highlighting the need for face-to-face appointment provision to remain accessible across the service.

This audit did not collect demographic data that may have provided insight into whether certain factors may have impacted attendance and could have acted as confounders, for example geographical location.

Introduction of a supportive reminder letter for patients, to bridge the wait between patient's referral and their initial assessment, was an outcome recommendation that was implemented by the service.

Measuring Physical Health in Patients on Antipsychotic Medications

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Aims. Mental illness is associated with poorer physical health and reduced life expectancy in comparison to the general population. This is influenced by many factors, one of which is medication related. Antipsychotics can have multi system effects on the body such as increasing the risk of metabolic syndrome and cardiovascular disease. Our objective was to understand current challenges when monitoring patients' physical health and thereby improve overall health outcomes.

Methods. Utilising a clinical audit template, the study group was 9 inpatients during cycle 1 and 10 inpatients during cycle 2, who were prescribed antipsychotics on an Old Age Psychiatry ward. Northumberland, Tyne and Wear (NTW) antipsychotic monitoring guidelines were used as criteria which stipulate that blood tests, ECGs, BMI, waist circumference, side effects and lifestyle effects should be recorded at defined intervals. A proforma highlighting these guidelines was created following audit cycle 1 and utilised by the MDT on the ward, the purpose of cycle 2 was to compare findings following the implementation of the proforma. The standard to meet was that 100% of patients should fulfil the guidelines. Data was collected by retrospectively reviewing paper and electronic notes.

Results. Audit cycle 1 revealed 0 of the patients met the physical health criteria. 0 had the full set of required bloods in the correct timeframe, 0 had waist circumference checked and 2 and 1 patients had side effect and lifestyle effects documented respectively. By comparison, ECGs and BMIs were recorded well. Audit cycle 2 demonstrated significant improvement in all areas. 9 patients had bloods accurately measured. 3 and 6 had side effect and lifestyle reviews respectively. ECGs and BMIs continued to be monitored well. However, waist circumference remained poor with 1 patient recorded. Qualitative feedback when presenting these findings to the MDT highlighted an interest debate into the cost/benefit of measuring waist circumference with the main point being not wishing to cause undue anxiety to the patient.

Conclusion. The use of an accessible proforma clearly outlining the criteria to meet for each patient proved valuable in improving the monitoring of physical health parameters. This study highlighted a need for increased awareness of metabolic syndrome and the importance of empowering patients with knowledge regarding their healthcare to help tailor a patient-centred approach to physical health monitoring. Our presentation aims to encourage discussion among attendees around measuring waist circumference and raise awareness of metabolic syndrome.

Improving On-Call Support for Doctors: A Quality Improvement Project

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Aims. Doctors completing on-call shifts at sites across a mental health trust identified a need to improve aspects of on-call work. This quality improvement project (QIP) aimed to improve response to trainee concerns arising from on-call work and support to junior doctors on-call.

Methods. A previous QIP cycle identified trainee concerns regarding on-call processes. In our first QIP cycle, surveys were sent to all consultants and SpRs working on non-residential on-call rotas, and Foundation, GP and Core Psychiatry trainees (on residential on-call rotas) in the Trust, regarding perceptions of on-call processes, senior support and on-call issues. A monthly, online forum was introduced in August 2023 to improve on-call feedback and communication. Trainees, consultants and SpRs from 2 localities were invited, along with representatives from the medical staffing team, medical education team and medical management. After 4 forums, participants who had attended an on-call forum were sent a further feedback survey collecting quantitative and qualitative data. Subsequently, forum frequency and scheduling were amended, advertisement improved, and the forum was expanded to include on-call doctors across the whole Trust.

Results. First cycle data revealed consultant support for a regular meeting with trainees and senior colleagues to bring issues from on-calls for discussion (56% felt that an on-call forum would be helpful, 33% felt it might be helpful). Mean forum attendance was 14, with attendance from all grades. Feedback data from trainees (5 responses) was that most found the forum useful (80%); 80% felt listened to; all felt able to raise concerns, and all wanted the forums to continue. Qualitative feedback included: '*we started a new QI project from the forum and many on-call guidelines became more defined.*' Consultant feedback (4 responses) was that most found the forums useful (75%); 100% gained a better understanding of trainee concerns; 100% thought forums should continue, although 50% thought the frequency should be reduced. Most consultants and trainees did not feel it would be useful to discuss clinical cases in the forums. Consultant qualitative feedback reported that the forum was helpful to understand trainee concerns, but there should be wider attendance.

