inductions, emails and through communication with trust junior doctor representatives. After a period of 8 and 24 weeks, we assessed the initiative's success by collecting both qualitative and quantitative data from on-call doctors about their experience with the handover system. Based on feedback, we made multiple adjustments to improve the system, which was later adopted at Lambeth Hospital. The *Microsoft To Do* app was then replaced by a channel on *Microsoft Teams* to ensure wider access.
Results. 15 doctors responded to the baseline survey. Handover practices were varied and included paper-based handovers, phone calls, and emails. Mean doctors' ratings for the pre-existing handover systems were 3.2/5 for overall quality (1: very poor; 5: very good) and 2.7/5 for safety (1: very unsafe; 5: very safe). 60% (n = 9) of doctors said tasks would sometimes be missed in the pre-existing handover system. 21 doctors responded to 2 post-change surveys. Mean doctors' ratings of overall quality were 4.6/5 and safety were 4.5/5. Qualitative feedback highlighted that a verbal handover was still necessary to complement the electronic system, and that locum doctors would need to have access to the system as well as consultants and registrars during periods of industrial action.
Conclusion. An electronic handover system was successfully implemented to replace a predominantly paper-based handover system at two large mental health hospitals in South London, and on-call doctors reported improvements in handover safety and handover quality. Future work aims to implement a consistent electronic handover system across other hospitals in SLaM and other trusts and transition fully to *Microsoft Teams* for broader accessibility.

Audit of Patients Prescribed Psychotropic Medication in the Community Learning Disabilities Psychiatry Services of the Black Country Healthcare NHS Foundation Trust

Dr Adeniyi Adetoki*

Black Country Healthcare NHS Foundation Trust, Dudley, United Kingdom
*Presenting author.

doi: 10.1192/bjo.2024.336

Aims. Stopping Overmedication of People with a Learning Disability, Autism or Both (STOMP) is an initiative of NHS England. This was in response to concerns raised as a result of the Winterbourne View scandal related to the inappropriate use and insufficient arrangements for the review of the prescription of psychotropic medication.

33,000–35,000 individuals with an intellectual disability (ID) are prescribed psychotropic medication daily. 20–45% are on antipsychotic medication, of which 14–30% take these to control behaviour problems rather than for specified psychiatric conditions. Psychotropic medications can have side effects with the potential to significantly impair an individual's quality of life.

This audit is to observe current practice of the prescription of psychotropic medication, with a view to identifying changes to the compliance with recommendations and outlining areas for further improvement in line with the Stopping Overmedication of People with a Learning Disability, Autism or Both (STOMP) initiative.
Methods. Data was collected from electronic records for randomly selected patients, 20 from each of the 4 Community Learning Disabilities Locality Teams within the Trust. The patients who were not currently prescribed psychotropic medication were excluded from the randomly selected samples.
Results. There was good evidence that capacity, consent and best interests were considered, as well as multidisciplinary input. There was also good evidence of regular review of medication, side effects and treatment response. The results suggests that psychotropic medication continues to play a significant role in the management of patients presenting with behavioural problems, and more needs to be done to identify approaches that will help to reduce their use.
Conclusion. In this patient group it is sometimes the case that medication is prescribed legitimately for indications other than their British National Formulary (BNF) recommended use. However, the findings suggest that the rationale could be more clearly recorded. Close collaboration with primary care to provide a comprehensive medication history, the involvement of carers and family members in the active preparation for effective medication reviews and the involvement of the multidisciplinary team should continue to be encouraged and clearly recorded.

Improving Information Distribution and Education Within Memory Clinic

Dr Rashed Alhadi*, Dr Isabella Harley and Dr Cara McDonald

NHS Tayside, Dundee, United Kingdom
*Presenting author.

doi: 10.1192/bjo.2024.337

Aims. The aims of this project were to improve patient education and overall information distribution within the Memory Clinic within the Old Age Psychiatry department, based at Kingsway Care Centre, Dundee.
Methods. This project originated, after there were concerns raised from relatives of a patient who had recently been assessed in the Memory Clinic. A suggested area for improvement included distributing information to patients, highlighting any potential tests or topics of conversation that may be explored during a Memory Clinic appointment. In response, our team engaged in a thorough collaboration with our colleagues in Psychiatry and the Post-Diagnostic Services (PDS). As a result of this partnership, a summary sheet was compiled, highlighting the spectrum of cognitive testing and assessments that may be conducted, potential medicinal treatments and other significant considerations, including driving and Power of Attorney statuses. To ensure these resources were both accessible and informative, they were systemically distributed to patients. The materials were paired with feedback forms to capture patient experiences and insights, to be later collected by the PDS.
Results. Whilst this project remains in the data gathering stages, provisional data has been very promising in showing improvement in clarity of information delivered to patients (both in current and future assessments), explanation to patients regarding medication and treatment options, and overall patient satisfaction.
Conclusion. Optimising educational resources for both patients and families attending the Memory Clinic through summary documentation can be utilised to improve overall patient satisfaction. Aiding patients' understanding of their diagnosis and further management of this, allows them and their families to feel more included in their care and optimises the delivery of holistic care within Psychiatry of Old Age.

