Aims. Assessment and management of the mental health needs of patients with dementia has been identified as a key role for a mental health liaison team (MHLT). The existing practice for referrals of patients with dementia made to Barnsley Hospital's MHLT was for them to be redirected to the memory team for assessment, who have limited scope for in-reach work into hospital, rather than being assessed by MHLT who are based on the hospital site.

This project aimed to clarify the pathway for dementia referrals presenting with psychiatric issues at Barnsley Hospital and determine which patients should be seen by either MHLT or the memory team. It also aimed for MHLT to increase the number of dementia referrals assessed compared with existing practice and increase the proportion of face-to-face reviews for these patients.

Methods. 2 periods of data collection took place within MHLT, where the outcome of referrals made from Barnsley Hospital for patients with diagnosed or suspected dementia requiring assessment was recorded. The first period recorded existing practice and the second period recorded practice following the implementation of a new pathway for referrals.

The new referral pathway was created in collaboration between MHLT, memory team and Barnsley Hospital's dementia nursing staff. MHLT would review cases of suspected dementia not currently open to memory team whilst referrals made for patients open to memory team would be referred to memory team initially, with the option of MHLT input subsequently being requested.

Results. First data collection period 3–28 April 2023:

4 referrals in total.

2 were assessed by MHLT, 1 seen face-to-face, 1 by telephone. 2 were redirected to memory team.

Second data collection period 17 July–17 September 2023 following implementation of the pathway:

10 referrals in total.

7 were assessed by MHLT, 7 seen face-to-face. 3 were redirected to memory team.

Conclusion. The implementation of the pathway led to improved outcomes, with absolute increases of 20% in the proportion of referrals assessed by MHLT and of 45% in the proportion of patients assessed face-to-face. Undertaking the project also helped to identify that there was a training need for MHLT practitioners regarding dementia assessment and management. The next aim is for MHLT to assess 100% of dementia referrals following dementia training being delivered to the MHLT practitioners, and to continue regular MDT meetings to monitor the efficacy of the pathway and maintain collaboration between MHLT and the memory team.

Physical Health Monitoring in Waverley Community Mental Health Recovery Service (CMHRS)

Dr Steve Calvosa*

Surrey and Borders Partnership Foundation Trust, Guildford, United Kingdom

*Presenting author.

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Aims. To audit the recording of physical health parameters for the clients of Waverley Community Mental Health Recovery Service (CMHRS).

To ensure Trust and NICE guidelines are met for monitoring of:

1) Psychiatric drug prescribing.
2) Psychiatric disease monitoring.
3) Past medical history and biophysical parameters relevant to prescribing decisions.

To develop a clinical review process for the clients to ensure that physical health parameters are monitored longitudinally.

Methods. A random sample of 100 patients from Waverley CMHRS was analysed. The data was collected between November 2022 and January 2023. The process involved establishing the cohort, dividing the caseload for review, and applying an audit questionnaire. The questionnaire was applied to both SystmOne Electronic Patient Records and GP Shared Care Records to assess compliance with physical health monitoring in both secondary and primary care. All data collected were compiled onto an Excel Spreadsheet. The level of compliance for monitoring of each parameter was calculated and audited against Trust and NICE guidance.

Results.

For secondary care:

1. Compliance with physical health monitoring requirements is consistently low.
2. Higher levels of compliance (>50%) for height, weight, Audit C (Alcohol), Smoking status.
3. Lowest compliance levels observed for: blood tests, ECG request, substance misuse status, sleep, medication side effects.
4. Evidence of a comprehensive physical health review was found in 1% of patients.

For primary care:

1. 95% of patients from our sample consented to giving access to their Shared Care Record.
2. Compliance with physical health monitoring requirements in primary care was higher.
3. Compliance was particularly high (> 87%) for: height, weight and BMI, BP, evidence of alcohol monitoring, evidence of smoking monitoring.
4. Smoking monitoring is the parameter with the highest level of compliance (95%).
5. Parameters are monitored more regularly.

Conclusion. The audit identified gaps in the documentation and assessment of physical health parameters within Waverley CMHRS. Compliance with monitoring requirements was significantly lower in secondary care, highlighting the need for intervention. Conversely, primary care demonstrated higher adherence to monitoring guidelines. The results show deficiencies in physical health monitoring that need to be addressed to ensure comprehensive psychiatric care.

The project was crucial in optimizing physical health monitoring within Waverley CMHRS. Recommendations include targeted training, improved communication between primary and secondary care, and the designation of physical health coordinators. An action plan was developed with assigned responsibilities and a timeline for implementation. A re-audit will follow to assess the impact of implemented changes.

Mental Health Policies in Low and Lower Middle-Income Countries (LLMICs): A Narrative Synthesis

Mr Usman Arshad[1,2], Prof Imran Chaudhry[1,2]*, Prof Nasim Chaudhry[1,2], Prof Rachel Jenkin[3] and Prof Nusrat Husain[2,4]

[1]Pakistan Institute of Living and Learning, Karachi, Pakistan; [2]University of Manchester, Manchester, United Kingdom; [3]Kings College London, London, United Kingdom and [4]Mersey Care NHS Trust Foundation, Prescot, United Kingdom
*Presenting author.

