Multiprofessional Caseload Review in the Community Mental Health Team: Improving Patient Safety and Supporting Safe Discharges to Primary Care

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Aims. To create greater capacity within the general adult psychiatry outpatient clinic to facilitate urgent medical review for patients when needed, and to reduce delays for those receiving ongoing routine care within existing resources by improving joint working processes within the multidisciplinary team. To support safe discharges to primary care and promote ongoing recovery by improving access to community resources and the voluntary sector.
Methods. Caseload review for all patients under the outpatient clinics within South Leicestershire community mental health team began in August 2022. A template was developed in consultation with clinical colleagues and approved by the Trust clinical governance process. This includes salient clinical variables such stability, risk and medication. A consultant psychiatrist and senior nurse spend 2-4 hours weekly reviewing each patient's electronic record chronologically from those waiting the longest for an appointment. Using the template, one of the following for the patient's next appointment is determined, based on patient need:

- Nurse discharge clinic
- Outpatient discharge clinic
- Outpatient clinic for ongoing treatment
- Transfer to another service (eg ADHD)

A pilot nurse discharge clinic was carried out offering face to face reviews for patients identified as clinically stable for discharge over 4 weeks, with regular senior nursing supervision and medical input as required.
Results. Between August 2022 to January 2023, 700 out of a total of 1717 caseload reviews have been completed. 39% of these are identified as suitable to be reviewed for discharge.

In the pilot nurse discharge clinic, 137 patients were offered appointments: 82 were discharged, 16 did not attend, and 39 subsequently needed an outpatient appointment. There have been no serious incidents, complaints or re-referrals.

The waiting time for an urgent outpatient appointment has reduced from six weeks to one week and for routine outpatient care from six months to four weeks.

No work related absence for staff, and qualitative feedback from the multidisciplinary team has been positive.
Conclusion. Reduction in high outpatient caseloads is achievable through robust multiprofessional caseload review, and patients can be safely discharged from the care of consultant psychiatrists by multidisciplinary team working. This creates greater capacity, flexibility and flow for those who need ongoing outpatient care to receive this is a timely manner, improving the safety and quality of patient care. This has also fostered a greater sense of cohesion for staff within the team.

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.

Monitoring of Physical Health in Patients Prescribed Antipsychotic Medication Within a Medium-Secure Forensic Inpatient Setting: Assessing Compliance With Guidelines and Improving Procedures

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Aims. Antipsychotic use is associated with haematological, metabolic and cardiovascular abnormalities. If not monitored and acted upon, these contribute to the increased burden of physical health problems in those with severe mental illness. Appropriate monitoring (including blood tests and ECGs) is required in accordance with NICE guidelines. The aim of our project was to assess our adherence (within a medium-secure forensic inpatient setting) to guidelines, and to improve procedures and processes within the unit. The majority of our patients are taking antipsychotic medication, but prior to our project there was no system in place to determine who was due which monitoring tests and when. Our suspicion was that patients' physical health was not being adequately monitored especially given the unit's lack of input from general practitioners.
Methods. Our initial audit of patient notes took place in October 2022, assessing whether each of our 35 patients had had appropriate ECG and blood monitoring. After gathering these initial data we then systematically offered patients their monitoring. We set up processes to ensure this would be completed in a timely and organised fashion in the future, via creating a spreadsheet available on the shared drive and a chart within the doctor's office, adding instructions to the departmental junior doctor handbook, and liaising with colleagues.
Results. Of 35 patients, 34 (97%) were prescribed antipsychotics, 18 (51%) of these at 'high dose'. Of those 34, blood tests for 22 (65%) patients were out of date or not completed as per NICE guidelines. ECGs for 21 (62%) patients were either missing or out of date. Following our gathering of the initial data and systematic completion of patient monitoring, at the time of re-audit in January 2023 monitoring was either completed or offered (with patient refusal) for 34 (100%) of patients.
Conclusion. We identified that monitoring of physical health in those prescribed antipsychotics within our unit was sub-par, with the majority of patients not up to date with bloods or ECGs as per NICE guidelines when initial data were collected in October 2022. Following our project, at the time of re-audit in January 2023 monitoring was either completed or offered to 100% of patients. We have implemented systems to ensure this continues in the future, beyond junior doctor changeovers. This has potential application to other longer-stay psychiatric wards such as general adult rehabilitation wards and other forensic units.

