comparison with locally provided services. Mental health Intensive Support Team (MhIST) is a specialist community rehabilitation service within Cheshire and Wirral Partnership NHS Foundation Trust which was established in June 2021. Although the team does not have specific diagnostic inclusion criteria, patients referred will typically have a high level of complexity in addition to severe, treatment refractory symptoms and impaired social, interpersonal and occupational functioning.

Methods. We analysed routinely collected data to explore two methods by which MhIST is reducing referrals for OOA placements including i) direct diversion of patients who would otherwise have been referred for OOA placements to the community with MhIST support, and ii) facilitating discharge from local high dependency inpatient rehabilitation services in order to improve patient flow, which in turn additionally enables repatriation from pre-existing OOA placements.

Results. We identified a cohort of 33 patients who had been supported by MhIST for ≥3 months. This cohort includes seven patients who would otherwise have been referred for an OOA placement. Further analysis for this group showed that initial referrals to MhIST were received from community mental health teams (CMHT) (n=1), acute inpatient wards (n=4) and high dependency inpatient rehabilitation services (n=2). Two patients (29%) were discharged to supported accommodation, and five (71%) were discharged to independent accommodation. Within the wider patient cohort identified (n=33), 66% of patients are living independently in the community.

In total, 13 patients have been discharged from high dependency inpatient rehabilitation services to MhIST during the review period.

Conclusion. MhIST uses a multi-disciplinary model which offers an intensive level of support and a high frequency of interventions. The team includes support workers, nurses, doctors, occupational therapists, psychologists and social workers, and in addition links with other community services involved in housing, employment and social projects. A bespoke and flexible approach allows complex needs to be addressed within local services, and here we highlight the role of MhIST in reducing referrals to OOA placements.

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Knowledge of Service Users' Voting Rights Amongst Mental Health Professionals in Haringey

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Aims. Voting is an intrinsic part of being a member of society and promotes social inclusion. The vast majority of mental health service users have the same right to vote as the general population but are a disenfranchised group and inpatients are half as likely to vote. Service users experience many barriers to voting including knowledge of their eligibility and the accessibility of the registration and voting process. Mental health staff need to understand service users' voting rights so they can offer appropriate support. This project aimed to explore staff knowledge of service users' voting rights.

Methods. 77 multidisciplinary team members from inpatient and community settings in Haringey were surveyed about voting rights.

Questions focussed on staff knowledge of service users' right to vote (whether or not subject to various civil or forensic sections), if capacity to vote was required and if those with certain diagnoses were legally disenfranchised.

27 Care Coordinators were asked if they discussed voting with service users and whether support around voting and registration was in care plans.

Results. The response rate was 96%. No respondents answered completely correctly. Staff knowledge was similar across all groups and settings.

The majority of staff believed community service users (89%) and informal inpatients (93%) were able to vote.

63% of respondents knew inpatients on civil sections could vote. 81% knew those on a Community Treatment Order could vote. 40% of responses regarding the forensic sections were correct.

56% believed service users needed to have capacity in order to vote.

Certain diagnoses were believed to legally prevent service users from voting, including dementia (19%) and schizophrenia (13%).

44% of Care Coordinators discussed voting with service users and 26% included voting in care plans.

Conclusion. Despite a national campaign, the level of staff knowledge is disappointingly low throughout all groups and settings, risking service users being given wrong information. This further disenfranchises a group that already experiences significant barriers to vote.

It is of particular concern that a significant minority of staff believed certain diagnoses legally prevent voting.

It was poorly understood that capacity is not relevant to the right to vote.

Voting rights and available support is not widely discussed by care coordinators with service users.

Clearly, education and training on voting rights is necessary for mental health professionals. We are planning staff education sessions and service user workshops as a quality improvement project.

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An Audit of Documentation Relating to a Decision-Making Capacity to Consent to Admission to the Peter Bruff Mental Health Assessment Unit

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Aims. Assessment of the capacity to consent to admission is an important legal and ethical issue in daily medical practice. Mental Capacity Assessment (MCA) should be carried out thoroughly based on all the domains mentioned in the Mental Capacity Act (2005) and be recorded in the patient's notes or admission. This audit evaluated the documentation available on the electronic database (Paris) in order to ascertain what information was and wasn't documented. The standard used: "Decision–

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making and mental capacity". NICE guideline NH108 (2018) recommendations 1.4 Assessment of mental capacity were used as a standard for this audit. 100% of all admitted patients should have MCA completed during the admission clerking.
Methods. The data were examined retrospectively from the MCA on admission, available on the electronic health record database (Paris). The audit tool focuses on quantitative data collection on Mental capacity documentation.

