharmaceutical Sciences, Monash University, Parkville, Australia and Monash Health, Melbourne, Australia

Aims and Hypothesis

To systematically review the neuroimaging evidence for a relationship between dopamine dysfunction and depressive symptoms in people with Parkinson's disease.

Background

Parkinson's disease (PD) depression is a common neuropsychiatric complication of PD and is associated with reduced quality of life and increased disability. There is a high prevalence of depression in people with PD, and many develop prodromal depression prior to motor symptoms. Growing evidence suggests that the pathophysiology of PD depression is the result of biological factors. However, it is controversial as to whether the underlying dopamine dysfunction of PD is associated with the subsequent development of depression.

Method

The existing literature on dopamine neuroimaging in PD depression was systematically reviewed. MEDLINE, EMBASE and PsycINFO were searched for keywords from inception through to January 2021. Authors independently screened all titles and abstracts according to the eligibility criteria and independently reviewed the full-text articles of included studies. Data extracted included year of study, study size, participant demographics, methodologies (depression assessment instrument, neuroimaging modality) and key findings.

Methodological quality was assessed using NIH Quality Assessment Tools. Results were collated and described using descriptive statistics.

Results

In total, 20 studies with 2048 PD participants were included. Studies ranged from 20 to 480 participants with an average age of 63.3 years and PD duration of 4 years. All studies were PET (n=9) or SPECT (n=11) and utilised a range of radiotracers. A negative association between dopaminergic activity and depression severity was found in 13 studies, 5 studies showed no association, and 2 studies found a positive association.

Multiple methodological issues were identified in individual studies. Small sample sizes (<50 PD participants) (n=10) and concurrent use of antiparkinsonian medications and/or antidepressants (which can interfere greatly with radioligand binding) (n=10) were identified.

Conclusions

To date, most neuroimaging studies suggest that there is a negative relationship between dopaminergic activity and depressive symptoms in PD. However, the results should be interpreted with caution as many studies had methodological issues which may have biased or confounded results. More research is required, and future studies should aim to minimize all potential sources of bias and confounders.

28. Trends in patients presenting to A&E with suicidality within a hospital Liaison service

Dr Rachel Menon, CT3 in Psychiatry, Cornwall Partnership NHS Foundation Trust. Dr Ella McDermott, Foundation Year 1 Doctor, Royal Cornwall Hospital NHS Trust. Dr Phoebe Heveron, Foundation Year 2 Doctor, Royal Cornwall Hospital NHS Trust. Dr Claudia Murton, Consultant Psychiatrist, Cornwall Partnership NHS Foundation Trust.

Aim and Hypothesis

This descriptive study captures trends in suicidal presentations to A&E across an evolving Liaison service with the aim of proposing suggestions for service improvement.

Background

There has been wide speculation about the impact of Core-24 on presentations to A&E; however this remains largely unexplored in the literature. In particular, we have seen increasing numbers of patients presenting with suicidality. We have tracked changes following our transition to Core-24 in April 2018 and the opening of a local Crisis Hub in early 2020 in response to the Covid-19 pandemic.

Method

We gathered a list of all patients attending A&E with suicidality over two specific points (April and May) over four years (2017-2020) at the Royal Cornwall Hospital, Cornwall. Patients requiring medical treatment for self-harm were excluded as it was recognised these would necessitate assessment in A&E regardless. We collected data on; referral time, referral source, mode of arrival, prior service involvement and outcome. We also sought qualitative patient feedback.

Results

The number of attendances with suicidality increased over the first three years of study (21, 29 and 59 successively) but declined in 2020 following the establishment of the Hub (5). There were no significant changes in attendances outside of normal working hours. Pre Core-24 most referrals were initiated via emergency services (52%), and the rest via the public. Post Core-24 saw referrals from GPs (5.6%), secondary MH services (6.8%) and third sector organisations such as college wellbeing teams and mental health charities (11.3%). Pre Core-24, 28.5% of patients were already involved with secondary MH services which increased post Core-24 (45%, 49%). No patients were under secondary services in 2020. Overall, most patients were discharged to primary care (30.7%), newly referred to secondary care (28.9%) or returned to secondary services (19.2%).

Conclusion

The initiation of a Core-24 service was associated with an increased number of suicidal attendances to A&E. Patients were more likely to be already under secondary MH services and were referred from a wider range of sources. Contrastingly, the establishment of the Crisis Hub appears to be associated with a decreased number of attendances and a lower proportion of patients already under secondary MH services. We plan to continue data collection over a longer period of time following service changes, including qualitative feedback, to establish how best to meet our patient's needs.

29. Improving Mental Health clinical pharmacy input to Psychiatric liaison service

Mrs Natasha Patel, Independent Prescribing Pharmacist, Lead Author ELFT NHS Trust Dr Angharad Ruttley, Consultant Liaison Psychiatrist, QI Sponsor ELFT NHS Trust Mr Sher Kayani, QI improvement Advisor ELFT NHS Trust

Aim and Hypothesis

The SMART aim is to increase Mental Health (MH) clinical pharmacy input by 100% to Psychiatric liaison service (PLS) for patients with mental health conditions on psychotropic medication within the acute hospital by June 2020.

