May 2023. Data was collected from 10 inpatient (6 general adult & 4 old age) wards. All patients who were discharged in the month of January 2023 were included for audit. Information was collected about driving status of patients at time of admission, during their stay on ward, and if any advice regarding fitness to drive was given at time of discharge. Data was recorded anonymously. Results are reported in percentages for descriptive statistics.

Results. Risk assessment was completed in 95% of patients on admission. About 12% (15/128) of the patients were driving at the time of admission, 80% of them were female. Assessment of driving risk during admission only took place in 11.7% (13/128) of cases. Advice on fitness to drive at time of discharge was given only in 12.5% (16/128) of cases. About ¼ of patients who were driving at time of admission, did not receive advice on fitness to drive at time of discharge from hospital.

Conclusion. There is a huge gap in clinical practice regarding compliance with fitness to drive policy. There is an urgent need to improve awareness among mental health teams that they have a role with regard to assessment of their patients' risks and fitness to drive. An educational training video will be prepared and shared with clinicians in December 2023 to fill gaps in the service. Further information will be collected on practices related to fitness to drive policy in March 2024 for further evaluation of services.

Thematic Analysis of Coroners' Prevention of Future Deaths (PFDs) Reports in Mental Health Related Suicide

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Aims. To identify professional and organisational-related themes in Coroners' PFDs reports which contributed to mental health related suicide.

Methods. We reviewed Coroners' PFDs reports via the UK Judiciary website. We filtered reports by those which were mental health related deaths and included the keyword 'suicide'. 100 reports were reviewed starting with the most recent which was August 2023. We reviewed which Coroner's area the reports originated from and the age and gender of the deceased. Then, we examined the contents of the PFDs reports including the inquest conclusion, circumstances of death and concerns raised by the coroner. Themes were identified and grouped into patient-related, professional-related, and organisational-related factors that may have contributed to the death by suicide.

Results. Reports were reviewed from across the UK. The highest number of reports were from the coroner area of Manchester South (12%).

From those reports whereby the deceased's age was mentioned, the mean age was 36 with an age range of 14–81 years (35% of reports did not include the deceased's age).

61% of reports were of males and 39% females.

The main professional-related factors identified from thematic analysis of the PFDs reports were issues around risk assessment and management (45%), lack of interprofessional communication and collaboration (33%), inadequate clinical queries/assessment (25%), lack of consultation of family/carers (17%) and lack of treatment/follow up plan following discharge (11%).

The main organisational-related factors were inadequate service provision for the population covered (20%), inadequate training/knowledge (18%), inadequate staffing or reliance on agency staff (15%), poor systems in place including information technology (13%) and lack of audit or evidence of learning from prior investigations & events (11%).

Patient-related factors were less commonly identified but included lack of engagement with services, denying suicidality and autistic spectrum disorder.

Conclusion. The commonest theme was issues around risk assessment and management which was identified in 45% of suicides. It is hoped by highlighting common themes arising from PFDs reports across the UK this analysis could inform targeted improvements in practice that will lead to reductions in mental health related suicide which is the need of the hour.

Using a Systems Wide Approach to Improve Medical Emergencies in a High Secure Forensic Psychiatry Setting

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Aims. Patients with severe mental illness are at a significantly higher risk of poor physical health outcomes than the general population and die on average 15–20 years earlier. The Royal College of Psychiatrists has published extensively on how to improve routine physical health monitoring in this cohort. Despite this, there is little data or guidance on improving emergency medical care for this cohort. We aimed to analyse and optimise the process of patients being sent to general hospital on an emergency basis.

Methods. A review was undertaken of the clinical notes for medical emergencies over a 12 month period by two core psychiatry trainees. Site visits and interviews with local A&E department clinicians, the covering General Practitioner and pharmacy were completed. A questionnaire was distributed to all nursing staff to gather their perspective on the considerations for emergency medical transfers out of The State Hospital.

Results. On review of the case notes, 44/44 emergency outings were deemed to be clinically necessary for investigations/interventions that would not have been possible on-site. Qualitative methodology highlighted a disconnect amongst staff groups and stake holders regarding thresholds for transfers relating to medical emergencies leading to a high level of staff dissatisfaction.

Conclusion. The interface between psychiatric and medical services is an area of risk to patients. Levels of staff confidence, knowledge and available resources all contribute to the risk of transfer. Further work is required to explore other aspects of patient care and treatment which can be impacted as a consequence of emergency transfers.