and 12 months, prompting consideration of the Saladax MyCare Insite Analyzer. This point-of-care device uses a finger-prick sample and delivers results in 7 minutes. Despite promising studies, its effectiveness depends on local acceptance, warranting a pilot.

Aims were:

To evaluate the acceptability of the finger-prick test among patients and staff.

To enhance patient care with a quicker method, enabling timely referrals and decisions.

Methods: Clozapine testing was conducted at Lyme Brook Clozapine Clinic (23.10.2023–17.11.2023) using the Saladax MyCare Insite Analyzer on pin-prick samples, with prior patient consent and staff training. Separate anonymised questionnaires were provided for staff and patients.

Results: Patients (n=31) were aged 21–70 years (64.5% male, 35.5% female), majority follow ups (64.5%).

96.9% of tests were completed within 15 minutes (32.3% within 0–5 min, 58.1% within 5–10 min, 6.5% within 10–15 min, 3.2% within 15–20 min). Compared with venous blood tests, 87.1% had a positive experience, 90.3% were satisfied with the test and care received, and 90.4% valued the time-saving benefits. Overall, the test was acceptable to 90.3%, and 71.0% preferred the finger-prick test (22.6% unsure) over venous, with 90.3% willing to use it again (6.5% unsure), and 83.9% would recommend it (9.7% unsure). 97% reported no issues, with only one instance of test repetition.

Staff (n=32) were aged 31–64: 56.3% doctors, 6.3% nurse associates, 12.5% STRs, 25% trainee nurse associates; 68.8% female, 28.1% male.

96.9% completed testing within 15 minutes (0–5 min: 9.4%, 5–10 min: 62.5%, 10–15 min: 25%, 3.1% unspecified). 96.9% highly rated their experience (3.1% no response), while 100% valued time efficiency, ease of use, and care quality. 93.8% found it acceptable (6.3% neutral). 94% reported no issues, with one test repetition. All staff preferred the finger-prick test and wished to continue using it.

Conclusion: The pilot project showed strong acceptability of the finger-prick method among patients and staff, with high satisfaction, minimal issues, and improved time efficiency. Both groups preferred it over venous testing, supporting its potential to improve patient care.

Further evaluation of cost-effectiveness, clozapine pathway integration, and training for wider implementation across trust is recommended.

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Length of Stay in Mental Health Acute Inpatient Units in Australia vs England: Exploring Differences in Clinical Practice and Service Design

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Aims: To explore factors in service design that can account for difference in length of stay (LoS) in acute inpatient care for general adult patients between a public mental health service in London, North London Foundation Trust (NLFT) with one in regional Australia, South West Healthcare (SWH).

Methods: Information was gathered from the mental health organisations as below:

1. Data comparison of the 2 services over the period Nov 2023 to Dec 2024 relating to patient flow.

2. Comparison of service design in the two systems such as staffing levels, availability of supporting services and clinical practice.

3. Audit in each service comparing factors that can affect LoS.

Results: SWH had a shorter length of stay compared with NLFT (13 vs 43 days) in keeping with national and statewide comparison of LoS. Re-admission rates were also lower in SWH (9% vs 15%). There was a significant difference in the number of very long stayers (>60 days) with no such patients in the Australian service.

NLFT had a higher proportion of patients admitted formally (88% vs 65%) and a higher proportion of patients with a psychotic disorder (85% vs 75%).

The service comparison demonstrated higher levels of senior medical input available in the Australian service (1.2 vs 0.6 FTE per 10 patients) and medical staffing in general and more frequent reviews with a Consultant Psychiatrist (4 times weekly in SWH vs once a week in NLFT).

The audit showed more frequent use of high-dose antipsychotic prescribing at discharge (25% vs 18%) and higher amounts of antipsychotic doses in general in the Australian service (79% vs 59% of BNF Maximum Antipsychotic dose) at discharge.

Conclusion: The difference in LoS between the services is consistent with benchmarking data. The service evaluation identified several factors that might explain the difference.

There were more patients admitted with psychosis and a higher use of formal admissions in the UK service, both associated with longer LoS.

There were higher levels of medical staffing and in particular Consultant and Registrar levels in SWH. This is likely to explain the difference in frequency of senior reviews for patients in SWH which may result in frequent changes in management plans. The results suggest the use of higher doses of antipsychotic prescribing in SWH.

Staffing models and prescribing practice is likely to impact LoS. It would be important to consider differences in patient experience in the two systems in future evaluations of services.

