This innovative and cost effective model of care delivery was first conceived in the US and has been gaining a strong foothold in the UK since 2016, mainly limited to GP settings.

The project goal was to attempt to transfer the model into a mental health setting by developing and delivering a novel intervention, to improve health and wellbeing options in a CMHT population.

Method. A four session course was developed focussing on stress, sleep and nutrition. These chosen topics covered common significant challenges to patient health in psychiatry. Sessions were delivered to proactively address these important health related issues in a group visit setting.

Baseline and post intervention feedback including telephone interviews were conducted to evaluate the effectiveness of the intervention.

Result. The qualitative data and the positive feedback obtained from participants indicate the intervention was highly valued and deemed effective in promoting positive health and lifestyle changes. Participants valued the educational and co-production aspects as well as the social and peer support elements of the groups. They appreciated the level of access they had with the clinicians involved, to explore their health and wellbeing in more detail without being limited by the usual 30 minute clinic follow-up sessions.

The clinicians involved found the sessions rewarding and more engaging than most of routine 1:1 clinic sessions as they were able to spend quality time exploring important issues and not just educate the patients but also be educated by their questions and feedback about their lived experiences.

Conclusion. The project aim was met and we believe this intervention can be successfully incorporated into the identified service provision gap within the CMH T model. There is potential to build on and embed this innovation with roll-out to a wide range of service users in different settings.

In line with existing literature from GP settings, the consensus was that the amalgamated group visits/consultations model could be successfully modified to meet the needs of patients in the Mental Health arena who have a range of physical health and lifestyle concerns.

We planned to obtain more information about improvement in patient self-management but this was affected by the pandemic. However, we believe it is a cost effective and helpful innovation which warrants further promotion and evaluation.

QI project: Improving the discharge advice from functional old age psychiatry wards for the monitoring of lithium and antipsychotic medication in the community

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Aims. NICE guidelines and Maudsley prescribing guidelines both stipulate that patients over the age of 65 prescribed lithium or antipsychotic medication should have their bloods and physical parameters monitored regularly. There is currently no provision from the community mental health teams in Edinburgh to provide this monitoring, which falls to the patients GP. Following an initial data collection, it was found that there was no monitoring advice being provided on immediate discharge letters (IDLs) for patients discharged from two functional old age psychiatry inpatient wards at the Royal Edinburgh Hospital. This patient group often have comorbid medical conditions and therefore monitoring of their psychotropic medication is especially important. The aim of the QI project was for 100% of patients discharged from thesewards on lithium or antipsychotic medication to have appropriate advice documented on their immediate discharge letter (IDL) with regards to medication monitoring.

Method. Data were collected monthly by reviewing the notes of all discharged patients to determine the frequency at which medication monitoring advice was documented on IDLs from the two wards. A proposed new template for discharge letters which included advice on medication monitoring was discussed and agreed with the old age psychiatry team in Edinburgh. This was disseminated to the appropriate medical staff members and was included in induction packs for junior doctors. Following this a new "canned text" template was implemented to automatically populate the discharge letter with advice depending on whether they were antipsychotics/lithium/neither.

Result. IDLs for 91 patients discharged between May 2020 and February 2021 were reviewed. Baseline data showed that 0% of patients (n = 15) had appropriate monitoring advice documented on their IDL. Following initial introduction of monitoring advice to the induction pack for junior doctors, the mean frequency of completed advice on IDLs was 50.9% across 6 months. Following implementation of the canned text, the frequency of completed advice on discharge letters for February 2021 was 100% (n = 7).

Conclusion. This QI project has been successful in improving the rate of appropriate advice for antipsychotic and lithium monitoring being provided on immediate discharge letters. It is hoped that this will help reduce adverse effects associated with antipsychotics and lithium in older psychiatric patients. Further work could be done on determining the frequency that the advised monitoring is being carried out.

Improving attendance in addictions - do quality improvement plans work?

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Aims. We assessed whether a quality improvement plan initiated in 2018 had sustained benefits for improving attendance rates at addiction prescriber reviews, after 13 months.

Method. The QIP re-audit had Humber Teaching NHSFT approval. We assessed electronic healthcare records of patients prescribed OST at a specialist addictions service, spanning a large geographical area, split into three Hubs. Data were analysed via Microsoft excel.

Baseline data for the whole addictions service were collected in April 2018 (n = 343), followed by QIP implementation. The QIP included a new appointment letter explaining the importance of the prescriber review, text message confirmation and reminder the day before, verbal reminder from keyworker and a call from the prescriber explaining the importance of attending (for persistent non-attenders). In the event of nonattendance, a medication safety review was completed. Further data were collected in December 2018 (n = 339) and a re-audit of one Hub (n = 91) was completed in Jan 2020.

Result. At baseline in April 2018, half (50% n = 170/343) of all patients had attended an addictions prescriber review in the last 3 months; Hub 1 (55%; n = 52/95), Hub 2 (34%; n = 45/133) and Hub 3 (65%; n = 73/115). The Quality Improvement Plan was implemented. Attendance rates for subsample (Hub 1) conducted in Oct 2018 showed a reduction in attendance (51%; n = 48/92). This led to the enhanced Quality Improvement Plan.

