the report was for a Quality Improvement Project to be carried out in order to formalise handover.

The handover procedure at Chase Farm Hospital for core trainee doctors 'on-call' prior to this QIP was not standardised and consisted of an informal, verbal handover. Frustrations had been raised by doctors and other staff members that this current method of handover was unreliable and unsafe.

Method. We sent out a questionnaire about handover to all doctors on the on-call rota to help establish what intervention would be appropriate.

We then performed a retrospective collection of documented handovers within a two month time period.

Our intervention was to introduce an email handover procedure.

Following a two month trial of this intervention, we resent the questionnaire and performed a second retrospective collection of handover documentation.

Result. Prior to this QIP we found that 0% of on call handovers were being formally documented. After the introduction of our handover email 88% of handovers were being formally documented using the handover email.

Satisfaction with the handover procedure went from 0% being very satisfied and only 33% being satisfied to 50% being satisfied and 50% being very satisfied.

Conclusion. A standardised and documented handover procedure is crucial for patient safety and to allow doctors to communicate jobs effectively with each other.

A secure email for handover is a successful way of formalising the handover process.

Limitations include:

Access to the handover email for new staff or locum staff.

Ensuring that doctors who aren't on the on-call rota know how to use it to handover their ward jobs.

Rehabilitation during a pandemic: psychiatrists as first responders?

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Aims. The South London and Maudsley High Support Rehabilitation Team supports a cohort of 120 long-term rehabilitation patients in the densely populated London borough of Southwark.

COVID-19 has a high transmission rate and is more lethal amongst the elderly, ethnic minorities and those with comorbidities.

For these reasons, COVID-19 poses a particular challenge to our patients. Most have significant comorbidities, live communally, engage infrequently with primary care and take high-risk medications like clozapine. Many are from black and minority ethnic backgrounds.

During the Spring coronavirus wave, we found that unwell patients or their carers would contact our service for advice ahead of 111, primary care or emergency services.

In response we designed a standard operating procedure to guide our response to possible cases. This aimed to ensure our advice and management for patients drew upon the latest emerging evidence.

We audited our work and the burden of disease within our service until November 2020.

Method. At a team level, we introduced same-day remote assessments structured around a standard operating procedure incorporating the latest primary care and national guidelines.

At a trust level, treatment guidelines were amended permitting consultant discretion when deciding whether an urgent blood count was required for those unwell on clozapine, and routine blood count monitoring was extended to 3 months for eligible patients

Result. By November 2020 we had only one confirmed case of COVID-19 on our caseload. This patient required ITU and recovered. Seven patients were judged 'suspected' to have suffered COVID-19 and eight were possible cases. One supported living accommodation had a possible outbreak.

Conclusion. We are surprised to have had just one confirmed case of COVID-19, despite the vulnerability of our cohort. The attentiveness of our patients and their carers to government guidelines will have contributed to this figure. They have shown remarkable resilience.

This pandemic has prompted trust-wide changes to clozapine monitoring and perhaps a permanently less intensive monitoring regime for some patients.

That our patients contacted our team ahead of 111, primary care or emergency services may reflect the close trust they place in us to support them through difficulty. It is fitting for a service aiming to provide holistic care that our scope should have expanded in this way during the pandemic. Community rehabilitation services are well placed to act as first responders.

Establishing safety huddles on a general adult acute psychiatric ward: staff's views and relation with restrictive practice

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Aims. To establish Safety Huddles (SH) on an acute general adult psychiatric ward, exploring links to restrictive practice. Additionally, to obtain multidisciplinary staff feedback on SH's impact on their workload/wellbeing and on patient care, and to identify barriers in implementation.

Background: A SH is a multidisciplinary daily briefing focused on patients most at risk, held at a fixed time and place, lasting max 5-10 minutes. Effective SH involve agreed actions, are informed by multidisciplinary staff feedback of data and provide the opportunity to appreciate and celebrate success in reducing harm. SH are a valuable team building activity, promoting situational awareness and helping with prioritising daily tasks.

Method. SH were introduced on September 2020. Templates were developed to prompt staff how to facilitate. Staff were encouraged to identify key goals and reflect on issues in the last and next 24 hours. Each participant was allocated a role, e.g. record keeping or dissemination of information. In December 2020, records of incidence of restrictive practice (numbers of restraints, seclusions and rapid tranquilisations) were obtained for the periods June-August 2020 and September-November 2020. Additionally, staff feedback was obtained through a short anonymous Survey Monkey questionnaire. It explored whether SH had an effect on patient care and staff's workload/wellbeing, and possible barriers to implementation.

Result. Comparing the two 3-month periods before and after SH implementation, restraint episodes were reduced from 47 to 21, seclusion episodes from 19 to 2, and rapid tranquilisation episodes from 10 to 3. Nine staff members responded to the feedback questionnaire. All believed SH had a positive impact on patient care, or had the potential to do so. Staff reported SH gave them

insight into incidents, made them feel safer and prepared for the day, played a part in reducing restrictive practice, and empowered staff from all professional backgrounds by giving them a voice. Low or late participation, cancellation of SH because of clinical activity, and vague questions in the meeting template were identified as barriers in implementation.

