

events including strokes and cognitive decline. Pimavanserin (NPI-NH-PS: -1.9 [$p = 0.045$]) also offered a notable reduction in psychosis symptoms, but was associated with increased agitation/aggression. Whilst commonly used in clinical practice, quetiapine, olanzapine, and haloperidol showed negligible therapeutic changes compared to placebo using multiple psychosis subscales. Olanzapine and haloperidol were associated with increased rates of severe adverse events including extrapyramidal symptoms. Quetiapine showed limited side effects.

Conclusion. Risperidone and aripiprazole offer effective means to help AD patients cope with psychosis, but these medications also come with an increased risk of developing life-threatening complications. They should, therefore, be administered judiciously. Pimavanserin shows early promise in treating this group of patients, with no life-threatening adverse effects associated with its use. Further research is required before endorsing the use of pimavanserin. There is little evidence to support the therapeutic use of quetiapine, olanzapine, and haloperidol in this patient population. No financial sponsorship declared.

Quality Improvement

Mind and body: physical health monitoring in clozapine treatment

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Aims. To evaluate physical health monitoring standards in patients on Clozapine in the community.

Standards

NICE and BNF guidelines for patients on established clozapine treatment advise annual monitoring of weight, waist circumference, pulse, blood pressure, fasting blood glucose, HbA1c, blood lipids and overall physical health assessment. Full blood count is monitored 1-4 weekly.

Background. In the management of schizophrenia, antipsychotic medication remains the cornerstone of treatment. Patients affected carry a significant physical health burden with a reduced life expectancy of 10-25 years. Factors that contribute include sedentary lifestyles, consequent obesity and cardiovascular disease, disengagement from health services, a higher incidence of suicide and the physical side effects of antipsychotic medication. For these reasons, comprehensive routine physical assessment of patients on antipsychotic treatment is of central importance.

Method. This audit is a retrospective study of patients known to South Kensington & Chelsea Community Mental Health Team (CMHT). Patients ($n = 48$) were audited from the Clozapine clinic SystemOne database over a one year period (October 2018-2019) to assess annual monitoring of full blood count (FBC), urea and electrolytes (U&Es), lipid profile, liver function tests (LFTs), HbA1c, thyroid function tests (TFTs), clozapine levels, ECG, and general physical and mental health review.

Result. Of the 48 patients, one was transferred to a different service so was excluded ($n = 47$ total).

All (100.0%) of the patients had annual FBC tests. All but one (97.9%) of the patients had a physical health review including blood pressure, pulse, weight and BMI measurement. Three quarters (74.5%) received annual U&Es and LFTs. Almost two thirds of patients had annual lipid and HbA1c screening (63.8%) and

over half the cohort had annual TFTs (61.7%). Regarding annual multidisciplinary mental health review, this was performed for the majority of the patients (70.2%).

Contrastingly, only a quarter of the patients received annual screening of glucose and Clozapine levels (27.7% for both). Only 12 patients had annual ECG (25.5%).

Conclusion. Following review it is clear that most parameters were monitored annually in a majority of patients. However, shortcomings were detected, specifically annual ECG and waist circumference monitoring.

In order to ensure comprehensive monitoring of mental and physical health of patients on Clozapine, flow charts of tests and reviews needed for each patient were written up clearly and will be included in the management pathway for every patient on Clozapine. This was agreed to minimise missing any step, particularly annual ECGs.

Transition of young people from CAMHS to AMH 2017-19

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Aims. Transition from CAMHS to AMH is recognised as a potential struggle for young people who suffer with poor mental health. In response to the 2017-19 NHS CQUIN project, LPT organised a monthly working group to establish the best transition process & deliver the CQUIN project.

Background. It is estimated that more than 25,000 young people transition each year. It is reported that this process is often handled poorly, which can result in repeat assessments and emergency admissions for this large cohort of service users at a critical stage in life. The result is that young may go on to develop more severe problems in the absence of an appropriate transition service.

Method. Cohort of service users eligible for transition (17yrs 6months) was identified. They were referred from CAMHS to AMH with a transition plan and referral letter. A face-to-face transition meeting was arranged which included the patient, carer & clinicians from sending & receiving services. A clinical audit was completed to ensure that care was transferred to AMH post-18th birthday of the patient. The process was followed up by pre- and post-transitions surveys.

Result. From 110 identified service users 46% had joint-agency transition meeting and 79% had transition plan in place. 72% felt prepared to transition to AMH and 89% felt their transition goals were met. Positive comments have been received from service users.

Conclusion. Link workers were identified to facilitate the transition process. Flow chart was established and disseminated across LPT. Services that need an improvement will be targeted and monitored. LPT will host an event for patients and carers to involve them in enhancing the transition process.

Transition from child and adolescent mental health services to adult mental health services: children in care and adopted children

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Aims. Mental health transition-related disengagement is a major public health problem. This study aims to review children in care (CIC) and adopted children's transitions from child and adolescent mental health services (CAMHS) to adult mental health services (AMHS). This study aims to illustrate the often overlooked complexities that are associated with this population's transitions.

