The Time to Psychology Assessment and Provision of Psychological Interventions for Perinatal Women in the Specialist Perinatal Community Mental Health Team

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doi: 10.1192/bjo.2024.582

Aims. According to NICE guidelines on antenatal and postnatal mental health, recommendation 1.7.3:

- To identify the proportion of women referred for psychological interventions in the perinatal period who are assessed for treatment within 2 weeks of referral.
- To identify the proportion of women referred for psychological interventions in the perinatal period who start psychological interventions within 4 weeks of assessment.
- To identify the barriers to accessing psychological interventions within 6 weeks of referral of women with mental health problem in the perinatal period.

Methods. The sample cohort were perinatal women referred for psychology interventions in the central specialist perinatal community mental health team (SPCMHT) between 12th June 2023 and 15th November 2023. Data was collected quantitatively and qualitatively. Quantitative data was collected retrospectively from the central psychology SPCMHT database shared drive and on Rio. Qualitative data was obtained through a purposeful sampling technique. Psychologists working in the central SPCMHT were identified. Survey link with specific questions was sent to the identified participants to complete. The SPCMHT psychology pathway was reviewed to clarify the local arrangement in place for women to start psychological intervention within 6 weeks of referral.
Results. 25 patients were identified in total in the 6-month review period. 16 had been assessed and 9 were on the assessment waiting list. The elapsed time for assessment waitlist was between 3 and 23 weeks. Of the 16 assessments, only 2 were done within 2 weeks of referral. The time to assessment for the remaining 14 patients was between 3 and 18 weeks. Following assessment, there were 11 cases on the therapy waiting list, 4 open cases, and 1 wait and watch case. The elapsed time for the therapy waitlist was between 4 and 22 weeks following assessment. None of the open cases started therapy within 4 weeks of initial assessment. Overall, none of the 25 patients were assessed or provided psychological intervention within the recommended timeframe. The qualitative theme suggests "*understaffing*" as the major barrier to prompt service provision. It also suggests a lack of awareness of the current NICE standards timeframe for provision of psychological intervention for perinatal women. The trust SPCMHT psychology pathway has no timeframe for the start of psychological therapy following assessment.
Conclusion. The audit findings suggest massive delays in service provision. The major barrier to this is limited capacity compared with the number of referrals. Hence, there is need for more resource allocation for perinatal psychology service provision.

An Audit of Venous Thromboembolism (VTE) Risk Assessment in an NHS Trust Mental Health Inpatient Setting

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doi: 10.1192/bjo.2024.583

Aims. To assess compliance with National Institute of Clinical Excellence (NICE) guidance (NG 89) recommendations on VTE risk assessment for mental health inpatients in Black Country Healthcare NHS Foundation Trust (BCHFT).
Methods. NICE guidance (NG89) set out recommendations on VTE risk assessment for adult psychiatric inpatients. It recommends that:

- All adult psychiatric inpatients have their VTE risk assessed as soon as possible after admission or at the first consultant's review.
- All patients have their VTE risk re-assessed at the point of consultant's review or if their clinical condition changes.
- Any patient found to be at VTE risk should be considered for prophylaxis with Low Molecular Weight Heparin III (LMWH III), if the thrombotic risk outweighs the bleeding risk. Fondaparinux sodium should be considered in those with contraindications to LMWH III.
- VTE pharmaco-prophylaxis should be continued until the patient is no longer at increased VTE risk.

Using these recommendations as standards, we retrospectively evaluated inpatient clerking charts and progress notes of 49 inpatients across all the 23 wards in the Trust. Data were collected using a standardised audit tool on concordance with these standards to check how many patients had VTE risk assessment within 24 hours of their admission, whether patients had VTE risk re-assessment at any point during admission, whether the patients found to have increased VTE risk at admission were commenced on pharmaco-prophylaxis. Data was also collected to see if the patients commenced on VTE pharmaco-prophylaxis were re-assessed for continued need of the prophylaxis.
Results. 30 patients (59.2%) were risk assessed for VTE within 24 hours of admission. Only 2% of patients had VTE re-assessment while on admission, but there was no record of the indication for this. All the 3 patients (6.1%), found to be at VTE risk on admission, were prescribed pharmaco-prophylaxis, but none of them had a VTE re-assessment to determine the prophylaxis' continued need.
Conclusion. The trust's compliance with NICE recommendation for VTE risk assessment is below standard. We felt the trust's compliance is a reflection of the medical staff's awareness on the importance of VTE risk assessment in mental health settings, and also lack of Trust's policy on VTE risk assessment. Recommendations were suggested to include VTE risk assessment in the junior doctors' induction programme and for the trust to have a VTE policy that factors in mental health risk factors.

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