has informed local strategies now being implemented to target community care and provide timely interventions to those groups at highest risk of readmission.

Follow Up After Hospital Discharge in Older Adult Psychiatric Patients

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Aims. To identify if patients discharged from an older adult psychiatric ward were followed up in line with national recommended guidelines. Current National Institute for Clinical Excellence (NICE) guidelines recommend follow up and final discharge letters (FDLs) being available within 7 days of discharge.
Methods. A record search was conducted to identify all patients discharged from one ward during a one year period.

Each patient's notes were reviewed to identify what follow up they had in place and how long it took for this to be implemented. We also examined the time taken for a final discharge letter (FDL) to be made available to their General Practitioner (GP).
Results. We identified 99 patients who were discharged from the ward within the specified period.

The mean time taken for patients to be followed up after discharge was 9.72 days. In 63.16% of cases this follow up was provided by Community Psychiatric Nurses (CPNs), with 51.58% being reviewed in medical clinic. A further 9.47% had their initial follow up with an occupational therapist, 4.21% with a psychologist, 4.21% with the addictions team, 4.21% with care home liaison, 2.11% with social work, 2.11% with continuing care and 1.05% with rehab.

FDLs were sent to GPs, on average, 13.6 days after patients were discharged.
Conclusion. Within our data set a few outlier values markedly increased the mean for both outcomes. Using median figures, average follow up time fell to 6 days, meeting national guidelines, and FDL time fell to 8 days, exceeding recommendations by just 1 day.

Within our department, measures have since been put in place to ensure secretaries are reminding medical staff of the recommended time frames for final discharge letters and it should be noted that an immediate discharge letter (IDL) is routinely sent to GPs containing key clinical information prior to patients being discharged.

The results show that our current practice does fall somewhat short of matching national guidelines and further work should be done to investigate how we can improve standards.

Treating Unmet Needs in Psychiatry (TUNE-UP): Developing a Novel Service for Individuals With Psychosis With Refractory Cognitive, Negative, and Positive Symptoms

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Aims. While dopamine antagonists are an effective treatment for positive psychotic symptoms, they are rarely effective when it comes to treating the cognitive (memory, learning, planning, etc.) and negative (avolition and social withdrawal) symptoms of the disorder. Furthermore, for a sizeable proportion, standard dopamine antagonists are not effective for positive symptoms either. As such, refractory symptoms are a major burden for patients, carers, and clinical services.
Methods. To address this, The TUNE-UP (Treating Unmet Needs in Psychiatry) clinic in Oxford was established in September 2023 as an innovative solution aiming to: (A) Undertake an in-depth assessment of cognitive, negative, and positive symptoms; (B) Identify potentially modifiable causative factors contributing to refractory symptoms (e.g., cholinergic burden, sleep disturbances, physical comorbidities, affective symptoms); and (C) Implement management plans including community clozapine initiation where appropriate. We have analysed data from the clinic's initial five months of operation to establish a baseline understanding of our patient population and identify trends in symptoms.
Results. In the first five months of operations, 21 referrals were accepted comprising 80.9% males (mean age 43.3 years, SD 13.7). 3 were referred for cognitive symptoms, 1 for negative and cognitive symptoms, 11 for positive symptoms, 3 for medication optimisation, and 3 for clozapine re-titration. Of those fully assessed (N = 17), mean total symptom scores measured using the Positive and Negative Syndrome Scale (PANSS) were of mild/moderate severity (70.5, SD 18.4). Objective cognitive testing via the Screen for Cognitive Impairment in Psychiatry (SCIP) demonstrated a total mean score of 54.1 (SD 12.1), markedly below what would be expected in a matched control population (76.3). Cognitive scores were lower in those of older age ($r = -0.62$, $p = 0.01$). Subjective experience of cognitive impairment was measured using the Subjective Scale to Investigate Cognition in Schizophrenia, poor subjective cognition was associated with more severe negative symptoms ($r = 0.57$, $p = 0.03$), but not objective SCIP results ($r = 0.12$, $p = 0.85$).
Conclusion. Refractory positive symptoms remain a priority for clinicians, but cognitive and negative symptoms are highly prevalent reinforcing the need for a comprehensive approach. Routine structured assessment of all symptom domains is feasible in clinical practice. Future work should examine the longitudinal impact of various interventions on different symptom domains.