retention rate (58% in 2019 vs 100% in 2021) and decreased attrition rate (42% in 2019 vs 0% in 2021).
Conclusion. The Hertfordshire Community Perinatal Team has responded to the pandemic by innovating existing groups and creating new forums; many of which will continue on even after the pandemic ceases. The groups have acted as a lifeline for women breaking up the monotony and isolation of lockdown life and providing an invaluable space for women to be heard.

Waiting list eradication in serious mental illness (SMI) "secondary care" psychology: addressing an NHS blind spot

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Aims. The poster focuses on the reduction, and eventual eradication, of waiting times within a community-based NHS psychology service in the North East of England. The poster aims to demonstrate the effectiveness of strategies implemented within a secondary care psychology service whilst examining patterns of help-seeking behaviour and treatment compliance in those waiting for therapy, and also the care needs of this cohort following a wait for services.
Background. Secondary care waiting lists for psychological therapy, as highlighted by a recent British Medical Association audit, remain a so-called 'blind-spot' in mental health care provision and a national problem. Tackling waiting lists within this sector has been stated as a priority within the Five Year Forward View, however "core ingredients" of waiting list eradication methodologies and the components leading to such, have yet to be disseminated.
Method. A historical audit and follow-up of clinical data were utilised to gather and analyse data of 208 individuals who were seen by the psychology service between October 2014 and March 2016.
Result. No significant differences were found between individuals who successfully completed therapy compared to those who disengaged in regard to demographic or epidemiological variables, or mental health service input. Despite lengthy waiting times of up to 3.69 years, waiting time did not significantly impact whether someone engaged with psychological services. Any form of input from psychological services led to a significant reduction in distress, as measured by the CORE-OM. No individuals who completed therapy were re-referred for psychological input at 12-month follow-up.
Conclusion. If imposed appropriately over a suitable time-frame evidence-based, effective and efficient needs-led psychological input can be provided whilst eradicating a waiting list and still remaining flexible, formulation-based and person-centred.

Polypharmacy and potentially inappropriate medications (PIMs) in older adults referred to a memory clinic

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Aims. The older adult is more likely to be prescribed a lot of medications (polypharmacy) on account of multi-morbidity and consequently being under the care of several specialists. Adverse drug events and reactions account for significant morbidity and mortality in this population group. Common sequelae include confusional episodes, dementia syndromes, falls, and higher rates of acute hospital admissions.Medications are not routinely reviewed in elderly care. We sought to estimate the prevalence of polypharmacy, and potentially inappropriate medications (e.g. anticholinergics or medications with central anticholinergic effects) in those referred to the Cognitive Impairment and Dementia Service (Elm Lodge), Older Persons Mental Health, West London NHS Trust.
Method. All referrals between 01/10/2020 and 30/11/2020 were screened for medications prescribed. Polypharmacy was defined as prescription of 5 or more medications. Medications with anticholinergic properties were considered examples of Potentially Inappropriate Medications (PIMs). The Anticholinergic Effect on Cognition (AEC) Tool, 'Medichec', was used to identify and rate anticholinergic burden. Anticholinergic load was also compared using the Anticholinergic Burden Scale (ABS).
Result. Total number of patients referred – 193

11 patients excluded due to unavailable/incomplete medication records.
Study number: 182
Polypharmacy:

79.67% (n = 145) were prescribed 5 or more medications.
44.51% (n = 81) prescribed 5–9 medications.
23.08% (n = 42) prescribed 10–14 medications.
8.79% (n = 16) prescribed 15–19 medications.
1.67% (n = 3) prescribed more than 20 medications.

Anticholinergics prescribed (AEC Tool):

37.36% (n = 68) prescribed an anticholinergic.
6.59% (n = 12) prescribed more than 1 anticholinergic.

Anticholinergics (ABS):

29.67% (n = 54) prescribed an anticholinergic.
7.699% (n = 14) prescribed more than 1 anticholinergic.

Conclusion. Polypharmacy and potentially inappropriate prescribing (e.g. anticholinergics) remain widespread within the older adult population. Anticholinergic load was broadly similar with the Anticholinergic Effect on Cognition tool and the Anticholinergic Burden Scale. Increased anticholinergic burden further compounds risks of cognitive impairment, delirium and death.Other categories of Potentially Inappropriate Medications, including those no longer needed, ought to be identified and reviewed. Over-the-counter medications also need to be screened for.

Elimination or reduction of anticholinergic burden may improve quality of life for patients, as well as cost burden on services.

Pharmacovigilance, collaborative working, and regular training are needed across services providing care for the older adult.

Polypharmacy and potentially inappropriate medications (PIMS) in older adults referred to a liaison psychiatry service

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Aims. The older adult is more likely to be prescribed a lot of medications (polypharmacy) on account of multi-morbidity and being under the care of several specialists. Adverse drug events and reactions account for a significant number of acute hospital presentations in this population group with increased risks of delirium, lasting cognitive impairment, falls and death.

