Methods. Following GPs engagement sessions, a 12 weeks pilot was conducted with the Bath and North East Somerset (BaNES) Primary Care Liaison Service (PCLS) and the 6 Primary Care Networks (PCNs) in BaNES. 22 GP surgeries were allowed access to Advice and Guidance (A&G) system using a digital platform. The pilot ran from 3rd April to 25th June 2023, focussing on answering non-urgent queries related to: psychotropic medications, mental health presentations, and the wider mental health system signposting and awareness.

One Consultant Psychiatrist and One Associate Specialist in Psychiatry were involved. The asynchronous system (eOpinion) with an expected response time of 3–5 working days was used.

To allay any governance risks and to act as a backup should the A&G system process fail to record appropriately, a dual recording of the A&G given – both in the A&G digital platform and the patient electronic record was implemented. Further governance structures were built into the project to establish that actions undertaken by the psychiatrists were effective and justifiable.

Results. 82 requests received over the 12 weeks period.

20 out of 22 surgeries took part.

The Psychiatrists spent on average of 3.5 hours per week answering A&G requests. The administrative team spent on average one hour and three quarter per week processing A&G responses.

Although no significant impact on total referrals was noted, there was indication that demand was moving from the referral to A&G request.

All requests were responded within 2 working days.

Requests from GPs were largely appropriate with 88% resulting in advice and guidance, indicating an improved patient journey.

Minimal impact on the operational processes.

Positive feedback from GPs with 91% finding the A&G system useful or very useful. They were keen for the offer to continue.

Conclusion. Effective inter-professional collaboration between GPs and psychiatrists is essential in enhancing patients' overall health outcomes and experiences. For mental health services, this transformational approach should continue to enhance the existing offer. However, we should remain mindful of the potential risk of increased workload burden in General Practices, and the implications of this new clinical model on staff based in specialist services.

Clinical and Non-Clinical Complaints Towards a Mental Health Service in the West of Ireland Over a Seven-Year Period

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Aims. To examine whether the rate of clinical and non-clinical complaints towards a mental health service (MHS) in the west of Ireland has changed over the preceding seven years. We aim to clarify the pathways for managing clinical and non-clinical complaints locally and compare with other MHS nationally. We aim to capture the nature of complaints, potential factors in any change in rate and quantify associated workloads via survey of senior clinicians involved in managing complaints.

Methods. We obtained anonymous data from a local database maintained by administrative staff regarding annual complaint numbers for the previous seven years (2016–2022). Data separating clinical and non-clinical complaints were available for the previous four years only due to previous recording practices. Current complaint pathways were captured via administrative staff. A survey via telephone or email of Executive Clinical Directors (ECDs) typically involved in complaint management was conducted.

Results. Annual rates of complaints have increased in the past four years, with these representing higher totals than any of the three previous years (2019–2022, n = 27,23,23,46 v. 2016–2018, n = 21,12,14). A significant increase in rate is noted in 2022 (n = 46) representing at least double the rate of five of the preceding six years. Clinical complaints are more predominant than non-clinical across a four year period (mean = 59% annual total) but no significant change in rate was noted. Rates of complaints are perceived to have increased in the previous five years by ECDs (n = 4). Repeat complainants are perceived to be common (n = 4). Workload regarding complaints is reported to be variable between services (n = 2, 0–4 hrs/week v. n = 2, 4–8 hrs/week). A clear appeals pathway is unavailable regarding clinical complaints across MHS (n = 4). A disparity between MHS around clinical complaints structures and recording practices between services is noted.

Conclusion. Overall rates of complaints towards MHS have broadly increased in the last four years, with a significant increase in 2022. There appears to be a significant disparity in structures between both clinical and non-clinical complaints pathways and between individual MHS. Further research in this area and a standardised national framework for management of clinical complaints is needed.

One Stop; Addiction, Obstetrics & Perinatal Mental Health Pathway in North East Essex

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Aims. Addiction services in Essex are provided as a collaborative by NHS run Essex STaRS, Open Roads, SHARP and ARC provide psychosocial care. YPDAS supports the young people.

Observed gap: Pregnant women with addiction problems were running from pillar to post to receive care and support needed during this challenging phase of their life.

The one stop clinic provided an all-encompassing care pathway to fill the above need and improving outcomes for mothers and babies.

Methods.

Description:

The new pathway was setup in 2019 on a hub & spoke model. The one stop clinic was at centre, comprising Substance Misuse, Midwifery and Obstetrics. The spokes included Perinatal-mental

health, Neonatal, Adult, Child Social services, CMHTS, Police, Criminal Justice and primary care.

