

Aims. With increasing awareness and reduction of stigma associated with Mental Health issues, referrals to services are increased, pushing specificity of commissioning and therefore declining patients of services when referrals are inadequate. Standards would be improved by better inclusion of information necessary for the Single Point of Access process (SPOA) in the Bolsover Community Mental Health Team (CMHT) to make prompt, effective decisions on allocating care.

A Quality Improvement project in a Mental Health Team was devised to improve standards, and acceptance rate, of appropriate referrals to the Bolsover CMHT from General Practitioners (GPs). This would encourage GPs to refer patients whose mental health difficulties do not meet CMHT thresholds to alternative services. A higher acceptance rate and lower rejection rate would indicate that the proportion of suitable referrals had increased.

Methods. Using the Plan, Do, Study, Act (PDSA) model, Driver diagrams were used to create a template with the crucial information necessary for GP referrals to psychiatry/SPOA. Data were collected to check aims of the referral, sufficient information of the presenting complaint, personal & family history, safety concerns, protective factors, comorbidities, medication and substance misuse. The outcome of each referral was recorded and categorised as either Community Psychiatric Nurse Assessment, Outpatient Appointment, Referral Rejected, Referred Elsewhere or No Patient Response.

All referrals in September and October 2021 were analysed to assess whether enough information had been included for each variable. The September and October data were compared to check if the template had been associated with improved quality of referrals.

Results. Pre-template, 17.4% of referrals were accepted, 13.0% received a SPOA assessment, 17.4% were rejected, 39.1% were re-referred elsewhere and 21.8% did not respond to the CMHT. After the template was circulated, 28.0% were accepted, 36.0% received a SPOA assessment, 4% received joint Doctor-SPOA care, 8% had a medication review and 12% were waiting for an MDT decision when data were analysed. The results for SPOA assessment and rejection were statistically significant ($p < 0.05$), while results for other outcomes were not.

Information on presenting complaint (82.1% to 100%, $p < 0.05$), personal history (39.3% to 92.3%, $p < 0.05$) and aims (50% to 88%, $p < 0.05$) increased, while other information did not change in a statistically significant manner.

Conclusion. The template led to an increased proportion of accepted referrals and a decreased proportion of rejected referrals. However, information on variables did not necessarily improve in the same manner. The template is useful to improve decision-making in SPOA.

Improving Efficiency and Quality of Handover in the Mental Health Liaison Team (MHLT): A Focus on Achieving Team Buy-In

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Aims. To Reduced Mental Health Liaison Team (MHLT) handover time to less than 30 minutes within one month and to improve the quality of handover. The non-medical staff have been part of the team for many years, whilst medical staff have recently changed or are on short rotations. Previous changes have not been well sustained. Much of the initial enthusiasm for this project was coming from the medical staff members. We felt that it was important to fully explore the driving human factors to achieve sustainable buy-in.

Methods. The total period of the project was 7 weeks. First two weeks were used for daily baseline data-collection and informal and formal discussions with team members to formulate driver diagram and change ideas. Two “Plan, Do, Study, Act” (PDSA) cycles with two intervention points at week 3 and week 4.

Results. Key human factors identified in the MHLT were burnout and emotional fatigue, core team values (cohesion, flexibility, and camaraderie), and disillusion with authority and imposed change. Contributing factors to burnout and emotional fatigue were long and short-term staff sickness, chronic under-staffing, and systemic changes in the general hospital due to the COVID-19 pandemic. The human factors were used to guide key decisions in methodology and creation of change ideas. These decisions included: Avoidance of surveys and questionnaires (staff request), limiting the total number of changes, any additional administration to be undertaken by medical staff, and avoiding a rigid handover system. Following 2 PDSA cycles, there were improvements in average length of handover from 44 minutes (2-week baseline data) to 30 minutes (4-weeks post second intervention). When compared to the baseline data there were also improvements in the average number of interruptions (7 vs 2), availability of key information (69% vs 92%), allocation of staff member (80% vs 95%) and allocation of review date (83% vs 95%). No difference in the average number of patients for handover discussion between 2-week baseline data (15) and the 5 weeks after (15).

Conclusion. The aims for the Quality Improvement Project were met and a plan has been set to re-audit in both 6 months and 1 years' time to test sustainability of change. Sudden illness and effects of the COVID-19 pandemic have led to short and long-term staff shortage, contributing to burnout and emotional fatigue. Attention to the unique human factors involved in team dynamics and staff morale can help achieve buy-in and real change.

A Quality Improvement Project on Improving Electronic Prescribing System in an Adult Mental Health unit

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Aims. Medication tasks are an integral part of a junior doctor's job. However, these can often be timely and use hours that could be spent doing other therapeutic work, especially due to the cumbersome nature of SystmOne. Our aim was to review the amount, type, and time spent on medication tasks and evaluate ways in which the system could be made more efficient and time effective, to release doctors to complete other clinical ward activities.

Methods. We used prospective data collection, with two ten-day cycles carried out across the 46 bedded adult mental health unit (AMHU). Data were collected by all junior doctors working on the AMHU and every medication task was recorded on a designated document at the time of completion. This included data