A random sample was selected of 15 patients admitted in May, June, September, and October 2022 to the Peter Bruff MH Assessment Unit (male and female). Total 60 patients.

All data were anonymised. Results were tabulated and presented in statistical form back to the clinical teams.
Results. All patients who were admitted to the assessment unit were subjected to capacity assessment, consenting to informal admission and acceptance of treatment.

MCA was completed and patients had capacity both on clerking and during the ward review in 85% of cases, (n=61). MCA was completed and 3 % of all patients were found to lack capacity on clerking (n=2). MCA was completed, and patients had the capacity on admission, however, they had no capacity during the review in 5% of cases (n=3). MCA was not completed, or the information was unavailable, for 7% of the cohort (n=4).

Capacity to consent is specific to a decision and can vary over time; a patient is therefore competent or not with respect to a specific decision and for a given moment in time.

We found that after the clerking assessment, when patients were reviewed by the unit doctor and the consultant, whether on the day of admission or shortly after (in a matter of hours), on several occasions some patients were lacking the capacity to consent to the admission.
Conclusion. The missing link to be identified between the MCA capacity assessment that was carried out by the clerking doctor, compared to the MCA that was conducted by the unit doctor and consultant. This could be a restrictive environment on the unit or less attention paid to the quality of capacity assessment and further training is needed for professionals.

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Audit

A Review of Unmet Needs – Making a Case for a High Dependency Rehabilitation Service

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Aims. The Kent and Medway Partnership Trust (KMPT) Rehabilitation service strategy 2020-2025 in line with NICE guidance for Complex Psychosis 2020, sets out to deliver a complete mental health rehabilitation pathway with local provision of high dependency rehabilitation units (HDRU), open rehabilitation units and community rehabilitation provision across the county. There is a lack of HDRU provision in Kent and Medway in its rehabilitation pathway. All HDRU provision is by external providers, often out of area, dislocating people from family support and local resources essential for their recovery and integration. Kent has a relatively high number of out of area (OAT) placements based on national benchmark data (GIRFT). The proposal to develop a HDRU locally led to a review of local population needs for HDRU. The review with the existing OAT data provided information on the number of HDRU beds required in Kent and Medway.
Methods. We identified 564 patients who had had 5 or more Mental Health Act assessments, in cluster 16 and 17, more than 3 admissions to psychiatric inpatient units and with CTO recalls. Two senior clinicians reviewed these patients against the HDRU eligibility criteria. Demographics, diagnosis and comorbidities were also recorded.
Results. 119/564 patients met the threshold for HDRU assessment. Using our conversation rate from referral to admission in our open rehab, it means about 20% (24) of this cohort would require treatment in a HDRU. Demographics, diagnosis and comorbidities were reviewed which gave important information about service provision requirements. This was compared with NICE guidance recommendations of 1 high dependency unit per 600,000 - 1,000,000. Therefore, based on this, we would be expected to have between 23 and 38 patients requiring HDRU treatment.
Conclusion. A high level of unmet need for HDRU exists in Kent and there is a need for further recognition of the relevance within the rehabilitation pathway. Lack of local provision of HDRUs means the use of longer, expensive and variable quality out of area or private placements. These can be not only detrimental for patients due to a loss of connection to an area and social network but a drain on resources. These results support the case for x2 12 bedded HDRUs. The lack of provision of HDRU impacts on the wider system and patient's timely access to appropriate treatment pathways.

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Application of Section 17 Leave on Old Age Psychiatric Ward Audit

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Aims. Most patients on the old age psychiatry ward have dementia so they would need extra care from the ward team regarding their rights for a better quality of life. Therefore, the purpose is to ensure that inpatients under MHA on the ward are not deprived from their liberty to time off the hospital grounds in accordance with the leave granted by the responsible clinician. Additionally, to ensure that the appropriate steps are followed before the patient leave the ward, to ensure safety for the patient and accompanied staff if escorted.
Methods.

1. Data were collected with approval of the ward consultant and the ward manger from RIO records.
2. Data included checking the forms for S17 on RIO, and answering the audit questions after checking the records for each patient.
3. Patients included admissions within the last 6 months on the ward under the MHA weather section 2 or 3 which included 28 patients.
4. Checked data were:

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