Conclusion. Acute psychiatric wards regularly face challenges of high clinical activity, low staffing levels, bed pressures, and high-risk patient cohorts. SH contributed to reducing restrictive practice and creating a safer and more positive work environment. It is important to ensure SH are taking place daily, using an appropriate template to guide staff who may be new to facilitating. Accordingly, the impact on restrictive practice, patient care and staff wellbeing can be sustained long-term.

Assessing DNA rates for new referrals in older adults

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Aims. To assess DNA rates for initial assessment medical appointments offered for new referrals within an Older Adults CMHT.

To establish any correlation between waiting time and DNA rates.

To establish if the initial appointments offered were in keeping with the National guidelines (18 weeks) and our local Trust policy (1-4 weeks).

Background. In the Uk 15% of adults 60 and above suffer from a mental disorder. Despite the increasing mental health burden, analysis indicate that a quarter of mental health trust received less investment from 2017 to 2018. Financial pressures have also increased appointment waiting time. The NHS has stated that by 2023 there will be a 4-week waiting time for older adult mental health services. Current national guidelines state that initial referrals should be seen within 18 weeks.

Method. This is a retrospective audit looking at all first time referrals to an Older Adult CMHT in East Birmingham. 110 patients were included in this audit. Factors recorded included age, gender, reason for referral, waiting time for appointment, and whether this complies with guidelines.

Electronic patients' notes (RIO) were used for data collection.

Result. Out of 110 new referrals 11 were not offered any appointments. Out of the remaining 99, 13 cancelled and 8 did not attend.

In total, 78 attended the initial appointment offered, out of which 77 were seen within 18 weeks as per national guidelines. 43 patients were seen within the 4-week period (trust policy). 1 patient was offered an appointment at 19 weeks and 3 days from the referral date. The patients who did not attend their appointments were followed up except for one, to find out the reasons of the DNA. This included 2 (physically unwell), 1 (unaware of appointment), 1 (refused), 1 (forgot), 1 (couldn't get to clinic), 1 (asthma attack). Another appointment was offered to those who could attend.

Conclusion. There was no significant correlation between a longer waiting time and an increased DNA rate for first appointments. Even though the time for an initial appointment was within the NHS guidelines, only 56% of the appointments met our Trust's policy of a 4 week wait.

When discussing the results with the relevant team it was clear that a number of factors affected the waiting time including: number of available clinicians and a large catchment area.

Phew! time to focus on physical health and wellbeing: improving the assessment and management of physical health in an early intervention in psychosis service

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Aims. NICE guidelines recommend that patients under Early Intervention (EI) in Psychosis Services have systematic monitoring and intervention of cardiometabolic risk factors. We undertook a Quality Improvement Project (QIP) in the Bath and North East Somerset (BaNES) EI Team to improve rates of compliance with national guidelines. We aimed to increase the percentage of service users with a physical health assessment documented in the past 12 months. Other aims included improving monitoring of physical health parameters in those taking antipsychotic medication and increasing the delivery of interventions for abnormal results.

Background. The most common cause of premature mortality in people who experience psychosis and schizophrenia is cardiovascular disease. The 'Standards for Early Intervention in Psychosis Service' states that patients should be offered personalised healthy lifestyle interventions, including advice on diet, physical activity, and access to smoking cessation services. Physical health should be monitored at least annually, with more frequent assessments if antipsychotic medication is prescribed.

Method. We identified seven key factors for improving physical health: Body Mass Index (BMI), Blood Pressure, Glucose Regulation, Blood Lipids, Smoking, Alcohol and Illicit drug use. Baseline compliance and intervention rates were measured in March 2019. Six 'Plan, Do, Study, Act' Cycles were completed over the following ten months. Examples of the changes made included: a new online diary and whiteboard, abbreviation of the assessment form, teaching for the EI team, and a new weekly 'Physical Health and Wellbeing' (PHeW) Clinic. This clinic involved phlebotomy, discussions around lifestyle choices, review of medication side effects, and neurological examination.

We measured the compliance with guidelines each month and the total number of interventions delivered at three-monthly intervals. We collected qualitative feedback on these changes in team meetings and with written questionnaires (including feedback from patients).

Result. Documentation of all key factors doubled from 30.2% at baseline to 63.3% in January 2020. The total number of interventions for raised BMI and lipid levels also increased. Feedback from staff and patients was positive. The clinic helped start conversations with patients about lifestyle choices, prompting improvements in weight, physical activity, lipid levels, and alcohol intake. Patient awareness and ownership over their physical health also improved.

Conclusion. This project utilised multiple strategies to reduce health complications for BaNES EI service users. A structural change in the assessment and management of physical health proved to be an effective and sustainable solution to optimise the health and wellbeing of this patient group.