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Psychiatric Inpatient Admissions–- Improving Handover Standards

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Aims. Within NHS Ayrshire and Arran for psychiatric inpatient admissions, the admitting clinician is to directly handover clinical details and relevant aspects of mental state, risk and management plan to the inpatient duty doctor. Over 2022, there was concerns this process was not being followed, resulting in prescription errors,

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difficulty in assessing risk at admission and difficulty in prioritising workload. The aim of the project was to first assess pre-intervention rates of handover for inpatient admissions. Then with these data, look for interventions. The final aim was to re-asses post-intervention, analysing if interventions improved rates of handover.

Methods. Pre-intervention quantitative data were gathered over a three week period in April 2022, with Junior Doctors noting for admissions to Woodland View Psychiatric Hospital whether handover had been received, or if the Duty Doctor had been alerted at all to the admission prior to patient's arrival on the ward.

Qualitative data were also gathered, specifically asking what factors admitting clinicians found impacted ability to handover.

Data were presented at the monthly division of psychiatry meeting, and subsequently interventions were discussed in a meeting with Hospital bed managers, Hospital co-coordinators and the clinical director for inpatient care. The outcome resulted in change to the local hospital admission protocol, with bed managers prompting the importance of handover, and transferring admitting clinician's phone calls to the duty doctor at the time admissions are accepted by bed managers.

Post-Intervention, the same criteria assessed in April 2022 was reassessed in January 2023.

Results. Pre-intervention, of 25 admissions, a handover was provided for 32% of patients. Duty doctor was alerted to 52% of admissions prior to the patient's arrival on the ward. Post-intervention, this increased to 71% and 82% respectively for 17 patients admitted in January 2023.

Qualitative themes thought to impact ability of handover were admitting clinicians feeling there was already a number of calls made when admitting, and one with duty doctor could be neglected. Secondly the clinicians thought another member of the team would alert duty doctor of admissions.

Conclusion. The project met its aims, showing pre-intervention rates of handover as low, and post-intervention rates rising after the admission process was changed, taking on the feedback from admitting clinicians. Given rates remain still significantly below 100%, there is still further work to be done. Results are due to be shared again with bed managers and at division to discuss further interventions.

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Evaluating a Pilot 'Hearing Voices Group' for People With Learning Disabilities

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Aims. Adults with learning disabilities have traditionally been excluded from psychosis research studies and intervention trials because of their learning disabilities. There is a distinct lack of knowledge about adults with learning disabilities and their lived experience of psychosis including specific symptoms such as voice hearing. Interventions such as Hearing Voices Groups (HVG) have been developed without thorough understanding of what these experiences mean for this population, I found one pilot study ran by South London and Maudsley (SLAM) in 2018 (1)

- Understand more about voice hearing experiences in people with a learning disability
- Evaluate whether an adapted HVG is acceptable and affective in this patient group
- To obtain feedback in order to improve the group for future practice

Methods. We set up a hearing voices group for people under the Bristol Community Learning Disability Team (CLDT) who experience hearing voices which causes them distress. The sessions for the group were inspired by ideas from the book "People with Intellectual Disabilities Hear Voices too" published by Psychologist Dr John Cheetham, which we adapted into accessible session plans. The group consisted of 6 service users and was facilitated by me and 3 mental health nurses and ran for 8 weeks on a weekly basis for 1 hour 30 mins. Each participant worked through an accessible handout which we then collated at the end to create a take home workbook of all the material covered throughout the group, as well as individual feedback from the group facilitators.

We used CORE-LD 30 and World Health Organisation Quality of Life (WHOQOL-8) tool pre-group and post-group which are both validated tools for use in people with a learning disability. We also conducted an adapted Maastricht's interview with each service user to understand more about their voice hearing experiences and a post group feedback questionnaire.

Results. All participants had a reduction in their CORE-LD score with lower scores indicating fewer distressing symptoms and lower risk to self, with an average reduction in score of 39%. Themes of why they thought they heard voices included: bereavement, bad neighbours, doing something bad in the past. When asked what the voices say, they were mostly negative insults towards the service user or telling them to harm themselves. Feedback post group included: more sessions/more time, learnt ways of coping with voices, helped to speak about the voices, felt safe and less alone, enjoyed sharing experiences, understand voices.

Conclusion. The NICE Guidelines 2017 Quality statement 4 states that we should be tailoring psychological interventions for people with learning disabilities. Previously there were specific interventions for people with a learning disability within the LD service. The evaluation of this group helps to support the effectiveness in adapting a well-established intervention and the value of offering this on a continued basis in the Bristol CLDT.

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Use of an Information Pack to Improve Relative", Friend" and Carer" Satisfaction With the Admission Process in an Older Adult Inpatient Service: A Quality Improvement Project

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Aims. We performed a Quality Improvement Project in an inpatient Old Age Adult ward to increase patients' relatives, friends and carers' (RFCs') knowledge about important aspects of hospital admission, through the provision of an information