

interventions to address both patient and clinician barriers to video consultation uptake. Moreover, we understand that motivating and mobilising the care team was a key factor. Possible future work includes improving the sustainability of the interventions and assessing their efficacy in other care teams.

Improving quality and assessment of referrals to the Enfield Crisis Resolution and Home Treatment Team (ECRHTT)

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Aims. Triaging referrals to crisis resolution and home treatment teams is a significant undertaking requiring experienced and dedicated staff. We observed that the volume of inappropriate referrals to ECRHTT was high, and that staff processing these often felt inexperienced or lacking in confidence to discharge them back to the referrers and signpost them to appropriate services.

The aims of this quality improvement project (QIP) were:

- to reduce the number of inappropriate referrals received by the team
- to reduce the number of inappropriate referrals accepted by the team

This would significantly improve access and flow to the service and facilitate better patient care.

Method. A pilot study was first completed of the quality (appropriateness/ inappropriateness) and source of all referrals to ECRHTT in January 2019 ($n = 177$).

Subsequently, the consultant psychiatrist for ECRHTT based himself within the assessment team. He was able to closely monitor the referrals, at the same time as providing medical input to patients at their first point of contact. To evaluate the impact of this intervention, the percentage of inappropriate referrals accepted pre- and post-change was compared by re-auditing all referrals received in February 2019 ($n = 175$).

Further interventions were instigated to improve referral quality. These included continuation of psychiatric medical input to the assessment team, teaching sessions for GPs and the crisis telephone service, and weekly meetings with psychiatric liaison and community mental health teams (CMHTs). Change was measured by reassessing the quality of all referrals made to ECRHTT in February 2020 ($n = 215$).

Result. 46.9% of inappropriate referrals to ECRHTT were accepted in January 2019 compared to 16.9% in February 2019 following the addition of medical input to the assessment team. The absolute difference was 30% (95% CI: 14%–44%, $p < 0.001$).

71% of referrals from GPs were inappropriate in January 2019 compared to 36% in February 2020 post-intervention (difference 35%, 95% CI: 8.84%–55.4%, $p < 0.05$). Inappropriate referrals from CMHTs decreased from 55.5% to 12% (difference 43.5%, 95% CI: 9.5%–70.3%, $p < 0.05$). Overall, the percentage of inappropriate referrals fell from 38% to 27.4%, a difference of 10.6% (95% CI: 1.3%–19.8%, $p < 0.05$). The percentage of inappropriate referrals from liaison teams did not change significantly.

Conclusion. This piece of work shows that better engagement with referral sources significantly improved the quality of referrals made to ECRHTT. Interventions included medical input at the point of referral, teaching sessions for general practitioners as well as ongoing liaison with referring teams.

Monitoring and investigation of tachycardia in patients receiving clozapine therapy; a quality improvement project

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Aims. Clozapine is an antipsychotic agent with a number of significant physical health risks which necessitate monitoring, including cardiac complications such as myocarditis and cardiomyopathy. Reliable detection of cardiac complications requires active vigilance, with consideration for investigations if serious cardiac side effects are suspected (including electrocardiograms, echocardiograms and blood tests). There was dissatisfaction in the outpatient department about delays to taking action on abnormal physical observations, such as tachycardia. This raised safety concerns about how these delays would limit our ability to investigate and diagnose cardiac complications in a timely manner. We set a project aim to reduce the rate of retrospective action on abnormal physical observations, by half in the 4-month project timespan.

Method. All correspondence sent to the outpatient department from the local clozapine clinic was monitored and assessed for the need for further action or investigation, and the proportion of retrospective action needed was recorded. This was then monitored during implementation of project interventions, to detect any change in performance.

Result. Baseline monitoring showed retrospective action had to be taken on 41.2% of patients attending the clinic with abnormal physical observations, with significant delays up to 51 days later. Our initial intervention was the design of a clinical protocol to guide and signpost clinical staff at the time of the patient's attendance. Unfortunately, due to wider organisational barriers, this was not able to be implemented during the timescale of this project; however increased staff awareness during the protocol implementation process led to a reduction of retrospective action to 26.7%. A follow-up intervention to increase staff awareness and education was carried out, with development of a poster for the clinical room. This approach maintained the improvement, with a further slight reduction to 26.3%, representing a decrease of 37.5% from the baseline rate. A total of 106 patient letters were assessed during the project.

Conclusion. We believe that developing a clinical policy to use at the time of the patient's clinic attendance still remains the optimal intervention; a view backed up by this project's identified drivers for change. However, wider organisational barriers prevented the implementation of this policy, and overcoming these barriers are outside the scope and timescales of this project. This project demonstrated maintained, but sub-target, success with measures that increase staff education and awareness. However, it remains to be seen if this improvement will persist, and this would be a potential target for further QIP or monitoring.