Background

The PLS team identified a need for clinical pharmacist input into their multi-disciplinary team (MDT). The expectation is the addition of a pharmacist to support the team with risk recognition and prevention of adverse reactions, co-ordination of medication supply and monitoring arrangements with acute pharmacy teams, adherence to treatment guidelines and an enhanced patient experience.

Method

A pharmacist is funded on a twice-weekly basis at PLS in Luton & Dunstable Hospital (L&D). Quality improvement (QI) methodology was used including model for improvement and 3 PDSA cycles. PDSA-Cycle-1: Initial intervention was a telephone call to PLS following each morning handover for medication related referrals. PDSA-Cycle-2: The initial cycle was not sustainable and yielding referrals. In order to build and strengthen on the referrals idea a poster was create with contact details for the pharmacist and circulated to the team and up in the PLS office. PDSA-Cycle-3: It was hypothesized the pharmacist being onsite one day per week to attend the handover and being more accessible would increase the referrals to the pharmacist and in turn the clinical interventions.

Results

The pharmacist received a total of 62 referrals for consideration and intervention. The baseline data was zero as PLS had no MH Pharmacist within their team prior to QI project PDSA-Cycle-1: Increase in the clinical input with 1 referral per week PDSA-Cycle-2: Increase in the clinical input with 1 referral per day PDSA-Cycle-3: Increase in the clinical input with 2 referral per day

Conclusion

A clinical pharmacist with a comprehensive knowledge of physical healthcare provides an ideal resource for medications management and allows other members of the PLS to focus

on other areas of concern more appropriately. An experience in MH is an obvious advantage for the pharmacist given the patient demographic encountered however the principals of the role remain the same without this background. Inclusion of a pharmacist in the PLS MDT has brought about other team benefits including MH medication teaching to the MDT and acute Trust, as well as allowing the limited consultant psychiatrist resource to be utilized across a broader range of activities. Due to the success of this project the Clinical Director will be looking at financing a substantive pharmacist post.

30. Learning Lessons from Serious Incidents involving Co-existing Mental Illness and Substance Misuse

Dr Rosie Pettit, FY2, Imperial NHS Trust Dr Amrit Sachar, Consultant Psychiatrist, West London NHS Trust Mrs Jenni Guest, Trust Head of Quality Improvement, West London NHS Trust

Aims

To assess how West London trust has been learning lessons about co-existing mental illness and substance misuse (CMISM) serious incidents.

To use a Quality Improvement framework to improve care and outcomes for people with CMISM.

Background

SIs in healthcare are events where the potential for learning is so great, or the consequences to patients, carers, organisations, or staff are so significant, that they warrant action. They must be identified correctly, investigated thoroughly and, most importantly, trigger changes to prevent them from happening again.

The human factors theory depicts a hierarchy in the strengths of recommendations made after SI investigations, with policy and training recommendations being the weakest, and system change being the strongest.

A previous trust-wide audit in West London found that 50% of all SIs involved patients with CMISM (2012-2014). It concluded that core assessment and management of these patients was poor and outdated. Changes to the trust's Dual Diagnosis Policy and training were implemented in response.

Methods

<u>Two phases:</u>

1. Re-audit through thematic analysis on 94 SIs that occurred between 2016-2020. Outcomes of Phase 1 informed Phase 2 methodology.
2. Model for Improvement methodology was used. Online facilitated conversation sessions conducted for front line clinicians with successive Plan-Do-Study-Act (PDSA) cycles. The 'conversation café' was designed to explore a different approach to learning lessons, asking front line staff to engage with each other to explore barriers to good care and potential solutions. Themes were drawn from the conversations and feedback sought

from the participants. Successive conversations were modified to reflect changes implicated by the previous cycles.

Results

1. The proportion of SIs affecting patients with CMISM decreased from 50% in 2012-14, to 32% in 2016-20. Only 12 (40%) of CMISM cases were managed with policy compliant care plans. Between 2016 and 2020 policy recommendations seemed to evolve, with increased strength of recommendations over time.
2. Each conversation brought new ideas to the table on how to learn lessons from serious incidents. An interventional benefit was established with successive conversations. Staff feedback highlighted the benefits of setting up a collaborative reflective space.

Conclusions

As an organisation, we are still in the early stages of developing a culture of engaging frontline staff in improving care. Staff working with CMISM patients do not have a space for collaborative multidisciplinary discussion. Conversation Café's may be a valuable tool for changing future practice.

