Aims. Neuropsychiatry Service in East Kent typically receives referrals for patients with brain injury, progressive neurological conditions, epilepsy specific neuropsychiatric conditions, rare forms of dementia, and functional neurological conditions. COVID-19 pandemic disrupted routine functioning of the service requiring multiple service innovations including introduction of remote access assessments, skills development clinics, and video-conferencing based psychoeducation groups. We conducted a service evaluation with governance approval to understand the impact of COVID-19 work model changes on referral sources, patient attendance, discharge destinations and the mental health professionals' involvement in the management of the patients referred to the service.
Methods. We applied to Service Evaluation and Audit Group of Kent and Medway NHS Partnership Trust for permission to collect service data using routinely collected clinical and business administration information. We used an approved data collection form for anonymized data collection. We analysed data for new patient assessments conducted over one-year prior to COVID-19 lockdown announced on 23rd March 2020 and compared it with one-year post-COVID lockdown period ending on 22 March 2021. We used Statistical Package for Social Sciences (SPSS) to carry out descriptive and statistical analysis of the data from two service evaluation period.
Results. The total number of new patient assessments conducted during the two designated service evaluation periods was 365. 233 new patient assessments (64%) were conducted during the one-year pre-COVID-19 lockdown and 132 (36%) new patient assessments were conducted during the one-year post-COVID-19 lockdown.

Neurology teams in the local area were the main source of referrals during the two study periods, referring 59% and 51% of total referrals during the two evaluation periods respectively. Other referral sources included local memory service, inpatient psychiatric units, community mental health teams, neuropsychology, neurorehabilitation, palliative care and acute medicine. The primary management model was multidisciplinary. 49% of assessment contacts were made by specialist nursing during the first evaluation period. 48% of assessment contacts were made by the medical staff during the post-lockdown period. 13.3% of patients did not attend their appointments during the first period, dropping to 9.8% in the Post-Lockdown period.

Most patients who completed treatment were discharged to GP care (89% pre-COVID-19 and 94% post-lockdown). 12% patients from Pre-Lockdown period were still receiving care at the end of one year and 35% were still receiving care in at the end of post-lockdown period.
Conclusion. The service evaluation identifies systemic differences in service use characteristics during Pre-lockdown and Post-lockdown periods.

What Is the Future of Primary Mental Health Care?: A Post COVID-19 Service Evaluation

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Aims. During the COVID-19 pandemic, many service lines needed to be transformed to enable more telemedicine and virtual consultations. This enabled seamless care across many service boundaries as all services adapted to operate virtually. During COVID-19, the mental health of many patients deteriorated. With easing of restrictions, we wanted the patient voice to be heard and to ensure our service was patient-centred. We undertook a service evaluation to understand our patients preferences. Our cross-sectional study evaluated patient preferences for their care which we felt was important as earlier during pandemic, patients did not have the choice to choose between virtual vs face-to-face consultations. We felt this was important to our patients so they could exercise choice of consultation and this would enable the patient voice to be heard.
Methods. 591 patients across three practices in primary care were identified from the Serious Mental Illness (SMI) and on the depression register. They were asked about their preference of care: telemedicine vs face-to-face consultations. Using a simple questionnaire, in order to record their preference on the patient screen. Of these a total of 495 patients (83%) participated in the study.
Results. Of the 495 respondents, 308 (52%) declined virtual telemedicine consultations and 175 (29%) patients were content with virtual consultations. Of the 175 patients who wanted telemedicine were 20 to 40 years of age. Reasons given included convenience (allows family and work commitment) and overall time management (reluctancy to travel). The 308 patients (52%) wanted face-to-face consultations because they wanted human contact, validation of their mental health problems, reassurance and were uncomfortable about discussions on the phone. They also had poor mobility especially the elderly who chose traditional models of care.
Conclusion. As services are restored to the new norm of patient care, patient choice should remain paramount if services are to remain patient centric. During the COVID-19 pandemic, many services transformed to virtual consultation of necessity without recognising the impact on patients themselves. Patients with serious mental health and depression are inherently vulnerable and our evaluation goes to show that despite the popularity of telemedicine. Patient choice should enable patients to access face-to-face care for greater patient satisfaction.

Quantitatively Evaluating the Impact of Eliminating Risk Assessment Checklists for Granting Leave in a Specialist Personality Disorder Ward

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Aims. Springbank Ward, in the CPFT NHS trust, is a specialist unit for patients with a diagnosis of emotionally unstable personality disorder (EUPD). Psychiatric wards often use restrictive practices to try and minimise suicide risk. Using risk assessment checklists to decide whether to grant leave is one example. Research shows that it is not possible to predict suicide or self-harm risk at an individual level, regardless of the assessment method used, so we questioned the utility of such an approach. A previous evaluation of our leave protocol showed that patients and staff would favour a less restrictive and more personalised approach. We introduced a new protocol that eliminated use of checklists, replacing them with an optional 1:1 conversation with staff before leaving the ward. Our aim in this service evaluation was to determine whether there was any significant change