Conclusion. Establishing an on-call forum was a valuable intervention for both consultants and trainees working on an on-call rota and has led to a further quality improvement project. Respondents felt that clinical supervision offered sufficient space to discuss clinical cases. Increasing trainee and consultant engagement with the forum is the next phase of this project.

Improving Clozapine Prescribing at a London District General Hospital: A Quality Improvement Project

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Aims. The liaison psychiatry team at North Middlesex Hospital (NMH) noticed that many patients on clozapine were missing doses in hospital, risking the need for re-titration and deterioration in mental state. Although clozapine is a widely used medication in psychiatry, non-psychiatric clinicians may not be aware of the importance of compliance. In addition, clozapine is often not widely available in acute medical hospitals and ascertaining the correct dosage can be difficult as it is not prescribed by the GP. Furthermore, clozapine can cause a variety of side effects that our medical colleagues may not be familiar with.

The aim of this project was to improve clozapine prescribing at NMH and improve communication with the liaison psychiatry team.

Methods. We reviewed the notes of 97 admissions in which patients were dispensed clozapine from the hospital pharmacy during the period April 2020 to December 2023 to determine what proportion had missed a dose of clozapine, and the clinical implications of this. We also reviewed the reasons for the missed doses to gather information on what could be done to improve patient safety.

From July 2022 we began implementing changes. This included the creation of a hospital guideline, putting in place an automatic email that would be sent to the liaison team when clozapine was prescribed, placing an alert on the online prescribing system to emphasise the importance of not omitting doses, and providing teaching to clinicians.

Results. We compared omissions of clozapine doses and referrals to the liaison team before and after changes were implemented. The percentage of patients inappropriately missing at least one dose fell from 67.4% to 31.1%. The proportion of patients who were referred to the liaison team rose from 40.8% to 89.2%.

We identified several recurring causes of missed doses. These included doctors not being aware of clozapine prescriptions or dosages, poor awareness that clozapine is a critical medicine and long stays in accident and emergency. There were also incidents where clozapine was stopped by the medical team without obtaining advice from psychiatric colleagues.

Conclusion. We were able to reduce the proportion of patients missing doses by improving awareness of clozapine compliance within the hospital. We were also able to improve communication between medical and psychiatric teams.

The clozapine guideline and prescribing alerts will continue to be utilised within the hospital. We plan to continue to provide regular teaching to rotational junior doctors and to pursue a similar project for lithium prescribing.

Implementing a Primary Care Referral Pathway for Further Investigations and Management of Fatty Liver Disease (FLD) in the Absence of Fibrosis Identified in Patients Who Have Undergone a Fibroscan Within the Belfast Addictions Service

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Aims. Alcohol misuse presents a major health concern in Northern Ireland with a 50% rise in alcohol-specific deaths in the past 10 years[1]. Excessive alcohol use may lead to fat deposition within the liver and risks progressive liver disease secondary to fibrosis and/or inflammation. The aim is to extend upon an existent Hepatology referral pathway for patients with alcohol misuse and liver fibrosis on Fibroscan; to include onward referral to primary care for investigations of patients shown to have FLD in absence of fibrosis and facilitate early identification and intervention of associated metabolic syndromes. There was previously no referral mechanism for screening for metabolic syndromes such as diabetes, hypertension and hypercholesterolemia for these patients.

Methods. Case records were reviewed for all patients offered a Fibroscan through the Belfast Addictions service. Patients identified with evidence of steatosis on Fibroscan without fibrosis/cirrhosis i.e. liver stiffness score < 8Kpa and controlled attenuation score (CAP) > 248, would trigger an onward referral to primary care for further investigation and management. A letter was sent notifying the patients' registered GP of the Fibroscan result and NICE recommendations for follow up liver function testing, HbA1c, lipid profile and Q-risk scoring for consideration of lipid lowering medication. A review of patients' electronic care record (ECR) 2 months following the dispatch of letters was conducted to identify those patients who received further investigations.

Results. 286 Fibroscans were conducted in the Belfast Addictions Service in 2023. Alcohol misuse was the indication for 92% of these scans with 32% identified as having evidence of fatty liver disease without fibrosis. This prompted onward referral for primary care follow up and letters were sent out to GPs from November 2023. Review of ECR 2 months post-intervention revealed of the 7 letters sent out in November, 57% (4) had follow up bloods and 75% (3) of those were shown to be deranged. Data collection is ongoing and will be complete by date of congress.

Conclusion. 32% of the patients who had a Fibroscan in the Belfast Addictions service in 2023 had evidence of fatty liver disease without cirrhosis. Initial data shows a positive change in clinical practice and patient care, and builds upon the existing hepatology referral pathway.

Developing a Pathway for Referrals of Patients With Dementia Within a Mental Health Liaison Team

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