31. COVID and its Impact on Liaison Psychiatry

Dr Akansha Rajan, CT3, Southernhealth NHS Foundation Trust

Aim and Hypothesis

To review the referrals received by OPMH Basingstoke from March to June 2020 and find the impact of COVID on Liaison services. To review especially to see if there was an increase in the no of patients being diagnosed with Delirium as a result of COVID when compared from last year. To look how Liaison assessments were carried out in context of COVID- Remote or face to Face

Background

Older people are at the greatest risk from COVID-19. If infected they may present with or develop a delirium. Delirium is a well-recognised complication of respiratory illness, such as pneumonia, in older adults. Despite this, there has been a concerning lack of attention paid to the implications of delirium identification and management in the public health response to this pandemic.

Method

This was achieved by reviewing the referrals Basingstoke OPMH Liaison received from March to June 2020 and using RIO entries to check the data retrospectively. Data were collected about the reason for referral, Diagnosis. Also looked at whether the assessments were conducted face to face or remotely in the context of COVID.

Results

Based on the data collected the referrals that were received were as follows- For Confusion and behavioural- 43%, Low mood- 20 %, Cognitive decline- 20 %, Anxiety- 4%, Psychosis- 3% and Inappropriate – 6% Following the assessment the diagnosis made could be broken down as follows- Delirium- 30% Dementia- 33%- vascular dementia constituted 64%, mixed dementia- 8% and Alzheimer's dementia- 8% Depression- 23% Mild cognitive impairment- 9% Psychotic episode- 4% Adjustment disorder- 1% When compared to the data from last year in 2019 delirium constituted 33% cases and this year it was slightly low at 30 %. It indicated that in contrast to our expectations the no of cases of delirium diagnosed was almost similar to last year. Could be either because it has been overlooked or underdiagnosed. There was also evidence of depression, anxiety, fatigue been diagnosed specifically linked to the lockdown brought by COVID-19. 81% of the assessment were conducted Face to face and 19% were carried remotely in the context of COVID-19

Conclusion

Delirium should be recognized as a potential feature of infection with SARS-CoV-2 and may be the only presenting symptom. In the case of COVID-19, older adults often do not mount the typical febrile response and sometimes the only change was altered mental status, agitation and confusion. Thus, the risk of overlooking potential COVID-19 infections is high, without inclusion of delirium as part of the screening criteria. Early management can improve the outcome thus necessitating the need of early screening.

32. An educational intervention in the knowledge and practice of the Adults With Incapacity (AWI) (Scotland) Act 2000.

Dr Elizabeth Robertson, ST4, NHS Lothian Hazel McPhillips, ANP, NHS Lothian

Aims and Hypothesis

Aims: To assess knowledge and practice of AWI in the hospital at night (HAN) team at an Edinburgh teaching hospital. To address any gaps in knowledge by designing an educational intervention that is useful and accessible to health care professional (HCPs) and is sustainable. Hypothesis: There will be gaps in knowledge in the use of AWI and any educational intervention will need to be online, both to make it accessible to HCPs on different shifts and due to covid-19 restrictions on in person training.

Background

AWI is used to treat patients who are deemed not to have capacity for aspects of their care. In this case a section 47 form is filled out detailing this. An annex 5 form gives space for a detailed care plan and accompanies this. It was anecdotally reported that there were often errors in this process and clinicians did not feel confident in how to proceed.

Method

Data was collected from the HAN team of mixed HCPs by means of questionnaire on two separate occasions (October 2019 and December 2020) to identify knowledge around AWI. The data demonstrated an overall poor understanding of AWI. This was presented at the regional Grand Round on Microsoft Teams in February 2021. An interactive poll was used to gather input from the audience on the barriers experienced, what would help to remove them and what they would want from any training intervention.

Results

Regarding barriers, the audience cited lack of time and knowledge and unfamiliarity with the section 47 form. Ideas to remove these barriers included further training, forms being readily available and prefilled examples to use as a guide. When asked about training the audience requested it be online. Other suggestions included case discussions and an assigned area in the electronic clinical notes system for capacity issues.

Conclusion

After reflecting on the suggestions made, we are initially focusing on making a dedicated regional intranet page to encompass the resources requested. This will include links to blank forms, prefilled example forms to use as a guide and a process map of the decision making process. There will also be example cases for illustration. Other ideas include, a

reporting tool for HCPs to submit cases they have found difficult, an online forum to discuss these cases and capacity champions to support HCPs.

33. Experiences of People Seen in an Acute Hospital Setting by a Liaison Mental Health Service: Responses from an Online Survey

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Aims and Hypothesis

The aim of this study was to describe service users' experiences of liaison mental health services (LMHS) in both emergency departments and acute inpatient wards in the UK, with a view to adapt services to meet the needs of its users.

Background

The aim of this study was to describe service users' experiences of liaison mental health services (LMHS) in both emergency departments and acute inpatient wards in the UK, with a view to adapt services to meet the needs of its users.