Enhancing Well-Being: Optimizing Service Delivery in Neighbourhood Mental Health Team (NMHT) for Administrative Staff and Service users

Dr Harith Ali*, Ms Danica Moller, Ms Amra Selim, Ms Taz Meah and Ms Selma Ali

East London Foundation Trust, London, United Kingdom
*Presenting author.

doi: 10.1192/bjo.2024.338

Aims. Promoting the well-being of staff is paramount within mental health services. However, a common issue arises where administrative personnel, often serving as the primary point of contact for service users, engage in mental health-related interactions without formal training. This deficiency can adversely affect their well-being, leading to diminished team morale and increased staff turnover, consequently impacting the quality of care provided by the Neighborhood Mental Health Team (NMHT). Moreover, it can contribute to dissatisfaction among service users, jeopardizing their rapport with the service. We aim to improve the wellbeing of staff and service users and to optimize service delivery at the local NMHT.
Methods. Data were gathered from a local NMHT catering to 1200 service users in the borough of Tower Hamlets in London. A pre- and post-implementation questionnaire was administered to both service users and six administrative staff members. The questionnaire highlighted several areas for improvement, including a lack of mental health understanding among administrative staff, reported low confidence when handling certain phone inquiries, and service user complaints. Change initiatives were then devised to address these concerns and evaluate their impact on enhancing the experience for both service users and administrative staff.
Results. Administrative staff uniformly expressed the need for increased mental health training prior to commencing their roles. Implementation of targeted change initiatives led to noticeable improvements in service user satisfaction and staff confidence in managing phone interactions. These enhancements culminated in an overall advancement in service delivery.
Conclusion. Through the strategic implementation of change initiatives informed by our initial findings, we not only augmented mental health literacy among administrative staff and service users but also bolstered their well-being. Consequently, this directly translated into an amelioration of local service offerings. Further research is warranted to ascertain the long-term efficacy of these innovative interventions.

7-Day Follow-Up Appointments Following Discharge From a Psychiatric Hospital

Dr Isra Mizher and Dr Ifeoma Amamilo*

Royal Cornhill Hospital, Aberdeen, United Kingdom
*Presenting author.

doi: 10.1192/bjo.2024.339

Aims. Following discharge from inpatient to community psychiatric services, the first 7 days is the most vulnerable and associated with an increased risk of suicide. According to the NICE Guideline 53, it is recommended that patients discharged from inpatient psychiatric services should be reviewed within 7 days by the relevant community services. Our aim was to determine how well we are adhering to this recommendation, appropriately documenting the appointment in the patients' discharge documents as well as the number of patients that attended the appointment.
Methods. We collected data on an excel spreadsheet of patients discharged from Huntly ward (a General Adult Psychiatry ward) in the Royal Cornhill Hospital from 01/09/2022 and 14/10/2022 (a period of 6 weeks).

The data collected included name, CHI, date of admission and discharge, community mental health team, follow-up appointment offered, appropriate documentation on Core discharge document and whether the patient attended the appointment.

After the first audit cycle, we had a discussion with the junior doctors on the ward highlighting the importance of 7 day follow up and the need for arranging with the Community mental health team prior to the discharge, documenting a date, time and name of the clinician for the 7 day follow up in the Core discharge document. We also encouraged the use of reminders like using the doctors' diary book on the ward to document anticipated discharges and adequate hand over of patients to the community mental health team at the start of each week's Multidisciplinary Teams meeting.

We subsequently did a re-audit on patients discharged from Huntly ward between 04/04/2023 and 12/05/2023 (6 weeks). We compared the results from the first cycle and the second cycle to identify a change.
Results. First Audit cycle.

Over the 6-week period, 27 patients were admitted into the Huntly ward and 23 patients were discharged.

48% (n = 11/23) of discharged patients were offered a follow up appointment.

91% (n = 10/11) had this appointment documented in the Core discharge document.

100% (n = 7/7) attended the 7 day follow up appointment.

Re-Audit.

Over the 6 week period, 16 patients were admitted and discharged from Huntly ward.

81% (n = 13/16) were offered a 7 day follow up appointment and this was documented in the Core discharge document.

100% (n = 13/13) of the patients attended their 7 day follow up appointment.

The result showed good improvement from 48% to 81%.
Conclusion. Using reminders, properly liaising with the community mental health team, appropriately documenting a named clinician, date and time for the 7 day follow-up ensures that the patient attends.

The importance of offering support during the first week after discharge from psychiatric hospital should continue to be emphasized to prevent adverse outcome during this vulnerable period.

Improving Quality of Multidisciplinary Team Meetings in Our Community Mental Health Team in NHS Greater Glasgow and Clyde, Scotland

Dr Prerna Ambardar* and Dr Rachel Brown