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.

Improving quality of remote mental health consultations during COVID-19

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Aims. During the first wave of coronavirus pandemic, many Psychiatry outpatient appointments moved rapidly to remote or 'virtual' to protect patients and staff from infection. Telephone consultations do not allow assessment of appearance or other visual aspects of behaviour/affect, yet these are core components of Mental State Examination. Videoconsultation software was unfamiliar to many mental health clinicians, with obstacles including hardware availability, software provision and skills, data security as well as lack of clinican motivation and confidence preventing rapid uptake. I wanted to take advantage of excellent IT support, and NHS England funding of software licence, to drive introduction of Attend Anywhere patient videoconsultation ('telepsychiatry') software within my local ADAPT (Anxiety, Depression and Personality Disorder,Trauma) Community Mental Health Team from April 2020 onwards.
Method. I assembled a small group of clinicans to take part in a local pilot of Attend Anywhere software. One Care Coordinator, a Consultant Psychologist, two Consultant Psychiatrists and myself completed satisfaction and confidience scores throughout an 8 week period. Number of videoconsultation outpatient appointments offered to and accepted by patients were also recorded. Weekly group meetings were deemed impossible to schedule given pandemic workloads, so we used 1:1 quick remote catchups, identifying and troubleshooting obstacles, working with IT implement a work-around when the team hit a technical brick wall.
Result. Clinician confidence and satisfaction increased significantly during this period, as did number of offered & completed video consultations.

Attend Anywhere consultations were used for up to 25% of clinician weekly workload.

Clinicians who manage their own diaries started quickly

It was difficult to successfully engage Administration team to organise Attend Anywhere test calls, leading to slow uptake for Consultant Psychiatrists who do not manage their own diaries.
Conclusion. Patient obstacles to use of Attend Anywhere appeared to be idiosyncratic and multifactorial, including poverty, digital exclusion, lack of privacy at home, and clinical history of online grooming. However, some patients already used Attend Anyhwere software with their physical health teams, while others prefer videocall to phone. Age was not an obstacle.

Once this small group of clinicians began to use software successfully, it had a snowball effect within the team and other clinicians asked to sign up for the service. Full support from Administration teams will be crucial to increasing videocalls within the service. Clinicians suggested offering videoconsultation as an opt-out service and requested additional functionality from the software to widen use.

Bowel monitoring in psychiatry of old age: a quality improvement project

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Aims. This project aims to ensure all patients in the dementia ward 1 in Kingsway Care Centre, Dundee have daily bowel monitoring and achieve a normal bowel habit. The hypothesis is that patients are inadequately screened and substantial undiagnosed constipation exists.
Background. Constipation has a prevalence of 16-50% among individuals over 65 years old in the community. Psychiatric illnesses are known risk factors with older psychiatric patients 3-6 times more likely to be constipated. Untreated constipation may progress to serious complications such as bowel obstruction and bowel perforation. Delirium, often mislabelled as worsening psychiatric symptoms, also may occur leading to additional psychotropic medications being prescribed, further worsening the constipation.
Method. All patients in Ward 1, Kingsway Care Centre Dundee over 4 months were included, amounting to 25 patients. Data were gathered from stool charts weekly. Quality improvement framework was followed with two plan-do-study-act (PDSA) cycles completed. Normal bowel function was assessed against ROME IV constipation criteria and less than 75% of Bristol stool type 6 or 7 due to the risk of overflow diarrhoea and laxative overuse. In the first PDSA cycle, stool charts were modified to account for patients independently mobilising to the bathroom and daily documentation even if bowel movements were uncertain. The second PDSA cycle introduced a sticker on charts folder to "ask the patient" along with a staff education leaflet on the complications of constipation. Data were anonymised and analysed with run charts using Microsoft Excel.
Result. At baselines, 50% of patients had a stool chart. This increased to 90% in cycle 1, 100% in cycle 2. 28% of patients had any stools documented at baselines. This increased to 31% in cycle 1, 59% in cycle 2. At baselines, 0% of patients had a normal bowel habit. This maintained at 0% in cycle 1 but increased to 13% in cycle 2. No serious complications were found in patients assisted with toileting. However, 34% of independently mobile patients developed serious complications.
Conclusion. Poor documentation existed in all patients, particularly those independently mobile. Independently mobile patients were particularly at risk of serious complications of constipation compared to assisted patients. Introduction of new stool charts in the first PDSA cycle resulted in increased documentation but limited benefit for identification of constipation. The second PDSA cycle, targeting staff education and compliance, showed an increase in identification of constipation indicating limited staff knowledge as a key barrier to improvement in patients' bowel habit.

Improving physical health for psychiatric patients detained in a low secure forensic psychiatric unit in the United Kingdom

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Aims. This project aimed to improve physical health and to tackle obesity in patients detained in a low secure forensic psychiatric unit.
Background. People suffering from severe and enduring mental health problems have a life expectancy of 15-20 years less than the general population. The main cause of death is cardiovascular disease due to lifestyle factors, such as smoking, substance misuse and obesity.

Physical health problems such as metabolic syndrome, diabetes and heart disease have a knock on effect on motivation, self-esteem and concordance with treatment.