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Aims.

Background:
Mental health policy is crucial for enhancing mental health and well-being. Despite the significant contribution of mental disorders to the global burden of disease, 68% of the countries possess a comprehensive mental health policy. This review aimed to identify similarities and differences between low-income countries' (LICs) and lower middle-income countries' (LMICs) mental health policies, along with key gaps, limitations, and strengths, to inform Pakistan's mental health policy.
Methods. We conducted searches on Google, the WHO Mental Health Atlas, and the country's Ministry of Health website for mental health and general health policies. Recent mental health policies were included from LMICs that were available in English, whether published or unpublished. Scholarly articles, commentaries, books, and health policies that did not address mental health were excluded. Data extraction covered document title, policy status, country, policy formulation process, human resources, suicide prevention, finances, health service delivery, governance, leadership, involvement of ministries, and implementation plans. We synthesized the data through a comparative narrative review in both text and tables.
Results. Fifty percent (8/16) of LICs and sixty-five percent (17/26) of LMICs have health and mental health policies in English. These policies cover topics like psychiatric disorders, psychotropic drugs, forensic mental health, substance abuse disorders, and communicable and non-communicable diseases. Approximately 65% of LMICs' policies outline the structure of their federal or national government, and 59% provide information on provincial and local government structures. Most LICs include their vision, mission, and objectives in their policies.
Conclusion. Mental health is often neglected in the healthcare policies of LICs and LMICs. To reduce the burden of mental illness and prevent self-harm, suicide, and substance misuse disorders, the implementation of evidence-based mental health policies in line with the Sustainable Development Goals (SDGs) is crucial.

Optimising MDT Huddles: A QIP Approach to Improving Efficiency and Satisfaction in an Older Adults Psychiatric Ward

Dr Adnan-Mustafiz Chowdhury* and Dr Tharun Zacharia

South London and Maudsley NHS Foundation Trust, London, United Kingdom
*Presenting author.

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Aims. At Chelsham House – an older adults, acute inpatient dementia mental health ward – morning handover meetings ('huddles') lacked structure and consistency, resulting in extended, inefficient patient handover discussions and unclear task allocation. These issues consumed valuable clinical time and impacted the continuity and effectiveness of care. Recognising these challenges, a need to revamp the huddle format emerged, prioritising clear communication, effective task distribution, and team cohesion to enhance patient safety and care efficiency.

This project aimed to improve the efficiency and effectiveness of morning huddles at Chelsham House by reducing their average duration by 10% and enhancing multidisciplinary team (MDT) staff satisfaction regarding patient handover dialogues, task distribution, and accountability within 2 weeks.
Methods. The intervention streamlined the huddle format by assigning a rotating MDT chairperson and task allocator, setting a strict 2-min per patient discussion target. New segments, such as a ward safety check and focused discussions on risks and discharge barriers within patient updates, were added. A task allocation board was implemented in the meeting room for assigning tasks. Staff surveys and data on meeting duration were collected pre- and post-implementation.
Results. The implementation led to a 16% reduction in huddle duration (from 64 to 54 minutes) and a 21% decrease in time spent per patient discussion (from 4.09 to 3.23 minutes). Staff surveys showed a significant increase in satisfaction regarding safety discussions (21%), task clarity (23%), and discharge planning efficiency (26%). The effectiveness of mental and physical health discussions was maintained, with a high average Likert score of 4.64 post-implementation, on a scale where 1 is 'Strongly Disagree' and 5 is 'Strongly Agree'.
Conclusion. This QIP achieved a notable 16% reduction in huddle duration, enhancing clinical operations on the ward. The progress, combined with improved staff satisfaction and maintained quality of discussions, underscores the QIP's success in boosting clinical efficiency and offers valuable insights for future initiatives in similar settings.

Co-Producing and Quality Assuring Multi-Modal Psychoeducation to Enable Early Engagement in Guided Self-Help for People With Functional Neurological Disorder

Miss Tahani Dahir[1]*, Miss Stephanie Lapitan[1], Miss Adna Mohamud[1], Miss Anushka Saxena[1] and Dr Verity Williams[2]

[1]King's College London, London, United Kingdom and [2]Kent & Medway Partnership Trust, Kent, United Kingdom
*Presenting author.

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Aims. People with Functional Neurological Disorder (FND) exhibit diverse symptoms, ranging from motor and sensory issues to non-epileptic attacks, potentially causing reduced functioning and quality of life. East Kent Neuropsychiatry Service developed written and video resources to educate patients about FND. We aim to improve patient education on FND through increasing resource options and identifying optimal implementation of the materials within the care pathway.
Methods. We implemented an existing symptom self-management psychoeducation booklet and novel video resources as part of a quality improvement project (QIP). The first QIP cycle trialled the resources across different treatment pathways using three groups, each of seven patients. Group 1 received the