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 ratel 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 CWTCH 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.

Consistent data patterns across patient demographics (age, gender, urban/rural location).

Consistent data patterns across clinical settings and Health Boards.

Conclusion. There is large appetite for VC in Wales, with high potential of sustainability and long-term use beyond COVID-19. The service is now working with clinicians, patients, carers and policy makers to explore the long-term use and sustainability of video consultations in Wales

Royal Australian and New Zealand College of Psychiatrists mood disorders clinical practice guidelines update

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Aims. To provide guidance for the management of mood disorders, both depressive and bipolar disorders, based on scientific evidence supplemented by expert clinical consensus.

Background. It is the EIT responsibility to monitor a patient's physical health and the effects of anti-psychotic medication for at least the first 12 months.

Method. The update has been developed in a consistent manner to the 2015 guideline. The composition of the working group has remained largely the same as has the process to evaluate the evidence and synthesise the findings. To approach the update, the working group identified areas within the 2015 guideline where significant changes had occurred, for example the development of new therapies or where thinking and practice have changed and new ideas have emerged. Recommendations were reviewed in light of any new findings and evidence. As only some sections of the 2015 guideline have been updated/revised, the time taken to develop the update has been considerably shorter. Public consultation and peer review informed the final version.

Result. This led us to review the mechanism in the team for arranging and reviewing these investigations.

Conclusion. The mood disorders clinical practice guideline update addresses both depressive and bipolar disorders. It provides up-to-date recommendations and guidance within an evidence-based framework supplemented by expert clinical consensus.

A quality improvement project (QIP) to address communication and safety concerns from the on-call team at the Bethlem Royal psychiatric hospital out-of-hours through the introduction of weekend safety huddles

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Aims. There have been long-standing concerns about communication and safety on the Bethlem site out-of-hours due to its size, acuity and the number of specialist services; these issues were exacerbated by the COVID-19 pandemic. A Quality Improvement Project was designed to address communication and safety concerns from the on-call team at the Bethlem Royal psychiatric hospital out-of-hours through the introduction of weekend safety huddles.

Method. Daily weekend safety huddles were introduced to improve communication regarding workload, acuity, new admissions, seclusion reviews, deteriorating patients; and to improve team cohesiveness and trainee support out-of-hours.

The QIP team involved the deputy medical director, the associate director for speciality units, consultants, the college tutor, specialty registrars and core psychiatry trainees. Prior to initiating the huddles, the QIP team met to decide which specialties to involve, to agree on an agenda and liaise with other sites regarding existing huddles. Once the huddles began in April 2020, the team met periodically to agree next courses of action and to troubleshoot. The huddles initially involved acute services and eventually included CAMHS, Forensic, Older Adults, Specialist Units, all on-call consultants, the on-call registrar, two core trainees, the psychiatric liaison manager and the duty senior nurse.

Result. Data were gathered throughout the QIP using Likert scale surveys which were sent to all junior doctors on the out-of-hours rota. Paper surveys were used initially but were later replaced with Microsoft Forms to ensure anonymity.

The percentage of respondents who answered "most of the time" or "all of the time" increased across all parameters when comparing data from before and after implementation of the safety huddles.

These results included improvement in: understanding of workload and acuity (9% before vs 69% after), discussion of new admissions on site (4% before vs 90% after), discussion of patients with deteriorating mental health (35% before vs 90% after) and physical health (22% before vs 83% after), understanding of number of patients in seclusion (61% before vs 93% after) and feeling part of a cohesive "on-call" team (17% before vs 86% after). In addition, the results suggested a reduction in frequency of safety concerns on site (83% answered at least "sometimes" before vs 62% after).

Conclusion. The results of the final survey demonstrated a measurable and positive impact on communications between the out-of-hours team, improved team cohesiveness and a reduction in safety concerns. The lessons learnt also influenced decisions made in formatting safety huddles at other trust sites.

A quality improvement project to increase patient feedback in the psychotherapy department, Tavistock Clinic

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Aims. A rigorous and systematic patient feedback system is important for identifying gaps, improving the quality of care and encouraging patient involvement in service delivery. In the Adult Complex Needs Service of the Tavistock Clinic, a tertiary psychotherapy centre, only 5% of patients have provided feedback when requested. This Quality Improvement (QI) project aimed at improving the return rates of the Experience of Service Questionnaire (ESQ) and the CORE Outcome Measure by 10% within a year.

Method. The QI methodology was used to help identify factors contributing to the low response rate, including views amongst stuff about how such feedback, and the method of its delivery, might affect a psychoanalytically-informed treatment. Previously these forms were posted or handed out in person. In the first Plan-Do-Study-Act (PDSA) cycle, the method of distribution was changed by sending out the questionnaires to patients electronically, using an online survey platform. In the second PDSA cycle, the