

Engages in challenging behaviours. Challenging behaviours defined as behaviours significantly limiting engagement in daily & family life, education and/or social activities, and have persisted for at least a period of 3 months. Data were collected from electronic recoding system of individual patients; using a data collection sheet on level of learning disability; comorbid neurodevelopmental or emotional and mental health disorders; profession of allocated clinician; joint working with discipline; involvement with social care; allied health professionals input; presenting difficulties and severity; CETR or hospital admissions; referral to National services; What interventions offered (Medications, Behaviour assessment and/or interventions); if medications offered, was it used as first line and how long for; parents' view on medication management.

Results. As we have expected, medication management were used as first line and there were limited offers of behaviour support. Joint working with social care, speech therapy and occupational therapy but with limited input especially occupational therapy in cases with high sensory needs. It was unclear with the cognitive assessment and diagnosing the learning disability in the population under 16s.

Conclusion. There is a service gap for CAMHS learning disability population and more joint working needed among relevant health professionals.

Physical Health and Mental Health Comorbidities of People With Functional Neurological Disorders Referred to a Community Neuropsychiatry Service Pre- & Post March 2020 Lockdown Due to COVID-19

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Aims. Health comorbidities contribute significantly to the development and maintenance of illness in patients with Functional Neurological Disorder (FND). As part of a service evaluation project, we investigated the physical and mental health comorbidities of people referred to a community neuropsychiatry service in East Kent, in one-year periods preceding and following the March 2020 lockdown due to COVID-19.

Methods. We included all people accepted to the service between 23rd March 2019 and 23rd March 2021, where the reason for referral was Functional Neurological Disorder (FND) or Non-Epileptic Attack Disorder (NEAD). Referrals to the service for other reasons were excluded, as were declined referrals. Routinely collected data sources were reviewed and data stored in anonymized fashion. Data were analysed using Statistical Package for Social Sciences (SPSS).

Results. Total number of referrals for FND in the 2-year period was 260, with 161 referrals for NEAD and 99 for other FND.

In the pre-lockdown period, 163 patients were referred due to FND (101 with NEAD, 62 for other FND). There were fewer FND referrals in the post-lockdown period: 60 referrals for NEAD and 37 for other FND. The majority were female (74% pre-lockdown, 81% post-lockdown). Where ethnicity was recorded, White British was the most common (94% pre-lockdown, 90% post-lockdown), with a small number of people from other ethnic groups (3.5% White Other, 1.4% BAME, 1.4% Mixed pre-

lockdown; 5.4% White Other, 3.2% BAME and 1.1% Mixed post-lockdown). Ethnicity was not specified in 21 cases (13%).

Of the pre-lockdown group, 15 patients had prior contact with Child and Adolescent Mental Health Services (9%), with 7 patients (7%) in the post-lockdown group. Many patients had previous contact with mental health services (47% pre-lockdown, 53% post-lockdown). The majority of patients had at least one physical illness (69% pre-lockdown, 73% post-lockdown). Most had 1–3 physical comorbidities but 9% (pre-lockdown, 7% post-lockdown) had more than 4. Fibromyalgia (14% pre-lockdown, 12% post-lockdown), chronic pain (23% pre-lockdown, 21% post-lockdown), and epilepsy (11%, 9%) were common. Over 90% had psychiatric illness in both periods. Most patients had 1–3 psychiatric illnesses; a few had more than 4 (6.1% pre-lockdown, 1.4% post-lockdown). Depressive disorder was the most common comorbidity in both groups (41% pre-lockdown, 44% post-lockdown), followed by anxiety (35% pre-lockdown, 36% post-lockdown). PTSD was present in 8% pre-lockdown and 8.2% post-lockdown.

Conclusion. Physical and psychiatric comorbidities are common in people with FND; multidisciplinary working and liaison between services is crucial for care of these patients.

Audit

The Effect of the First Coronavirus Lockdown on Psychiatric Outpatient Attendance, a North Fife Survey

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Aims. There has been a significant change in the way we see patients during psychiatric consultations, this has led to challenges we face in delivering safe and effective care to patients under our care. “Telepsychiatry” has been used in literature from countries like Australia and India, there is very little around coming from the UK but there appears to be many ongoing research making the rounds. It is interesting to know that the existing literature on remote/virtual consultations during the COVID-19 pandemic are on the rise. The idea of this study was conceived during outpatient clinics after making an observation that many patients were likely to miss their appointments when they had telephone appointments compared to video consultations. This prompted a study to know if this is more likely to be observed in other outpatient clinics. The purpose of this study was to establish if virtual/remote consulting has affected patient attendance rate and whether this is also affected by the type of virtual consultation.

Methods. The data were collected using the “2020 stats sheets” for inpatient appointments between North Fife consultants from January to October 2020. This was registered with the NHS Fife clinical effectiveness team in January 2021.