Method

This cross-sectional internet survey was initially advertised from May-July 2017 using the social media platform Facebook. Due to a paucity of male respondents, it was re-run from November 2017-February 2018, specifically targeting this demographic group. The survey featured a structured questionnaire divided into three main categories: profile of the

respondent, perceived professionalism of LMHS and overall opinion of the service. Space was available for free-text comments in each section. Descriptive analysis of quantitative data was undertaken with R statistical software V.3.2.2. A latent class model was fitted to cluster responses of service users into interpretable groups. Qualitative data from free-text comments were analysed independently by three researchers using framework analysis.

Results

184 people responded to the survey, of whom 147 were service users and 37 were partners, friends or family members of service users. 31% of service users and 27% of close others found their overall contact with LMHS helpful. Latent class analysis identified three clusters - 46% of service users generally disliked their contact with LMHS, 36% had an overall positive experience, and 18% did not answer most questions about helpfulness. Features most frequently identified as important were the provision of a 24/7 service, assessment by a variety of healthcare professionals and national standardisation of services. Respondents indicated that the least important feature was the provision of a separate service for older people. They expressed that a desirable LMHS would include faster assessments following referral from the parent team, clearer communication about next steps and greater knowledge of local services and third sector organisations.

Conclusion

This survey identified mixed responses, but overall experiences were more negative than indicated in previous research. This may be related to the implementation of the four-hour wait target in emergency departments. Additionally, dissatisfied service users are more likely to volunteer their opinions. The evaluation and adaptation of LMHS should be prioritised to enhance their inherent therapeutic value and to improve engagement with treatment and future psychiatric care.

34. Making mental health a golden thread in North West London Diabetes Care: a model for all long term conditions?

Dr Amrit Sachar, Consultant Psychiatrist, West London NHS Trust

Aim and Hypothesis

To embed mental health into all aspects of diabetes care across all of North West London. Hypothesis: 1. That small, short term financial resource is better utilised to create system change wherever possible to get sustainable change rather than used for a short term clinical pilot. 2.That if this model can be shown to work for diabetes it is transferrable to other long term conditions.

Background

North West London (NWL) has 8 Clinical Commissioning Groups (CCGs), in a diverse area with significant deprivation and a complex commissioning landscape. Self-care is central to diabetes management but self-care is negatively affected by mental illness which is common in diabetes. Addressing mental health improves diabetes outcomes. In NWL, there are about 79,000 People With Diabetes (PWD) struggling with mental health issues but there is variation in mental health service provision, no standard mental health screening, so data analysis is challenging, and only 15 staff working in diabetes mental health across 8 CCGs.

Method

We used small, short term funding to build sustainable change rather than deliver a short term clinical service to a small number of PWD. We engaged a wide stakeholder group and task and finish group co-chaired by a PWD. We mobilised a Model for Improvement approach with a simple driver diagram to implement system-wide interventions. Over two years, mental health was fully embedded throughout the entire suite of products we had in NWL: •10-year service specification and commissioning documents for all tiers of services across diabetes pathway •Diabetes clinical guidelines •Diabetes training for staff and PWD •Diabetes digital platform.

Results

We saw system wide behaviour and culture change for clinicians, commissioners, public diabetes/anxiety screening rates in PWD went from 4% to 38% (59,000) of PWD; improved MH detection led to: improved collaborative care planning (80%), take up of patient education programmes (30%), and reduction of diabetes complication admissions (12%) in 12 months.

Conclusion

Sustainable, wide spread change was achieved by using short term funds to embed system change. Working with all stakeholders around coproducing a simple driver diagram was useful for taking a wide view of the issues and for engaging all parties. The author has used a similar driver diagram for NWL renal care and is now working with Kidney Care UK to create a mental health pathway for kidney care using this driver diagram as a starting point. The model is potentially transferrable to other long term conditions.

35. Don't forget about cognitive impairment in the renal dialysis unit: how common is this and what do the staff think?

Dr Amrit Sachar, Consultant Psychiatrist, West London NHS Trust Ms Aida Abdulwahed, medical student, Imperial College Ms Lana Al-Nusair, medical student, Imperial College Ms Edagul Ulucay, medical student, Imperial College

Aim and Hypothesis

Pragmatic study aimed to assess the prevalence and severity of cognitive implement on the dialysis unit and then cross match with staff perception of whether the person was cognitively impaired. Hypothesis: cognitive impairment is highly prevalent but underestimated in dialysis unit by staff

Background

Disproportionate high cognitive impairment within the dialysis population is well documented and a number of aetiological factors are cited. This is important because cognitive function is required for good self for such a complex long term condition. Behavioural and psychological symptoms of dementia may also make dialysis, transport to and from dialysis challenging for the person with Chronic kidney disease (CKD), their loved ones and the professionals supporting them. And yet, it is not routine practice to assess the cognitive function of people with CKD within the trusts where this study took place.