After the enhanced Quality Improvement Plan implementation in Dec 2018, attendance rates improved for all Hubs to 76% (n = 258/

339); Hub 1 (77%; n = 72/93), Hub 2 (73%; n = 97/133), Hub 3 (79%; n = 89/113). For non-attending patients, a medication review was conducted in their absence by the prescriber for most (94%; n = 74/81) patients (see table 1 and Figure 1).

In January 2020, reassessment of attendance rates for Hub 1 (subsample), in January 2020 (n = 91) which showed attendance had increased to 86% (n = 78/91). All (100% n = 13) patients who did not attend for the prescriber review in person, had a medication review in their absence. In addition, the reasons for nonattendance were discussed with the patient and their keyworker, following which they were booked for a subsequent appointment.

Conclusion. Nonattendance at clinical appointments causes a significant financial burden across the NHS. It was fantastic to see that the QIP improved patient attendance rates and this was sustained and improved, over a year later. Serial non-attenders may need an enhanced strategy.

Exploring the views of young people with autism spectrum disorder (ASD) on how to improve medical consultations

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Aims. The aim of this study was to explore experiences of consultations with non-specialist health professionals in a group of young people with ASD and their parents and what they considered would help to improve these interactions.

Background. Research has shown that general awareness around autism is poor among the general medical community and this can result in poor communication during medical consultations.

Method. An opportunistic group of 4 young people with ASD and 8 parents from a local support group in Exeter were interviewed in an informal environment about their experiences of healthcare consultations after seeking verbal consent.

Result. Among the 8 parents interviewed the themes emerging were a deep lack of understanding and awareness among medical staff of the challenges faced by individuals with autism, the importance of the doctor-patient relationship to allow children to open up to healthcare professionals, and the need for all children to be respected as individuals.

Among the 4 young people (13 to 19 years) with ASD interviewed they identified significant anxiety around waiting for appointments and expressed a desire for a distractor to relieve stress, questions posed by clinicians were often vague and should be clearer, 3D models/mannequins could be useful to support understanding of anatomy and physiology, patience and a calm demeanour were vital with a quiet clinical environment to avoid distraction, time for mental preparation is important and efforts should be made to avoid delays or cancellation of appointments where possible.

An interactive website was generated in the light of feedback from the client group and their parents, aiming to educate clinicians regarding the challenges faced by this client group and provide a guide suggesting how to facilitate effective consultation through the use of simple techniques to promote engagement/reduce anxiety in the clinical environment.

Conclusion. Simple changes to the approach to consultation with clients with ASD - a quiet consultation space, no delays and better communication - could reduce stress and promote positive interactions with a beneficial effect on healthcare delivery for this client group.

No time to die: improving response to emergency scenarios in the 136 suite

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Aims. Improve confidence and experience of trainees performing preliminary medical reviews in the 136 suite.

Improve patient safety by increasing trainee's confidence in responding to emergency scenarios, including crash calls of patients in the 136 Suite.

To orientate trainees to the 136 suite and the emergency crash equipment, in order to better prepare trainees for emergency scenarios.

Background. The authors encountered a crash call in the 136 suite, in which a patient had concealed an opiate overdose. The patient was successfully resuscitated but concerns were raised by the junior doctors that they were unaware of what or where the emergency equipment was kept in the 136 suite. Following a debrief session, we established that junior doctors needed more orientation to the 136 suite and more teaching on performing preliminary medical reviews and responding to emergency situations.

Method. Trainees, were asked to complete an anonymous, qualitative questionnaire with 16 questions asking about their confidence to respond to emergency situations in the 136 suite.

Based on the feedback, an interactive teaching session was delivered two weeks later. The session covered a structured approach on how to perform a preliminary medical review and scenario-based teaching on emergency situations. Trainees were then shown the 136 facility, introduced to the lead nurse and shown the emergency crash equipment and drugs stores.

Trainees were then re-consulted, with the same questionnaire to ascertain whether confidence and knowledge had increased.

Result. Following initial induction, only 25% of trainees felt confident performing 136 Suite preliminary reviews. 50% of trainees had encountered crash calls at Park House Hospital, however 93% did not receive orientation of emergency equipment locations. Only 44% of trainees felt confident managing a crash call; reasons included feeling 'rusty, little recent experience, not being familiar with the equipment'.

Post-interactive teaching session, 89% now felt confident performing 136 Suite preliminary reviews. 100% knew where the crash equipment was located in the 136 Suite.

Conclusion. Trainees should receive a robust induction on how to perform 136 preliminary reviews and have orientation of the facility, including crash equipment during induction

Trainees require refresher training in addition to their basic life support training on common emergency scenarios encountered in psychiatric hospitals.

A resuscitation skills training session is being organised for new trainees and hopefully incorporated into each forthcoming rotation.

Dublin's homeless crisis – is this reflected in emergency department psychiatry referrals?

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Aims. This study seeks to explore the prevalence and impact of homelessness in an adult sample of psychiatry referrals over a