Medications are not routinely reviewed or rationalised in the elderly, often contributing to preventable harm.

We sought to estimate the prevalence of polypharmacy and potentially inappropriate medications, anticholinergics in particular, in patients (65 years and older) referred to the St Mary's Hospital Liaison Psychiatry Department over a 3-month period.
Method. Between 01/06/2019 and 31/08/2019 all referral forms (from in-patient wards and A&E) for patients aged 65+ years were screened for medications currently prescribed and administered. The medications were confirmed via the St. Mary's Hospital electronic records, pharmacists' completed Medicines Reconciliation and GP Summary Care Records. Polypharmacy was defined as patients prescribed 5 or more medications. Drugs with anticholinergic properties were considered as an example of Potentially Inappropriate Medication (PIMs) using the Anticholinergic Burden Scale. 77 patients were referred in the time period. 9 were excluded due to incomplete/unreconciled medication information.
Result. 77.94% (n = 53) were prescribed 5 or more medications.
38.24% (n = 26) were prescribed over 10 medications.
10.29% (n = 7) prescribed over 15 medications.
69% of (n = 47) prescribed an anticholinergic.
42.65% (n = 29) prescribed more than 1 anticholinergic.
Conclusion. Polypharmacy and potentially inappropriate prescribing remain widespread within the older adult population.

Increased anticholinergic burden further compounds risks of cognitive impairment, delirium and death.

Other categories of Potentially Inappropriate Medications, including those no longer needed, ought to be identified and reviewed. Over-the-counter medications also need to be screened for.

Elimination or reduction of anticholinergic burden may improve quality of life for patients, as well as cost burden on services.

Pharmacovigilance, collaborative working, regular and systematic medication reviews, and on-going training are needed across services providing care for the older adult.

Utilisation of mental health transfer checklist proforma from acute physical health hospitals (Liverpool University Hospitals NHS Foundation Trust) to mental health hospitals (Mersey Care NHS Foundation Trust)

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Aims. Testing the compliance and completion rate of a transfer checklist (proforma) created in accordance with local hospital policies.
Background. The proforma was developed following serious incidents where medically unstable patients were inappropriately discharged to mental health hospitals, requiring readmission to acute medical hospitals. Frequently these events reported an inadequate handover from medical to mental health teams and patients were often prematurely deemed medically fit with evidence to the contrary.

Although parity of esteem between mental and physical health has been a high profile political issue in the UK since 2011, evidence indicates that parity is far from being achieved. This first ever checklist was designed to improve safety of patient transfer from acute physical health hospitals to mental health hospitals by ensuring patients are medically fit and better communication between the two trusts.
Method. Data were collected retrospectively over a six-month period between August 2018 and January 2019 and retrieved from patient notes available at relevant trusts. Electronic notes were obtained from medical wards, accident and emergency and Mersey Care electronic systems. Notes were specifically scrutinised for presence of the proforma, quality of completion and, number and reasons for readmission from mental health hospitals to acute physical health hospitals following their medical optimization. Readmissions were considered as admissions to physical health hospitals up to one month following discharge with evidence of ongoing concerns.
Result. 6597 referrals were made to liaison services from Liverpool University Hospitals, of which 5–6 % were admitted to inpatient mental health units. 31% of admissions from Liverpool University Hospitals were readmitted to a physical health hospital within one month of discharge indicating inappropriate and unsafe discharges. Of all those readmitted, 10% had ongoing acute medical concerns prior to admission to a mental health hospital. The proforma was filled in 13% of admissions from Liverpool University Hospitals. None of the forms were fully complete.
Conclusion. 10% of patient admissions to mental health hospitals were identified as inappropriate due to ongoing acute medical concerns. The proforma served as structured guidance and evidence of medical fitness at time of transfer. However poor compliance was observed, which could be secondary to lack of awareness of the proforma and inadequate dissemination of the policy. Findings were shared and discussed with the appropriate teams both in acute physical health and mental health hospitals and steps will be taken to raise awareness of the proforma before completing a second audit.

The organization of a mental health phoneline in Buenos Aires City: its role to minimize the impact of mental health services disruption amidst COVID-19 pandemic

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Aims. The main concern of this research is to evaluate the performance of a new Mental Health Phoneline Programme, developed to facilitate access to Mental Health Services and to lower the impact of Mental Health Services disruption due to COVID-19 lockdown. Crisis resolution, new referrals, and patients' reconnection with their former Mental Health Teams were recorded.
Method. The data obtained from 11,406 calls made to the Mental Health Phone Line from April 14th, 2020 to March 1st, 2021 were analysed. Crisis resolutions, new referrals, and patients' reconnection with their former Mental Health Teams were calculated.
Result. Of the 11,406 calls registered, 72.2% of them were made by women. Mean age was 50.13 years, SD 18.51; median: 50.