Method

The study was conducted on a large dialysis unit in West London 1.MOCA (Montreal Cognitive Assessment) ·Three medical students were trained to conduct the MOCA and evaluated for accuracy against the first author's assessment. 2. Electronic records were searched for evidence of radiological evidence of brain disease and of a pre-existing diagnosis of mild cognitive impairment (MCI) or dementia. 3.All staff on the dialysis unit were asked for their best guess about the cognitive function of each of the patients on the unit and this was averaged and compared against each patient's actual score.

Results

50 patients were tested for MOCA. Aged 28-88 years. MOCA scores 88% had MOCA scores in keeping with some form of cognitive impairment (42% scored in range of MCI, 24% in mild dementia, 20% moderate dementia and 2% in range of severe dementia). Dementia diagnosis Of the 23 people who scored in the range of mild. moderate or severe dementia, 7 had a diagnosis, a further 6 had radiological evidence but no diagnosis, and 10 had no imaging. Staff perception 26 staff were surveyed about the 50 patients. On average there was a 35% underestimation of MOCA scores by staff compared to the actual scores.

Conclusion

Prevalence of cognitive impairment on dialysis units is high and it is underestimated by staff. Given that this has a major impact on self care, and ability to engage with care planning decisions, this is a significant quality issue. We are in discussion about how to implement routine screening in the unit.

36. “Well, well, well?” Co-producing a staff wellbeing strategy with Liaison Psychiatry staff during the COVID-19 Pandemic

Dr Amrit Sachar, Consultant psychiatrist, West London NHS Trust Dr Mariam Alexander, Consultant psychiatrist, West London NHS Trust Dr Katharine Alder, FY2, West London NHS Trust Dr Serena Banh, FY1 West London NHS Trust, Dr Zoe Cass-Tansey, FY1 West London NHS Trust, Mr Shaun Hare, Service manager West London NHS Trust, Dr Dervla Ireland, FY2, West London NHS Trust, Dr Vincent Law, Consultant psychiatrist, clinical lead, West London NHS Trust Dr. Ernest Mutengesa, FY2) West London NHS Trust Dr Roise Pettit, FY2, West London NHS Trust Dr. Emily Sapsed, FY1, West London NHS Trust Dr Krisha Shah, ST6 West London NHS Trust, Dr Michael Yousif, Consultant psychiatrist, West London NHS Trust Dr. Agata Zielinska, FY1, West London NHS Trust,

Aim and Hypothesis

To use a Quality Improvement approach to optimise wellbeing of our liaison psychiatry services in preparation for Wave 2 of COVID-19. Hypothesis: coproducing wellbeing offers with staff will lead to improved engagement and therefore better health.

Background

Much has been written and implemented on the wellbeing of health and social care staff during the COVID-19 pandemic and rightly so. Liaison psychiatry staff in West London NHS Trust experienced increased acuity of cases and 33% increase in referrals after the first lockdown lifted in the summer. Despite a plethora of NHS wellbeing offers locally and nationally, the take up was low in our services but we didn’t know if this was because the need was low. A listening event after the first wave, identified that staff did wanted to address wellbeing at service level. A working group with input from each of the three sites in West London NHS Trust was convened.

Method

1.Using the Model for Improvement, a driver diagram was drafted by the working group, exploring organisation, team and individual level drivers. 2.September 2020: a. burnout questionnaire (the ‘Professional Quality of Life Scale V’ or ProQOL) circulated to the three teams b. bespoke survey about what has a positive/negative impact on wellbeing and ideas about solutions was distributed to three teams to further develop the driver diagram c.each team discussed their results to devise team specific strategies for their individual and team wellbeing. 3.Interventions implemented over the next few months 4. Both surveys repeated in March 2021

Results

September 2020 results 1. ProQOL data a. 95% of staff derive at least a moderate level of professional satisfaction from their work b. 60% were experiencing moderate burnout. 2. Bespoke survey a. 85% of staff felt their wellbeing was at least 4/6 b. Positive wellbeing factors: majority named own team, senior support and their patients with smaller numbers talking about resources eg, food, PPE, office. c. Negative wellbeing factors: stress related to increased workload and working relationships especially at interfaces. D. Suggestions for change broadly spilt into working patterns, working relationships and resources March 2020 results: Being collected and will be ready in time for conference.

Conclusion

Despite sustained lockdown, more challenging workload, personal and professional bereavements between the two sets of results, early indications suggest that wellbeing has been maintained in our liaison psychiatry services. We suggest working with our staff on wellbeing aided this. Next steps include further PLAN-DO-STUDY-ACT cycles.

37. Assessment and Management of 17 years olds by a working age mental health liaison service

Dr Habib Syed, Dr Alice Bennett, Dr Claire Jones

Aims and Hypothesis

Aims: 1) Review the total number of patients aged 17 managed by the working age mental health liaison team (MHLT) at the Royal Sussex County Hospital (RSCH), Brighton between September 2020 and February 2021.

