Methods. Through purposive sampling we conducted a five-point Likert Scale on members of the multidisciplinary team (MDT) on one medium-secure forensic ward, within Oxleas NHS Foundation Trust, which provides 124 forensic inpatient beds to southeast London. We collated physical health data from across electronic patient records to create a single-point-of-access workspace on Microsoft OneNote, accessible to all members of the MDT contemporaneously, comprising past medical history, psychotropics requiring close monitoring (e.g. lithium, clozapine, valproate), vital signs, weight, bloodwork, electrocardiogram findings, hospital appointments/results and cancer screening.

We re-sampled members of the ward MDT after the workspace had been created and implemented.

Results. Nine members of the multidisciplinary team were sampled before and after the OneNote workspace was implemented.

- Pre-intervention, 56% disagreed that they were confident in quickly viewing recent investigation results. Post-intervention, 99% of users agreed/strongly agreed, with no negative responses.
- Pre-intervention, 67% disagreed or strongly disagreed that they were confident in knowing what physical health appointments were scheduled. Post-intervention, 100% of respondents agreed/strongly agreed.
- Pre-intervention, 78% disagreed or strongly disagreed that they were happy with the availability of past medical history information. Post-intervention, this increased to 99% agreed/strongly agreed.
- Pre-intervention, 89% disagreed/strongly disagreed that they knew where to see patients on psychotropics requiring close monitoring. Post-intervention, this increased to 100% strongly agreed.
- Pre-intervention, 66% disagreed/strongly disagreed being able to see single-point, up-to-date physical health information, at baseline. This increased to 99% agreed/strongly agreed post-intervention.

Overall, 89% agreed/strongly agreed the workspace would allow them to better understand the physical health and monitoring needs of patients, whilst 78% agreed/strongly agreed it allows for more effective work across wards/sites in the Oxleas forensic directorate.

Conclusion. Physical health information is often overlooked in secure inpatient settings. Due to the limitations of the electronic patient record, it can be difficult to find relevant physical health information quickly. This can lead to dissatisfaction and a lack of confidence in the MDT, as shown in the baseline data.

After the Microsoft OneNote dashboard was introduced, there was a marked improvement in staff confidence, happiness, and awareness of physical health requirements for each patient.

Further data needs to be collected to assess for sustainability of these improvements. We intend to expand the scope of this system across the secure inpatient units in the Trust.

The Impact on Inpatient Stays, Crisis and Emergency Department Assessments In Patients With Emotionally Unstable Personality Disorder Who Complete an 18-Month Mentalization-Based Therapy Programme in a Tertiary Personality Disorder Service in Northern Ireland

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Aims. The Personality Disorder Service in the Northern Health & Social Care Trust was originally set up to deliver evidence-based treatment for people with the diagnosis of personality disorder. This group of people historically have been stigmatised, excluded and let down by services, despite their complex needs and frequent history of childhood trauma. The team developed a Mentalization Based Therapy (MBT) programme originally commencing in 2013.

To identify recent completers of the MBT 2 18 month programme and to assess whether there was any reduction or change in pattern to the number of days spent as inpatient both during and after having completed the programme, whether there was a reduction in the frequency of same day assessments with community mental health teams or unscheduled care and finally whether there was any reduction in terms of volume of crisis assessments and presentations to Emergency Department.

Methods. Using validated Quality Improvement Methods, a Plan Do Study Act Cycle was commenced which involved identifying patients who had begun and finished the MBT programme and minimum of 12 months had passed since completion in order to follow-up.

We then broke down this data into 3 domains. By using EPEX, Paris and Electronic Care Record computer systems, it was possible to analyse days spent as inpatient, same day assessments and crisis assessments as well as Emergency Department attendance.

For these periods of time, they were split into pre-commencement of programme (18 months), during programme (18 months) and post-completion of programme (12 months) to see if there was any tangible decrease in these numbers.

19 service users were identified that had initially been referred to Personality Disorder Service between 2016 and 2018 and who subsequently began MBT2 programme between 2017 and 2019. Given the length of completion of the programme, this allowed us to gather a full set of data with regard to these patients up to completion of programme in 2021. Subsequent period of 12 months was then analysed post-completion of treatment taking us up to 2022.

Results. The average time spent in inpatient admission days prior to starting therapy for 18 months (n = 19) was 21.74 days, this decreased to 6.53 during therapy and 3.68 post-therapy (12 month follow-up) = 5.52 adjusted for 18 months. This represents a reduction of 74.61%.

The average number of same day assessments and unscheduled care (n = 8) seeking prior to admission was 1.38. This decreased to 0.75 during therapy and 0.88 post-therapy adjusted to 1.32 for 18 months, which represents a small decline of 4.35%.