Results. The results were categorized for the purpose of this survey as January – March (Pre-lockdown) and April – October (lockdown). It is important to note that some face-to-face appointments occurred during lockdown because there were emergency assessments and drug monitoring appointments scheduled.

The results of this survey showed that there was a clear reduction in clinic appointments made during lockdown compared to pre-

lockdown and slight observable improvement in attendance rates during the lockdown. There was no statistical significance seen using t-test comparing attendance rates between video and telephone consultations including new patient virtual consultations.

Conclusion. The large sample size over this period suggests that the results are reliable and valid, we can therefore say virtual/telephone consultation does not affect attendance. It should be noted that the attendance rate may be a good indicator but we should also consider patient/clinician satisfaction, communication quality/effectiveness and other factors which could influence patient's compliance to outpatient follow-up. It is important to acknowledge the lack of a control group and the COVID-19 pandemic were major confounding factors. Mental health services should continue the use of virtual consultation post-pandemic and possibly integrate it with in person consultations (hybrid), this may help with attendance rate of patients with difficulty attending face-to-face appointments.

Audit on the Quality of Outpatient Letters From Cherrywood Clinic

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Aims. Letters between secondary and primary care are an integral part of continuity of patient care. It is crucial letters are comprehensible, focused and useful. The quality of letters can be of a variable standard, we aim to see if the letters sent from Cherrywood clinic are in line with the Royal College guidance.

Methods. Data were collected manually by 2 doctors using dictated clinic letters and patient notes, from the 3 community teams. 20 outpatient letters were sequentially selected from each team from the 1st to 31st of March 2017; 60 letters in total. The letters were divided equally between consultants and junior doctors. In the team where there were 2 Consultants; 5 letters of each were taken, and in the team where there was a junior doctor and a specialist registrar, 5 letters from each were taken. The data were collated onto an Excel spread sheet and analysed.

1. Demographic Details including Name, Date of Birth, Address and the Date of Appointment
2. Who was the patient been seen by; Consultant or Junior doctor (FY/GPST/CT/SPR)
3. Current diagnosis
4. Current medication including doses
5. Mental State Examination (MSE) findings
6. An update of the current problem(s)
7. Current/relevant Risks
8. Plan/recommendations
9. Follow-up plans

Results. Of the Consultant letters the diagnosis, medication and dosage was mentioned in 93%, 93% and 90% respectively. Mental state was found in 66%, risks in 83% and follow-up plans in 96%.

Most of the content derived from the registrar letters were unremarkable; with 80% in MSE in the 5 audited letters.

In the Junior doctor letters; the diagnosis was mentioned in 88% of letters, medication and dosage 76%, mental state 100%, risks 80%, follow-up 100%.

Conclusion. Our letters are largely meeting the Royal College standards, more than 85% of the data were up to the standard. The main area's to improve are;

- Documentation of the MSE.
- The medication and the dosages.
- Diagnosis.
- Risks should always be present.

The areas which require improvement are the areas which are essential for GPs to safely manage psychiatric patients in the community.

Improving Clinical Care in Tobacco and Smoking-Related Problems: A Report of Clinical Audit and Quality Improvement Project

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Aims. Around 40% of people with serious mental health problems smoke, which is significantly higher compared to the general population of the United Kingdom. The Welsh Government has set the target to reduce the overall prevalence of smoking in Wales to 16% from 19. In order to reduce the impact of smoking on the population, the first step is to identify the problem. Hence, a comprehensive history of smoking will help to identify the addiction-related problems. Hence, this combined clinical audit and quality improvement project (QIP) is aimed at the evaluation of the admission clerking around the assessment and management of smoking-related problems in an inpatient mental health unit.

Methods. This clinical audit was carried out at the local inpatient general adult mental health units in Wrexham. It was based on NICE smoking guidelines "Smoking: acute, maternity and mental health services". Clinically relevant information without personal identification information was collected based on a proforma. The first re-audit was repeated without a specific intervention to see any change in pattern and the need for intervention. This was followed by the first intervention, i.e., the sharing of a PowerPoint™ presentation discussing commonly utilised measurement tools in the assessment of smoking-related behaviours and the second re-audit.

Results. The first round of clinical audit involves 32 admissions, the first re-audit was 19 admissions, and the second re-audit was 37 admissions. The baseline showed 71.88% of inpatient admissions were asked about their smoking history, but only less than 10% of them were assessed in detail around the types and quantity of tobacco products, features of dependence and withdrawal, the motivation of the clients to quit smoking, and any help offered to the patients. The number of inpatient admissions which was assessed for their smoking-related behaviour dropped to 36.84% during the first re-audit, and less than 16% of them were assessed in detail. The number improved slightly to 57.14% after the first intervention, although less than 40% of the inpatient admissions were assessed in detail.

Conclusion. There is an inconsistent pattern of change in the percentage, and it seems that the intervention leads to minimal improvement of the assessment of smoking-related problems during admission clerking. The minimal change may be attributable to the change in posting around the intervention period. The