Background

Departmental registers were analysed to calculate the total number of patients aged 17 seen by the working age MHLT at RSCH during the past 6 months. The reason for attendance, previous mental health service input and outcomes for all patients were documented. A questionnaire was designed and disseminated to MHLT nursing colleagues to measure their level of experience, confidence and previous training in assessing and managing patients under 18. Current stands were compared to guidelines published by National Institute of Clinical Excellence (NICE) and the Royal College of Psychiatry

Results

Results Between September 2020 to February 2021, 59 patients aged 17 were assessed and managed by working age MHLT colleagues. The most common reason for presentation was overdose with the majority of patients already being under Children and Adolescent Mental Health Service. Only 1 nursing colleague had received training in managing patients under 18, albeit, during their mental health nursing degree. The degree of confidence varied; not very confident (2), neutral (6) and confident (4). 56% of the staff were unaware of local services or pathways in managing this age group.

Conclusion

The audit demonstrated that the current standard recommended by NICE and RCPsych. Consequently, children and young people's people mental health training has been organised for all colleagues of the working age MHLT. Clearly defined pathways have been created and signposted to staff including how to access advice from a consultant child and adolescent psychiatrist.

38. Reflecting on reflective practice: A pilot study of virtual reflective practice for foundation year (FY) doctors during the covid-19 pandemic

Dr Krisha Shah, FY2, West London Healthcare Trust, Dr Mariam Alexander, Consultant Liaison Psychiatrist, West London Healthcare Trust

Aim and Hypothesis

To provide virtual reflective practice sessions for FY doctors at a district general hospital with the intention of supporting their clinical practice, professional development and wellbeing.

Background

The GMC's outcomes for graduates states that students should be able to 'manage the personal and emotional challenges of coping with work and workload, uncertainty and change' and 'developing a range of coping strategies such as reflection, debriefing, peer support and asking for help, to recover from challenges and set backs'. Research suggests that avoiding reflection of feelings and emotions leads to burnout and low morale. Ealing Liaison Psychiatry Service (ELPS) was particularly concerned about the emotional impact of the pandemic on FY doctors, who have started their career 'thrown into the deep end'. As such, we offered virtual reflective practice sessions for the FY doctors working in Ealing Hospital with the aim of supporting their clinical practice, professional development and wellbeing.

Methods

FY doctors were invited to attend virtual reflective practice sessions via Microsoft Teams. Three one hour long sessions facilitated by a Consultant Liaison Psychiatrist were conducted. Each session began with an introductory presentation about reflective practice provided by the ELPS FY2 doctor. At the end of each session participants were asked to complete an anonymous feedback questionnaire via Survey Monkey, covering domains of utility, interest, wellbeing, career planning and clinical practice. We also recorded minutes of the sessions in order to identify any emerging themes to the discussion.

Results

Participants responded positively when asked about the impact of RP across multiple domains (utility, interest, wellbeing & clinical practice). On average, 5 participants attended each session with 100% of the participants wanting to attend future sessions. Our qualitative analysis revealed emerging themes of balancing the desire to provide compassionate care with preserving personal wellbeing, perceived lack of autonomy around working patterns, feeling disconnected from colleagues, the desire to advocate for

patients' needs in a pressurised system and managing uncertainty in both professional and personal life.

Conclusion

This pilot study has demonstrated that virtual reflective practice sessions for FY doctors are a valued resource which can have a positive impact on clinical practice, wellbeing and career planning. We plan to expand on the work of this pilot and would appreciate the opportunity to share our latest findings at the conference.

39. Observational study of mental health patients in A&E, before and during the first lockdown due to COVID-19

Dr Alexandra Shaw, F2, Guy's and St Thomas' NHS Foundation Trust Dr Charlene Ng, F1, Guy's and St Thomas' NHS Foundation Trust

Aim and Hypothesis

To ascertain whether there was any difference in the patient characteristics among mental health patients in A&E, before and during the first lockdown due to COVID-19.

Background

The COVID-19 lockdown is reported to have had a negative effect on people's mental health. We wanted to evaluate how it impacted patients presenting to A&E, as this is where people often come when in crisis.

Method

This was an observational cross-sectional study of patients presenting to St Thomas's Hospital A&E. We reviewed the notes from every patient attending A&E who was referred to liaison psychiatry during February 2020 and April 2020. For each patient we recorded data on demographics – e.g. age, gender, presentation, diagnosis and outcome.

Results

There were much fewer patients in April 2020 (n=125) presenting with mental health concerns, than in February (n=221); nearly 50% reduction in referrals. Waiting times improved slightly – in February 84% of patients were seen within the target time of 1 hour; in April it was 91%. In February 55% of patients were male, 45% female. In April, 60% were male, 40% female. Overdose, suicidal and deliberate self-harm comprised 53% of presentations in February and 55% in April. However, deliberate self-harm accounted for 1.8% presentations in February, and 8.8% in April. In February 5.88% were diagnosed with alcohol and drug related ICD-10, this more than doubled to 13.6% in April. Personality disorder diagnoses increased from 12.6% to 16.8%. There were no noticeable differences in diagnoses of mood, anxiety or psychotic disorders. In both months 20% of patients were admitted to a psychiatric ward. However, detention under the Mental Health Act decreased from 15% to 9%. The proportion of homeless patient was 10% in February and 7% in April. Of homeless patients in February, 43% were detained under the Mental Health Act, compared to 11% in April.

