

is detected, it should be clearly documented to aid handover to primary care providers and medical teams (8,9).

Method. The standard for this audit was set according to SIGN 157 (9). Data were collected retrospectively from consults sent to a liaison psychiatry of old age service within an acute hospital setting. The medical discharge summaries from July to December 2019 were reviewed. Two key data points were collated, the diagnoses of delirium by either medical or liaison psychiatry team and the inclusion of this diagnosis in the patient discharge summaries. An updated delirium protocol was devised and introduced in the hospital setting in January 2020 to include tools for effective diagnosis of delirium and instruction to include this diagnosis if made in patient's discharge summaries. Re-audit was initiated following the introduction of the updated delirium protocol for the period of January to March 2020.

Result. A total of 116 patients were assessed from July to December 2019. 102 discharge summaries were available for review for the purpose of this audit. Prior to the introduction of the updated delirium protocol, delirium was diagnosed by the liaison team in 57% of all referrals. Delirium was underdiagnosed by medical teams in 73% of those subsequently diagnosed. The diagnosis of delirium was present in 42% of all discharge summaries to primary care providers. Subsequent to the introduction of the updated protocol, delirium was diagnosed in 48% of all liaison referrals during the time period specified. The proportion of under-diagnosis of delirium by medical teams stayed at 73%, the diagnosis of delirium was present in 53% of discharge summaries.

Conclusion. The recognition and diagnosis of delirium in the general medical setting continues to be a key issue in the management of older adults. The importance of this diagnosis and its associated after effects needs to be disseminated amongst all care providers. Greater efforts to enhance these aspects of delirium management in the acute hospital setting are required.

Lithium monitoring in patients over 65 in NHS Greater Glasgow and Clyde

Catriona Ingram^{1*}, Karli Dempsey², Gillian Scott³ and Joe Sharkey¹

¹NHS Greater Glasgow and Clyde; ²NHS Lanarkshire and ³NHS Ayrshire and Arran

*Corresponding author.

doi: 10.1192/bjo.2021.138

Aims. Our aim was to identify current practice for Lithium monitoring for >65s in NHS GGC and assess compliance to local Lithium monitoring guidelines.

Method. A retrospective analysis was undertaken of patient data (demographics, diagnosis, biochemistry results) with Caldicott approval at two points over the course of 2018/19. For the first analysis, old age Community Mental Health Teams (CMHTs) were approached and asked to provide a list of their patients on Lithium. This was then assessed for compliance to Lithium monitoring guidelines.

For the second analysis, pharmacy provided data for every patient in the health board dispensed lithium, regardless of whether they were open to a CMHT or not. We were then able to identify patients who we had not picked up on our initial analysis, and re-assess the entire data set for compliance to Lithium monitoring guidelines.

Result. From our first analysis, 13 CMHTs identified 155 patients on Lithium. There was a high variability in how these patients were identified. 44% of patients were monitored by CMHTs

who took bloods and chased them, 38% were monitored by GPs who were prompted by CMHTs in routine clinic letters, and 14% were monitored by GPs who were prompted by CMHTs more assertively using a lithium register. Overall, Lithium plasma monitoring was done well irrespective of method (91%), however compliance to the local standards was poor (58%) with proactive CMHT prompting GPs appearing to be the most effective method (71%).

In our second analysis, we identified 508 patients >65 in NHS GGC prescribed Lithium. Of those, 44% were open to old age psychiatry, 25% general adult psychiatry and 19% were not open to anyone. Of those open to old age services, only 58% had been identified in the previous audit. Lithium monitoring compliance was better in those open to a CMHT versus those not (61% to 23%), and better in CMHTs where monitoring was done by CMHTs rather than GPs. For each CMHT, there were roughly 7 patients per catchment area on Lithium not open to psychiatry.

