inconclusive – but case series analysis shows examples of admission avoidance.
Conclusion: We believe the development of this service shows that close working between psychiatrists and physicians enhances patient care in Parkinson's disease. Our integrated service is acceptable and beneficial for patients. It is valued by professionals and appears to be cost-effective through medication rationalisation and admission avoidance. In terms of future direction, we have applied for additional funded psychiatrist hours from the Trust to ensure sustainability of the clinic and are in the process of developing linked psychological therapy and clozapine prescribing services as a result of the success of the pilot clinic.

A Retrospective Case Series of Older Adults Requiring Electroconvulsive Therapy (ECT) in Surgical Theatres

Dr Jennifer Parker and Dr Seona Duroux

Avon & Wiltshire Mental Health Partnership NHS Trust, Bristol, United Kingdom

doi: 10.1192/bjo.2025.10518

Aims: This observational case series describes 11 patients who underwent emergency ECT under the care of the later life liaison psychiatry team at the Bristol Royal Infirmary over a 12-month period between February 2024 and January 2025. This represents a 5-fold increase in ECT delivery from previous years. We describe patients who required ECT treatment for their psychiatric illness but were deemed to be too medically unwell or too high risk for a general anaesthetic outside of surgical theatres in an acute hospital setting. The aim of this case series was to evaluate the volume of patients requiring emergency ECT and to understand the various clinical rationales for this.

ECT is an evidence-based intervention which is recommended for the treatment of severe depression, psychosis, catatonia and other conditions. Typically, ECT is delivered by psychiatrists in dedicated ECT suites located apart from acute hospitals – as is the case in Bristol. General anaesthesia is required to safely deliver ECT.
Methods: Case notes of the patients who underwent ECT in acute hospital surgical theatres were retrospectively reviewed and data was extracted on demographic features, medical and psychiatric history and details of ECT treatment. Clinical outcomes were measured using the Clinical Global Impressions (CGI) scale.
Results: 9 out of 11 patients who required emergency ECT in theatres were older adults (>65 years) with a skew towards advanced old age (>80). The most common reason for this treatment was severe depression and/or catatonia with associated need for enteral feeding due to not eating and drinking which required acute medical admission and increased anaesthetic risk. Other medical and surgical concerns included severe heart failure and uncontrolled Parkinson's disease. Overall clinical improvement was seen across 9/11 of patients. 2 patients died within one month of undergoing ECT due to physical morbidity.
Conclusion: This case series which was conducted to evaluate a service being offered by the liaison psychiatry team illustrates the challenge of treating severely mentally unwell patients due to their associated poor physical health. We contend that ECT can (and sometimes should) be offered in the acute hospital when patients are too severely unwell or high risk to receive ECT in peripheral settings, which will particularly benefit those multimorbid older adults who stand to gain the most from ECT.

Given the volume of ECT being delivered and the apparent clinical necessity for this service, next steps will include additional training and service considerations including training liaison nurses in ECT skills.

Understanding the Care Home Psychiatric Service in North Kent

Dr Emily Pettifor and Dr Mohan Bhat

Kent and Medway NHS & Social Care Partnership Trust, Dartford, United Kingdom

doi: 10.1192/bjo.2025.10519

Aims: Over 300,000 people in England and Wales reside in care home settings, with a large proportion of these people thought to have memory difficulties. Within North Kent (Dartford, Gravesham and Swanley) there are 31 care homes, with around 1,540 residents over 65 years old. The North Kent community psychiatric service therefore aims to meet their clinical needs through an in-built care home service, comprised of medical, nursing and support staff. The service facilitates medical reviews and memory assessments, liaises with social care and psychological services, offers care home-based training for staff and supports family carers. The aim of this review was to better understand the patients being supported by this service and interventions being utilised.
Methods: A review was completed of the service caseload, documenting patients' demographics, diagnoses and current medications as of November 2024. Clinical notes were also reviewed to better understand when and why patients had been referred, and what prior contact they may have had with services.
Results: Fifty-two caseload patients were identified (around 3% of North Kent older adults in care homes), residing across 20 care homes. All were aged above 60, with the majority in their 80s (44%). Referral was mainly from GP practices (73%), most frequently for support with behavioural or psychological symptoms of Dementia. This can include verbal or physical aggression, agitation, psychotic symptoms and mood disturbance. Referrals were also received for memory assessments, medication advice and support with functional symptoms. Most patients (81%) had never been under the service previously. At the point of caseload review, the majority of patients had formal diagnoses of Dementia (81%). Ongoing intervention was predominantly for medication adjustment and response monitoring (56%). Patients were also receiving behavioural and psychology interventions, and support with depot administration.