Conclusion

We suggest the following could be reasons for the reduction in presentations: the government's 'stay home, protect the NHS' message, not wanting to waste hospital time, and fear of catching coronavirus. Fewer homeless patients presenting could be due to more government support, including accommodation. We suggest that reduced community services support could have contributed to the increase in deliberate self-harm and personality disorder diagnoses. The increase in alcohol and drugs related diagnoses could be due to stress and lack of social support. We suggest repeating the study with data from 6 months and 1 year post-lockdown.

40. Do patients receive the same standard of care out of hours? A comparison of daytime and out of hours mental health presentations to Beaumont Hospital Emergency Department in 2020.

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Aim and Hypothesis

Our aim is to identify any differences in diagnosis and management of patients presenting to Beaumont Hospital Emergency Department (ED) during normal working hours as compared to out of hours (OOH). Standards of care will be compared to the policies set by the HSE National Clinical Programme Self-Harm Model of Care.

Background

In 2018, there were more than 12,000 self-harm presentations to EDs in Ireland with 50% occurring between 7pm – 3am and alcohol misuse being a factor in a third of cases. There is evidence that the quality of assessment and follow up is variable and so the Self-Harm Model of Care was developed to set clear standards.

Method

This is a retrospective audit of mental health ED presentations for 2020. Data was generated by the Psychiatry Electronic Patient Record and collected via NetDiver, a data analysis program. Pearson's chi squared testing was used to determine any differences between normal working hours and OOH presentations.

Results

Of 1299 mental health referrals to Beaumont ED in 2020, 49.6% attended during normal working hours. A third of all cases had self-harmed (33.4%; 37% during normal hours vs 30% OOH, $p<0.001$). Over half of all cases had expressed suicidal ideation (54.0%; 63% during normal hours vs 45% OOH, $p<0.001$). The most common diagnoses were for personality disorder (15%; 10% during normal hours vs 21% OOH; $p<0.001$) and alcohol-related disorders (14.8%, 19% during normal hours vs 10% OOH; $p<0.001$). There were no differences in referral to community mental health teams (41%; 37% during normal hours vs 47% OOH) or psychiatric admission (15%, 16% during normal hours vs 14% OOH). There were significant differences in the recommendation of addiction services (17% during normal hours vs 7% OOH, $p<0.01$) and the voluntary sector (7.5% during normal hours vs 0% OOH, $p<0.001$).

Conclusion

In contrast to previous findings, there were higher proportions of self-harm and suicidal ideation during normal hours compared to OOH in our study. Alcohol-related disorders were diagnosed at twice the rate during normal working hours with more referrals being made to addiction services. Given the association between alcohol, self-harm and completed suicide, this an area that merits further exploration and potential expansion of funding. Furthermore, the voluntary sector appeared to be under-utilised by OOH services and this presents an important teaching opportunity.

41. The impact of the COVID-19 Pandemic and subsequent lockdown on referrals to the Mental Health Liaison Services at Croydon University Hospital.

Dr Katherine Thompson FY2 & Dr Claire Boothman FY2, Nathan Appasamy PLN Croydon University Hospital, South London and Maudsley NHS Trust

Aim and Hypothesis

We hypothesise that the number of mental illness presentations to liaison psychiatric services decreased during the initial period of lockdown 2020 in comparison to 2019 figures. As the pandemic slowed and lockdown lifted, we predict there was an increase in presentations, above that of the previous year.

Background

Due to fear of catching COVID-19, there was an initial avoidance from the public seeking prompt medical attention. We want to know if this pattern was reflected in patients seeking emergency mental health services.

Method

We compiled all referrals made to Working-Age Adult Liaison Psychiatry Service at Croydon University Hospital from March to August for both 2019 and 2020. We included all referrals made in A&E and the medico-surgical wards. The data was split to form a “lockdown” dataset which included referrals from March to May 2020 and a “post-lockdown” dataset including referrals from June to August 2020. We averaged the number of referrals made within a 24-hour period for the two groups and compared the averages. We used the same method for the 2019 data to assess for seasonal variation.

Results

In total, 2099 patients presented between March and August 2020 in comparison to 2139 patients over the same period in 2019. In the “lockdown” period of 2020 there were on average 9.6 (CI 8.8,1 0.3) presentations to liaison services per day compared to 12.9 (CI 12.2, 13.6) ($p<0.005$) in the three-month period after lockdown. Comparing this to pre-pandemic results, the average presentation for March to May 2019 was 11.3 (CI 10.55,12.2) and June-August was similar at 11.8 (CI 11.1,12.5).