Conclusion. Lithium monitoring does appear to be highly variable and not particularly compliant with local standards. CMHTs have inconsistent methods of identifying patients prescribed Lithium. There are a significant number of patients not open to old age CMHTs prescribed Lithium, and these patients have poorer compliance to Lithium monitoring. Of patients open to CMHTs, CMHT-led monitoring appears superior to other forms.

A national cross-sectional survey and interviews exploring the relationship between well-being and burnout in doctors

John Jenkins^{1*}, Emma Boxley¹ and Gemma Simons²

¹University of Southampton and ²Centre for Workforce Wellbeing, University of Southampton

*Corresponding author.

doi: 10.1192/bjo.2021.139

Aims. Doctors' mental health is a national concern – the General Medical Council, British Medical Association and Health Education England pledge to improve their well-being. Well-being has no common definition, instead pathogenic measures such as burnout are published as a demonstration of doctors' wellbeing. Yet, the relationship between burnout and well-being has not been explored.

Aim. to investigate the relationship between burnout and well-being.

Hypothesis. they are negatively associated, but not opposites.

Method. An online cross-sectional national survey was distributed to doctors of all grades and specialties via the Royal Colleges and doctor organisations. The Oldenburg Burnout Inventory (OLBI) measured burnout, and the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) measured well-being. Correlation coefficients between total scores of these measures estimated the relationship. Additionally, semi-structured interviews explored personal definitions of wellbeing and its relationship with burnout. Thematic analysis was carried out.

Result. 64 doctors completed the OLBI and WEMWBS. Comparing the total scores for the questionnaires with Spearman's rho indicates a moderate negative correlation ($r_s = -0.658$, $p = 0.00$, $n = 64$). Total scores were made into binary variables, a Chi-square test showed that a low WEMWBS score (<40) and a very high risk OLBI score (≥ 2.85 exhaustion and ≥ 2.6 disengagement) were statistically significantly associated ($X^2(1, N = 64) = 4.232$, $p = 0.04$). Three themes emerged from the 10 interviews conducted: the importance of networks/relationships outside work; scepticism towards

the proposal of an NHS wellbeing check-in; and how participants do not strive to improve their wellbeing until its decline.

Conclusion. This research demonstrates that wellbeing and burn-out have only a moderate negative correlation when using commonly employed measurement tools. Therefore, measures of burnout are not a surrogate for wellbeing. Further research could adopt a salutogenic approach by using the WEMWBS to monitor doctors' wellbeing and could explore interventions to increase well-being, rather than waiting for its decline.

Referrals to liaison services for older adults with deliberate self harm during the SARS-CoV-2 national lockdown - a collaborative service evaluation using liaison referral data

Josie Jenkinson^{1*}, Kehinde Junaid², Sara Ormerod³, Sunita Sahu⁴, Hugh Grant-Peterkin⁵, Mazen Daher⁵, James Lee-Davey⁵, Atilla Yetkil⁵, Julian Beezhold⁶, Adrian Leddy⁶, Elizabeth Sampson⁷, Tasnia Chowdhury¹, Bushra Babar¹, Parthiepan Visvaratnam¹, Divya Vamathevan¹, Rogin Deylami², Tristan Sawle², Mollie Delaney³, Ahoane Qureshi³, Rabeya Rahman³, Neelam Sharma³, Kareem Pabani³, Jack Hubbett⁵, Yuki Takao⁵ and Ellie Hanton⁶

¹Surrey and Borders Partnership NHS Foundation Trust;

²Nottinghamshire Healthcare NHS FT; ³Birmingham and Solihull MH NHS FT; ⁴Oxleas NHS FT; ⁵East London NHS FT; ⁶Norfolk and Suffolk NHS FT and ⁷Barnet Enfield and Haringey MH Trust

*Corresponding author.

doi: 10.1192/bjo.2021.140

Aims. Social isolation and living alone have been associated with increased suicidality in older adults. During the SARS-CoV-2 pandemic, older adults were advised to keep isolated and maintain social distancing. Lockdown periods in England may have led to increased isolation and loneliness in older people, possibly resulting in an increased rates of DSH and suicide. This study aimed to explore whether numbers of older adults referred to liaison services with deliberate self harm changed during the SARS-CoV-2 pandemic.