Simple entry criteria: 1. Substance Dependence 2. Positive pregnancy test with referral taken from any service. Patients receive comprehensive initial assessment covering addictions, mental health, social circumstances, obstetric history and physical health evaluation including foetal US scanning. Led by a team of psychiatrist, midwife, obstetrician and substance worker.

Evaluation identifies risks from mental, physical health, safeguarding, support needs and formulates an initial engagement and management plan. Referral into all necessary organisations. A staggered follow up plan per every trimester agreed.

Commencement or planned reduction of Opiate Substitution Therapy (OST), medication rationalisation, nutritional advice, enhanced antenatal monitoring. The regular follow-up via fortnightly midwife, drugs worker review. Monthly medial review in the clinic.

The support from perinatal psychiatry teams, CMHTS, Social services, Criminal Justice safeguarding teams is roped in when needed. Child protection, safeguarding issues are addressed. Clear multi-directional communication is maintained at all times. A safe delivery plan along good neonatal management ensured with appropriate outcomes for mother & baby are achieved.

Results. Since 2019, this initiated 16 patients with various complexities. 12 women left hospital with their baby in their care. 1 left the area during the pregnancy. 2 babies were removed into care. 1 had a miscarriage, 1 had a false positive test. All women received contraceptive advice, one got tubectomy and many on long-term contraception. No significant mental health relapses or admissions. All managed to stabilize or reduce their opiates issues.

Conclusion. This One Stop Clinic has effectively addressed the complex needs of perinatal addiction patients. Centralised provision of care, duplication avoided, clear communication was a welcome relief for patients. Clinic has won a quality award.

Staying Too Long – A Review of Delayed Discharges From Paediatric Wards

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Aims. Since 2020, there has been an increase in children with mental health presentations ending up on general paediatric wards. Hospitals are identified as a place of safety for young people in crisis, though admission to a paediatric ward is not without risk for the child and staff involved in their care. Stays are often prolonged and classed as delayed discharges. This evaluation looks at 22 admissions to general paediatric wards within an acute health trust in Greater Manchester.

Methods. Local CAMHS teams identified 22 patients with a mental health presentation who had been admitted to paediatric wards and had delayed discharges between September 2021 and December 2023. Their electronic notes were analysed to identify number of bed days and CAMHS contacts, legal status, and discharge destination. Incident reports of each admission were analysed, and categorised into 'Restraint/Rapid Tranquilisation', 'Assault on staff' 'Self harm' 'Abscondence' and 'Other'.

Results. Of the 22 cases analyses, total bed days were 1469. The average number of bed days was 66.7. 6 admissions were over 100 days with the longest being 186 days. The majority (19) of the presenting complaints were categorised as 'self-harm' and /or 'suicidal ideation'. The average number of core CAMHS contacts was 23 per admission, with an average of 9 consultant contacts, 5 Junior doctor out of hour contacts, and 32 meetings (e.g. discharge meeting, strategy meeting) requiring CAMHS attendance. 11 admissions involved assault on staff, with the highest number of assaults 48 during a single admission. 18 of the admissions required additional staffing (clinical support worker, security). Three patients required police to be called to the ward due to assault on staff. 9 of the patients were discharged to a social care placement, 8 were discharged home. The remaining were discharged to inpatient unit, day unit or to a family member.

Conclusion. Mental health admissions to paediatric wards are associated with a high level of CAMHS contacts provided by Tier 3 staff, which creates a previously unseen burden on the service. Admissions can be prolonged. Patients are cared for in an environment which is not designed to meet their needs. This is demonstrated by high level of patients absconding from the ward and increased restrictive measures such as restraint and 1:1 observation. Admissions are also associated with high levels or assault on staff. Further work is needed to evaluate the economic impact of additional staffing on paediatric wards, as well as the impact on paediatric nursing and security staff.

Assessing Physical Health Risk in People With Intellectual Disability Using the Decision Support Tool for Physical Health [DST-PH]

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Aims. Accurately and comprehensively assessing physical health risk for people with intellectual disability (ID) is paramount in improving health outcomes, reducing the need for acute hospital admissions and preventing mortality. We aimed to compare the existing approach to assessing physical health risk with the use of a novel standardised risk stratification tool, the Decision Support Tool for Physical Health [DST-PH]. We hypothesise that DST-PH will be useful in improving and streamlining the assessment of physical health risk factors in people with ID.

People with ID are more likely to have poorer physical health outcomes and are at increased risk of premature and preventable death. Annual data from LeDeR (Learning from lives and deaths – People with a learning disability and autistic people) consistently underlines the need for developing strategies that reduce the risk of people with ID developing conditions associated with high causes of morbidity and mortality.

The DST-PH is an online tool that helps clinicians to identify people with ID who are at increased risk of early and preventable death. The tool captures key patient data about underlying health issues and risk factors that can contribute to poor health outcomes. Patients are then stratified according to their overall

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