Across the caseload, 52% of patients were on antidepressants or mood stabilisers, 42% on benzodiazepines or promethazine and 38% on antipsychotics. NICE guidance advises that for people with Dementia, antipsychotics should only be used if they are severely distressed and at risk of harming themselves or others. We therefore also analysed this for patients with diagnoses of Dementia, of which 33% were on antipsychotics, including risperidone, olanzapine and quetiapine.
Conclusion: Through identifying where patients reside, why they were referred and their ongoing needs, we can better understand the

population accessing this service, develop links with other community health services and adapt training offered to care home staff to improve the care received by their residents.

What Is the Current State of Training to Recognise and Treat Eating Disorders in Medical Schools in South Wales?

Dr Thomas Prew[1], Dr Rhiannon Kihara[2], Dr Umer Jalal[2], Ms Lois Bown[3] and Dr Isabella Jurewicz[4]

[1]Cardiff and Vale University Health Board, Cardiff, United Kingdom; [2]Swansea Bay University Health Board, Swansea, United Kingdom; [3]Cardiff Medical School, Cardiff, United Kingdom and [4]Service for High Risk Eating Disorders, Cardiff, United Kingdom

doi: 10.1192/bjo.2025.10520

Aims: Eating disorders represent a major challenge for psychiatric and broader medical care. The rate of hospitalisation has almost doubled in recent years and anorexia has a higher mortality rate than any other mental illness. Beat Eating Disorders has made recommendations for educating medical students. When making the recommendations, they did not receive responses from Cardiff or Swansea Medical Schools. This review assesses the provision of eating disorder teaching and whether it is sufficient for effective medical training.

Methods: Clinical lecturers in Cardiff and Swansea Medical School reviewed each other's medical curricula and compared the prevalence and extent of eating disorders in each. From 1 December 2024 to 5 February 2025 we reviewed the types of learning provided, opportunities for self-directed learning, and other areas where eating disorders could arise. We compared this against the guidelines recommended by Beat for an effective curriculum. We also reviewed the schools' official exam guidelines to assess whether eating disorders are listed as a topic in psychiatry or the broader curriculum.

Results: In Cardiff there is a dedicated lecture on eating disorders in the Year 4 psychiatry rotation, which covers all major eating disorders. There is also an optional online module written by an Eating Disorders Consultant which goes into further detail. There is no practical training in examining or communicating with a person with eating disorders.

In Swansea there was no mention of eating disorders in the curriculum yearbook. There is a lecture in Year 2 and Year 3, each an hour long. Eating disorders exist on the GMC MLA content map, so can come up in the final year OSCE (CPSA) but it is not clear whether this happens in practice in Swansea or Cardiff.

Across South Wales, clinical attachments with eating disorder services were haphazard and locality-dependent. Beat would classify both medical schools as providing "insufficient" education.

Conclusion: Medical students in Wales are not receiving education on eating disorders that satisfies the Beat recommendations. Despite achieving proficiency in academic teaching, neither medical school provides the practical experience necessary to examine, support, and treat someone with eating disorders.

Greater emphasis on eating disorders is required, not just within psychiatry, but within broader medical teaching such as cardiology and gastroenterology. Eating disorders should be better incorporated into communication stations, practical examinations, and psychiatric teaching. Better access to Eating Disorder Services for medical students would also allow them to meet patients and build vital clinical experience

An Evaluation of the Mental Health Referrals to the Dales Living Well Team in Derbyshire

Dr Adeel Rauf and Dr Mark Broadhurst

Derbyshire Healthcare NHS Foundation Trust, Chesterfield, United Kingdom

doi: 10.1192/bjo.2025.10521

Aims: To examine the referrals in a newly established Living Well service at Dales community mental health team, Derbsyhire.

Methods: A retrospective review of notes on SystmOne (electronic patients records) referred for a period of 6 months from April–October 2024.

The source and rationale of the referral to the living well team, acceptance by the team, written communication to the referrer and the processes leading to the outcomes of the referral were examined.

Results: 75% of the referrals were from GP, 9% were from community IAPT teams.

67% of the referrals were accepted for input by living well teams.

70% of the referrals had a written letter sent to the referrer.

96% of the referrals led to a triage-based MDT meeting.

96% of accepted referrals had allocated member of staff making contact with the patient. 71% received a welcome call.

18% of the referrals had an outcome of being referred to the outpatients clinic.(as a long-term offer), 10% had psychology input as an outcome.

10% of the referrals were deemed after MDT discussion not to be appropriate for the service.

8% didn't engage leading to discharge from the living well team.

15% of the referrals were due to symptoms of low mood, 14% with symptoms of anxiety, 12.2% of the referrals related to emotional dysregulation.

Conclusion: Two thirds (67%) of the referrals were accepted for a short-term offer by the team in providing support indicating a role of the living well team to provide prompt interventions regarding the mental health of patients.

A multidisciplinary approach in the team consisting of varied professionals has helped manage a lot of referrals with community-based support. 96% of the referrals were discussed with MDT approach.

A high proportion (70%) of the referrals had a letter written to the referral independent of the outcome. Written communication to the referrer is to be improved upon regardless of outcome of the referral.

A further qualitative review of the process to take place in 12 months time.