Method. Reason for referral and total number of referrals to liaison services for older adults data were collected across 6 mental health trusts who had access to robust data sets. Data were collected prospectively for three months from the start of the UK national lockdown and for the corresponding 3 month period in 2019, via trust reporting systems. This study was registered as service evaluation within each of the participating mental health trusts.

Result. Overall numbers of referrals to older adult liaison services went down, but the proportion of referrals for older adults with DSH increased. Across the six mental health trusts there were a total of 2167 referrals over the first three month lockdown period in 2020, and 170 (7.84%) of these referrals were for deliberate self harm. During a corresponding time period in 2019, there were a total of 3416 referrals and 155 (4.54%) of these referrals were for deliberate self harm

Conclusion. Although numbers of referrals for older adults with deliberate self harm appeared to stay the same, the severity of these presentations is not clear. Outcomes of referrals and severity of self harm could be explored by examining individual case records. As there have been subsequent lockdowns the data collection period should also be extended to include these. Triangulation with national and local datasets on completed suicide is planned.

A quality improvement project focused on improving the completion of 'notification of diagnosis' forms for the dementia register, in an outpatient setting

Katherine Johnston* and Lauren Megahey

Southern Health and Social Care Trust

*Corresponding author.

doi: 10.1192/bjo.2021.141

Aims. The dementia register is designed to keep a record of all patients diagnosed with mild cognitive impairment (MCI) or dementia. Following diagnosis, a 'notification of diagnosis' form should be completed and the patient added to the register. The register is used to collate figures and to assess capacity and demand on services.

Our baseline audit revealed suboptimal completion of these forms, therefore we initiated a quality improvement project. Our aim was to achieve completion of the 'notification of diagnosis' forms in 50% of new memory patients seen in clinic and diagnosed with MCI or dementia, within 3 months.

Method. A baseline audit of a random sample of 52 patients, from the 380 patients on the memory clinic list was analysed. 40 of these 52 patients had a diagnosis of MCI or dementia and when cross-matched with the dementia register, only 12 (30%) of the 40 were on the register.

We designed an improvement project which focused on improving awareness of the process and facilitating ease of completion of the form, for example, by placing the form in all new patients' notes. Our results were then monitored and reviewed on a monthly basis for 3 months, to assess the impact of these changes.

Result. Each month, the percentage completion of the 'notification of diagnosis' forms was calculated for new memory patients diagnosed with MCI or dementia in clinic. In the first month of the project (November 2020), 75% completion of forms was achieved. This was a significant improvement from baseline. In December, 66.7% completion was achieved (plus one patient was already on the register) and in January 2021, there was 50% completion (plus one patient was already on the register).

Conclusion. The results showed an improvement in the completion of forms from baseline, and we did reach the initial aim set at 50% by 3 months. However, the trend of the results showed a steady decline in percentage completion of forms over the 3 month period. We noted that over time the forms were no longer consistently placed in the new patients' notes, reducing accessibility to the forms. Other potential factors include a reduction in enthusiasm/ a decline in prioritisation of this project over time. Suggestions have been made to facilitate ongoing improvement and the results will continue to be reviewed.

The Staff Mental Health Service in Cambridgeshire and Peterborough: a new model for assessment and treatment of healthcare workers in the context of COVID-19 pandemic

Muzaffer Kaser^{1*}, Zoe Martin² and Cathy Walsh³

¹Cambridgeshire and Peterborough NHS foundation trust, Department of Psychiatry, University of Cambridge; ²Cambridgeshire and Peterborough NHS foundation trust, Cambridge University Hospitals NHS Foundation Trust and ³Cambridgeshire and Peterborough NHS foundation trust

*Corresponding author.

doi: 10.1192/bjo.2021.142