Conclusion

This data shows that lockdown had a significant effect on the number of patients accessing mental health services during the pandemic, confirming our hypothesis that there was a reduction in presentations to emergency mental health services during the lockdown which then significantly increased when lockdown lifted. Whilst the exact mechanisms

that drive mental health presentations during an unprecedented pandemic are not clear, they could prove beneficial when trying to predict service requirements in future global disasters, and therefore warrant further investigation

42. Intramuscular clozapine in the acute medical hospital - experiences from a liaison psychiatry team

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Aim and Hypothesis

Clozapine is the antipsychotic of choice where all other treatments have failed. In patients with treatment-resistant psychosis presenting with serious physical illness, it can be challenging to continue treatment with oral clozapine in cases where they are unable or unwilling to take oral medication. Discontinuation of clozapine at this precarious time puts them at high risk of acute deterioration in their mental state, which can impede recovery from their physical illness and cause significant distress. Clozapine is available in intramuscular (IM) format, though its use is predominantly restricted to that of specialist inpatient psychiatric units, and it is not routinely administered in the acute general hospital.

Background

We present two clinical cases of psychotic patients admitted under section to the acute hospital with serious physical illnesses. IM clozapine was used effectively to alleviate their psychotic symptoms and facilitate urgent medical investigations and treatment: 1) Mrs A was a 50 year old woman with schizoaffective disorder who presented to A&E with abdominal swelling, pain and nausea. She had non-compliance with her clozapine and had delusional beliefs of being pregnant with Jehovah's child. Imaging showed lesions on her liver which were suspicious of abscesses or metastases and she required a liver biopsy for definitive diagnosis, but refused based on her delusional beliefs that it would harm the unborn baby. 2) Mr B was a 47 year old man with schizophrenia, transferred to ITU from a mental health unit after he jumped out of a window and sustained multiple fractures. He refused his clozapine on the psychiatric ward and had been given zuclopenthixol. Mr B was floridly psychotic, aggressive towards ITU staff and repeatedly pulled out his lines, making treatment of his physical condition very challenging.

Method

We describe the use of IM clozapine in these patients, including dosing decisions, administration routes and frequency of dosing. Outcome was measured by a reduction in psychotic symptoms from clinical assessment, sufficient to allow treatment for their physical illness.

Results

Both patients successfully received IM clozapine, allowing timely treatment of their physical health conditions. There were no adverse events and significant improvement in their mental health presentations was achieved.

Conclusion

From these cases, IM clozapine has been demonstrated to be a safe and effective treatment for patients with serious mental illness in the acute hospital, though it should be considered on a case-by-case basis in view of the numerous logistical and ethical quandaries involved.

43. PLAN Standards and writing to patients: Quality Improvement by Audit

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This quality improvement project aimed to assess the adherence of a hospital psychiatric liaison team's documentation of assessments to the Psychiatric Liaison Accreditation Network (PLAN) standards framework; to identify areas of improvement; to identify barriers to and improve adherence.

PLAN is a quality improvement and accreditation network of mental health liaison services. PLAN standards provide a clear and comprehensive description of best practice in liaison psychiatry services, including offering copies of correspondence written to other health professionals after interaction with psychiatry liaison services. The suggested way to achieve this within the team was to always offer a copy of their GP discharge letter, or an edited version of this if required.

Data was extracted from 27 randomly selected patient assessments from 01/07/2020 to 31/08/2020 and then 27 assessments from 01/10/2020 to 30/11/2020 for re-audit. Quantitative data was collected by calculating the percentage of assessments which documented each specific aspect of PLAN standards. Qualitative data including attitudes specifically towards writing to patients was gathered from 1:1 discussions with members of staff. Interventions between rounds of audit: Presentation of results of 1st data collection to team in November 2020 followed by discussion Emailed instructions to create a template based on PLAN standards for assessments to staff Lobbied for Cerner access at liaison team office to facilitate use of above

Quantitative – overall improvements were seen in adherence to all aspects of documentation of assessments including collateral history (from 23% to 67%) past medical history (30% to 70%) and acknowledging the patient/carer perspective (46% to 74%). Some improvement was seen in offering written correspondence to patients (0% to 20%). Qualitative – the majority of comments regarding writing to patients were positive, with no staff members opposing the standard (“it is best practice”, “should become a habit”). However, some barriers were identified including increased workload (“requires more editing”, “could take a lot more time”).

Team adherence to PLAN standards for documentation of assessments was improved through low intensity interventions. Overall adherence was high, however certain areas leave space for improvement. The audit facilitated conversations around writing to patients on discharge, both in the form of formal gathering of qualitative data and informal discussions between staff. Attitudes towards writing these letters were positive and some improvement was seen between audits. Ongoing audit activity aims to further improve adherence and monitor improvements.