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Smoking and Mental Health: A Framework for Action in Wales

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Aims: Smoking contributes to poor mental health and increases inequalities in physical health and premature mortality. Smoking is a leading contributor to the 7–23-year lower life expectancy among people with severe mental illness (SMI) compared with the general population.

In Wales, an estimated 14.1% of people are smokers. Smoking is much more common (33% prevalence) among people with mental health conditions and is even higher among those with SMI (40.5% prevalence).

Welsh Government commissioned NHS Wales' Joint Commissioning Committee and RCPsych Wales to develop a framework to help reduce smoking rates among people with mental health conditions in Wales.

The framework sought to address three priority areas for action:

Address misperceptions about smoking in mental health settings.

Improve implementation of quitting strategies in mental health settings.

Address the lack of data on smoking and quitting among people with SMI.

Methods: In partnership with the Public Mental Health Implementation Centre; a review of data, current interventions, policy and strategy across Wales was undertaken.

This was complemented by consideration of:

Overview of current evidence-based strategies in Wales.

Scaling evidence-based interventions for smokers with mental health conditions and SMI.

Addressing misperceptions among smokers and health professionals.

Upskilling mental health professionals to enable them to motivate and support quit attempts.

Results: In addressing the three priority areas for action, the framework focused upon:

Understanding local needs and assets.

Working Together.

Taking action for prevention of smoking, mental health promotion, and reducing inequalities.

Evaluation and measuring outcomes.

Additionally, a deficit in the following areas, led to several recommendations:

Provide training resources for upskilling people working in mental health to support smoking cessation.

Review and augment the implementation strategy for Help Me Quit and the Tobacco Control Delivery Plan to support people with mental health conditions.

Improve accessibility to nicotine replacement therapy (NRT) and other smoking cessation medication. People wanting to quit should have access to more than one quitting aid.

Address data gaps by collecting reporting information on rates of smoking, including among people with mental health conditions.

Conclusion: Several next steps are necessary to reduce smoking among people with mental health conditions in Wales:

Develop an implementation strategy for the Tobacco Control Delivery Plan to target people with mental health conditions including SMI.

National campaigns promoting positive mental health should include messages about the mental health harms of smoking.

Major gaps in data on smoking and quitting must be addressed.

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Service Evaluation of Transition Pathway and Audit of National Institute of Clinical Excellence (NICE) Guidelines Compliance

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Aims: This project aimed to evaluate our transition service for young people, from Child & Adolescent Service (CAMHS) to Adult Mental Health Services (AMHS), and to audit NICE transition guidelines compliance.

Methods: A retrospective case note survey of complex patients who had transitioned between January 2021 and September 2024 was undertaken. NICE Guideline standards on transition were compared with current practices.

Results: All individuals had been seen by a consultant psychiatrist prior to transitioning, usually with diagnoses confirmed, and medications stabilized.

37 participants were female and 7 male. 38 were transferred to community mental health team (CMHT), 3 to a learning disability team and 3 to early intervention in psychosis service.

13 participants had a diagnosis of bipolar affective disorder. 21 had a diagnosis of autism spectrum disorder (ASD) and 5 had attention deficit hyperactivity disorder (ADHD). A few awaited diagnoses confirmation. Emotionally unstable personality disorder was the second most common diagnosis, seen in 8 cases.

Individuals with severe anorexia nervosa and possible autism proved the most difficult to engage in treatment following transition. Most individuals continued to be managed in the community. Only 3 required brief admission to hospital for a maximum stay of 3 days.

Only one had contact with the criminal justice system.

Two continued to receive care from CAMHS post 18th birthday, as they didn`t meet the adult service eligibility criteria.

We compared our current practices with NICE standards. There was good compliance with most, other than Standard 1, regarding age at transition planning. Adult service policy was to identify a named worker only a month before the young persons` 18th birthday. Hence, most individuals transitioned aged 17 years and 11 months.

There was NICE compliance for having a coordinated transition plan, a named worker to coordinate transition care and support before, during and after transition., and a patient meeting practitioner from each anticipated adult service.

Conclusion: This review has helped us in confirming that our transition pathway is largely effective in transitioning complex and enduring cases to adult services and has identified gaps which require attention. We believe that having a dedicated consultant psychiatrist providing continuity of care, pre and post transfer has been pivotal in reaching these goals.

Additionally, good and early patient preparation, and focused, prioritised, multidisciplinary support for complex cases has been crucial.

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