It is hypothesised that this population is at an increased risk for disengagement post-transition. Such is hypothesised as a result of the population's increased prevalence of complex mental health problems, neuro-developmental needs and developmental trauma. This population would benefit from a transition (optimal), as opposed to a transfer of care (suboptimal).

Method. This retrospective case study included young people from Lewisham CAMHS's team for looked after and adopted children. Optimal transition was evaluated using four criteria: continuity of care, parallel care, a transition planning meeting and information transfer.

Result. A total of 34 cases (male = 14, female = 20) were included, 88% of which were CIC (12% were adopted children). 85% of the cases included reports of at least one form of abuse and/or neglect. 59% of the cases were categorised as having more than one diagnostic group of mental health problems.

30% (n = 11) of the cases were discharged and were not recorded to have re-engaged with Lewisham AMHS. 12% of the cases had an outcome as 'unknown' due to miscellaneous reasons.

Only 18% (n = 6) of the cases had an 'optimal' transition. 18% (n = 6) had a suboptimal transfer and of those cases, 66% (n = 4) did not engage with AMHS beyond three months post-transfer. 21% (n = 7) were re-referred to Lewisham AMHS after being discharged from CAMHS. None of the re-referred cases engaged with AMHS post-referral.

Conclusion. In conclusion, these findings demonstrate that this population is highly complex and can often experience suboptimal transitions from CAMHS to AMHS. Anything less than an 'optimal' transition yields a low rate of therapeutic engagement. Recommendations for clinical practice includes an extended period of 'overlap time' between CAMHS to AMHS for CIC and adopted children. This overlap period will enable mental health practitioners to provide more informed and consistent support that incorporates the needs of CIC and adopted children. Such a provision will enhance therapeutic engagement and subsequently, promote better outcomes for CIC and adopted children. These findings have important resource implications for both CAMHS and AMHS teams.

Using an electronic discharge notification system reduces the time delay between discharge and a summary being sent to the GP

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Aims. All patients discharged from our Paediatric Liaison Team will have an electronic discharge summary sent to their GP within 24 hours by January 2020.

Background. Writing a GP discharge summary is an essential part of patient care and is a patient safety issue if not completed on time. The NHS England Standard Contract states discharge summaries should be completed and sent to a GP within 24 hours of discharge. Baseline data showed our median time between discharge and a GP summary being sent off as 3 days

and a baseline survey of staff in our team rated our discharge summary process as inefficient and time consuming. At baseline our discharge summary was typed on a word document which was then emailed to admin staff who would print and post to the GP. Our electronic patient record had an inbuilt discharge notification function that generates and sends summaries via email to the GP that other teams in the trust were already using.

Method. We utilised the Model for Improvement Quality Improvement methodology. Initially we created a driver diagram breaking the process of discharge summary writing into its constituent components to generate change ideas. We then tested out these out in plan, do, study, act (PDSA) cycles whilst continually collecting data using a shared team spreadsheet to monitor for change.

Result. We found that switching to electronically sent discharge notifications improved our time from discharge to a summary being sent to the GP from a median of 3 days to 1 day. We noticed that alongside a shared team spreadsheet monitoring when summaries were written we also reduced variation of time between discharge and a summary from a range of 0-27 days (with an outlier of 161) to 0-9 days.

Conclusion. On average the time from discharge to a summary being written met the standard and we reduced the variability of time delay by using an electronic notification. However only 56% of summaries were sent within the 24 hour limit. Key factors for continued variability identified during regular team meetings included overall caseload of patients, amount of staff on shift and technical issues with the form. Our plan for sustainability is to discuss monthly in the team meeting any discharges that took longer than 1 day and target further PDSA cycles to these issues.

National video consultation service- changing the way we deliver future care

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Aims. In March 2020, when the COVID-19 outbreak emerged, Technology Enabled Care (TEC) Cymru went into partnership with the Welsh Government and CWTC Cymru to offer a safe solution to protect the NHS and the public by developing and rolling-out a National Video Consulting (VC) Service on an All-Wales basis.

The aim was to quickly develop and roll-out an NHS-approved communication platform (Attend Anywhere) to all primary, secondary and community care services, and into care homes, prisons, dentistry, optometry and pharmacy to offer video consultations to patients.

Method. The NHS Wales Video Consulting (VC) Service used a robust mixed methodology of surveys and interviews with patients, families and professionals. The real-time quality improvement approach was invaluable to the team as findings continually informed the approach and direction.

Result. Based upon 10,000 survey responses from patients and professionals, and more than 300 interviews the results demonstrate that video consulting is consistently high in satisfaction, clinical suitability and acceptability across a wide range of patient demographics and clinical specialties in Wales. The key findings are

Very high in patient and clinician satisfaction (slightly higher in patients).

Clinically suitable across a wide range of specialties, care sectors and Health Boards.

Very high in patient and clinician satisfaction (slightly higher in patients).

High acceptability of VC, which is believed to be associated to the 'Welsh Way' of digital implementation processes.