Finally, the average number of Crisis contacts and Emergency Department assessments were 2.63 in the 18 months before commencing therapy, 1.26 during therapy and 0.58 in the 12 months post-therapy, 0.87 adjusted for 18 months. This represents a reduction of 66.92%

Conclusion. It is clear from analysis of the data that there has been a substantial decrease in time spent as admitted inpatient as well as number of contacts with Crisis Assessors and Emergency Departments in association with completion of the MBT 18 month programme.

This demonstrates that, by using an evidence-based and well-established programme, which carries a high time commitment for both service users and practitioners, it is possible to

considerably reduce use of other, more acute services and keep patients with a diagnosis of EUPD out of hospital longer and on a sustained basis and also to reduce presentations to Emergency Departments which was often on the basis of self-harm and/or overdoses.

The dual result is that it can be validated objectively that service users are suffering less distress after having completed the programme, which will lead to better quality of life, whilst also reducing the burden on costly inpatient services with the end result being an important investment in mental health services in Northern Ireland and the prototype for the developing regional service.

Improving the Quality of Junior Doctor Handover in Tyrone and Fermanagh Hospital, Northern Ireland

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Aims. To improve the quality of junior doctor handover in the Tyrone and Fermanagh hospital. The hospital is spread across a number of inpatient sites making it difficult to complete an in-person handover. Each day the handover is completed on a Word document and sent via trust email to relevant staff. Issues were identified with the quality of information shared and how the outstanding tasks were handed over.

Methods. A PDSA cycle was implemented to explore outstanding issues with the handover and consider how change might be implemented. Junior doctors identified various issues including the lack of a common format, the amounts and relevancy of information shared and identifying an individual or team to conduct the outstanding tasks.

A baseline audit for a 3 month period (July–September 2023) was completed. Results were reviewed and a driver diagram was established. Suggestions identified for improvement included the use of new template and an in-person handover.

A new template for recording information was drawn up and agreed by the group. It included basic demographic prompts such as staff member on shift and the date of handover. The template included prompts for key patient information identified from initial audit as frequently forgotten.

The template was emailed to doctors on the rota and was also highlighted to new staff at junior doctor changeover points. This new template was the intervention chosen for re-audit between November 2023 and January 2024.

Results. Following the application of our intervention, completion of the handover improved. From an information governance perspective the identification of staff and shift dates improved (to 98% & 99% respectively). The security of information shared improved through use of password (69% to 91%).

The quality of information sharing also improved with the percentage improvement of key demographics increasing, such as patient initials (29.4%), Healthcare number (9.2%), MHO status (15.46%), patient summary (19.76%) and working diagnosis (34.91%) and finally an increase of 88.74% in identifying the person for following up outstanding tasks.

Conclusion. The use of a handover template has improved the quality of information shared across a number of key areas. The identification of person for handover has improved significantly with this tool and is felt to represent an improvement in patient safety. Following re-audit cycle, other areas were identified for further changes such as adjusting prompts on the template and a secure folder for storing the handover. These changes could be easily implemented in a subsequent audit cycle.

A Retrospective Assessment of Referrals Between the Mental Health Liaison Team and Memory Assessment Service; Does Delayed Referral Due to Delirium Lead to Some Patients Being Lost to Follow-Up?

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Aims. The assessment, diagnosis, and management of memory problems in older adults are routinely undertaken by memory assessment services (MAS) typically following referral from a GP. Mental health liaison teams (MHLT) newly identify many older people in acute hospitals with memory problems. Delirium is often diagnosed acutely and should be managed prior to any consideration of dementia diagnoses, however many of these people still have histories which also suggest underlying undiagnosed dementia. Referral policies advise of 3 months delay between delirium and MAS review to avoid misdiagnosis of dementia. MHLT therefore often request GP to refer at 3 months if still indicated. It is felt that some patients may be lost to follow-up via this route; our aim was to explore this further with a view to establishing a more robust direct referral pathway if indicated.

Methods. Electronic records of patients under the care of MHLT aged over 65 from June 2022 to June 2023 were reviewed. This excluded patients who were referred and discharged from MHLT after a single assessment. We collected retrospective data for 8 months during this 12-month period. For any patients with memory concerns, we recorded where MAS referral was recommended and whether they were subsequently referred and seen.

Results. 108 patients over the age of 65 under the care of MHLT were identified. 69 patients had memory problems, 28 of whom already had established diagnoses or were already under MAS and 41 had newly identified memory problems. Of these 41 patients, 15 were felt to need MAS referral due to possible dementia. 3 were referred directly to MAS by MHLT and were seen. 5 were later referred to MAS by GP on MHLT recommendation and were seen. 7 were not later referred to MAS despite it being recommended.

Conclusion. All 3 patients whom MHLT were able to refer directly to MAS were seen, whereas 7 out of 12 (58%) patients for whom 3-month delayed referral by GP was requested were not seen. The policy of 3-month delay avoids misdiagnosis due to delirium, but in practice also leaves some patients with missed opportunities for diagnosis and management of dementia. There is a need for a more robust delayed referral pathway to memory assessment services from mental health liaison teams.