12.4% of admissions were readmissions within 30 days following discharge. 95.38% of these 30-day readmissions were to Acute MH wards.

Results: Although KMPT has an improving picture in the number of 30-day readmissions compared with previous years, it is still 3% above the national average.

The 30-day readmissions have reduced over time from September 2019 to August 2024, an improving trend.

On an average KMPT currently has 24 readmissions per month. In order to achieve the national average, KMPT would have to reduce this from 24 per month to approximately 16 per month.

Patients aged between 25–35 had the highest 30-day readmission rate in the last year's data.

There was a higher rate of readmissions for female patients.

The majority of 30-day readmissions have either not had their referral reason recorded but secondly indicate 'In crisis' as the reason for readmission.

Patients readmitted within 30 days of previous discharge were predominantly of cluster 8. They were also predominantly of ICD–10 code F603 at 18.75%.

Conclusion: This project is progressing under the Re-admissions pillar of the Patient Flow Improvement Project looking at both avoidable readmissions and high intensity user readmissions.

The Improvement project will look at data in greater detail and identify avoidable readmissions and high intensity users.

The purposeful admission pillar of the Improvement project will address the need to explicitly state what inpatient admission can achieve and the expected outcome from the admission.

Ultra-Processed Food in an Inpatient Mental Health Setting

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Aims: The consumption of ultra-processed food (UPF) is associated with many adverse health outcomes including cardiometabolic disorders, mental health disorders and mortality.

The aim of the service evaluation project is to assess the menu items of a 32-beded low secure forensic mental health hospital against the NOVA criteria for ultra-processed food. All the inpatients have a variety of severe mental health illnesses such as schizophrenia or bipolar. All are treated with antipsychotics and rates of complex physical health comorbidity are high.

Methods: 14 different menu items available from the catering department were analysed and the NOVA classification was assigned by reference to the ingredient list. The percentage of ultra-processed food in each menu item was calculated based on amount of NOVA 4 (ultra-processed food) items contained in relations to the total number of each food composition.

Results: Analysis of all 14 menu items, using the NOVA criteria, showed they contained about 68% of ultra-processed food material. This included unexpected items such as roast potatoes and omelettes. Each menu item was wrapped in plastic and had significant amount of processed material, artificial flavouring, colouring and other preservatives sufficient to be classed as ultra-processed food.

Conclusion: 'Don't just screen, intervene' is the motto used to try and improve the physical health of people with severe mental illness. The Lester tool used to assess the cardiometabolic health of people with severe mental health disorder, focuses on the individual person but without the consideration of the institutional context that surrounds those detained in the forensic mental health unit for many years. The interventions all include advice to eat healthily which is impossible if all the food provided is ultra-processed. Whilst individual organisations might be able to change their catering standards to remove ultra-processed food from their menus, a systemic change to nutritional standards for mental health inpatients may be more effective.

Developing Integrated Old Age Psychiatry and Care of the Elderly Medicine Services for People With Parkinson's Disease: Service Development and Evaluation

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Aims: Parkinson's disease is a neurodegenerative condition with a lifetime risk of 2.7%, with a rise in prevalence expected in line with an ageing population. Whilst characteristically associated with motor symptoms, it is a multi-system disease with neuropsychiatric sequelae which are frequently missed by non-psychiatric specialists. Patients face barriers to access psychiatric services.

We describe a 15-month pilot of a novel integrated service for people with Parkinson's disease in the Bristol Royal Infirmary. A monthly joint outpatient clinic was established whereby old age psychiatrists from the later life liaison psychiatry team and geriatricians saw patients within the same appointment. Additionally, we collaborated for weekly multidisciplinary team (MDT) meetings, inpatient reviews and wider liaison. Our aim was to develop a holistic integrated service with the hypothesis that this would offer value to our joint patient cohort and the wider healthcare service.

Methods: Patients were identified through triage of outpatient referrals, as inpatients and at MDT meetings. Clinical outcomes from the integrated clinic were measured using the Clinical Global Impressions (CGI) scale. Patient and professional quantitative feedback was gathered. Hospital admission data was measured against baseline admission rates for similar outpatient groups.

Results: Between November 2023 and January 2025, eleven integrated clinics were run and 33 patients attended; some patients were seen on multiple dates. The rationale for integrated working included new psychiatric symptoms (17%), pre-existing psychiatric diagnosis complicated by dopamine treatment (28%), cognitive conditions (39%) and complex psychotropic prescribing (33%). Major treatment outcomes included medication adjustment (78%), diagnostic reformulation and psychological therapy provision. There was a clear positive trend in CGI data showing benefit to patients, with overwhelmingly positive patient and professional feedback. Formal analysis of data looking at hospital admissions was