each memory service across the trust. The final numbers that fulfilled the inclusion criteria and analysed were 142. The audit of the collated data was done between July and September 2024. The analysis of the data, including inferences, deductions and diagrams was done using Excel.

Results: Across the trust, patients were given a dementia subtype where possible in 100% of cases. The overall practice in offering medications when indicated was 96% and 10 out of the 15 memory service achieved 100% in this area. There were clear documentations in most areas regarding the rationale for not prescribing medications or switching to another alternative. In the study, mixed dementia was the most common diagnosis by subtype, representing 35% of the data analysed, followed by Alzheimer's dementia with 32% of the data analysed. Only 2 memory services offered Cognitive stimulation therapy (CST) to all the patients who were suitable. 10 teams scored below 40% in offering CST, and 3 teams scored between 50 and 67% for CST.

Conclusion: There was consistency across the Trust in the domain of considering clinical history to make a diagnosis. This good practice extends to the use of neuroimaging, cognitive screening and in some cases neuropsychology to make a diagnosis. A limitation of this study is that the small sample size per service could have limited the representativeness of the audit.

Clinical Audit to Evaluate the Quality of GP Letters From Psychiatry Clinic at TEWV NHS Foundation Trust

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Aims: This audit aims to evaluate the quality of review letters from Psychiatry clinics against standardized practices in clinical communication with General Practices (GPs). The evaluation is based on the guidelines issued by the Royal College of Psychiatrists regarding GP letters in January 2021.

The 10 main domains letters will be judged by are:

1 – Contact details for the psychiatrist.

2 – Venue and date of meeting.

3 – Attending people + care coordinator/Lead professional.

4 – Diagnosis of the patient.

5 – Medications and allergies.

6 – A record of difference of opinion between the patient and the psychiatrist "the consultation".

7 – Mental state examination and risk.

8 – Agreed on Plan that includes (changes in medication + treatment + follow up plan).

9 – User friendly evidence-based information and relevant links.

10 – Copying the patient into the letter/or asked if patient would like a copy.

Methods: The audit was conducted from December 2023 to January 2024. A Medical Secretary compiled 30 clinic letters sent to GP practices over three months, and auditors assessed compliance with Royal College guidelines using specified audit tool parameters. All audit data was collected from service users' letters on the hospital system between September and December 2023.

Results: Good Practice:

100% (green compliance): Psychiatrist contact details, review date, consultation, participants, and agreed plan documented.

97% (green compliance): Venue and diagnosis documented.

93% (green compliance): Medications documented.

Issues Identified:

60% (amber compliance): Care coordinator details included.

70% (amber compliance): MSE included.

50% (red compliance): Risk assessment included.

13% (red compliance): Allergies documented.

23% (red compliance): User-friendly info/links included.

3% (red compliance): Service users copied in.

Conclusion: Based on the audit findings and identified issues, the following actions will be implemented:

Update GP Letter Template: Add sections for Allergies, Risk, User-Friendly Information, and Copying Patients into Letters, adhering to the Royal College of Psychiatrists' January 2021 guidelines.

Standardize Letters: Ensure all prescribers use the updated template to maintain consistency.

Dissemination Plan: Present the updated template during team huddles.

Provide it to new trainees during handovers.

Laminate and place templates in all prescribers' offices for reference.

Distribute the template via email to the team.

Audit on the Recommendation of Exercise by Clinicians in a Community Mental Health Team

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Aims: Determine the proportion of patients who have exercise documented as part of their initial treatment plan. Identify any trends in exercise recommendations across different mental health conditions. Highlight areas for improvement and develop strategies to increase the incorporation of exercise recommendations in clinical practice.

Methods: A retrospective review of patient records from September to October was conducted, focusing on documentation of exercise recommendations in their initial assessment. Data extracted included patient demographics, diagnoses, documentation of exercise advice, type of exercise (if specified), and clinician type. Variations by diagnosis and clinician practice were analysed.

Results: A total of 63 patient records were reviewed and of these only 4 (6.3%) had a documented recommendation of exercise in their care plan. Of these, 2 patients were recommended to go for walks, one to continue with horse riding, there was no specific recommendation noted for the fourth patient.

26 (41%) of the patients had a diagnosis of depression, 16 (25%) of anxiety, 11 (17%) had ADHD and for 12 (19%) patients, there was no diagnosis recorded. 27 (43%) of patients had pre-existing physical co-morbidities. 25 (40%) were seen by a Doctor, 24 (38%) by a

Mental Health Wellbeing Practitioner and 14 (22%) by a Lead practitioner (Mental Health nurse or social worker).
Conclusion: The audit highlights a gap in the integration of exercise recommendations into care plans, despite strong evidence supporting its benefits for mental health, in particular for depression and ADHD. A re-audit will be done in 3 months' time to assess progress after presenting our findings to the team, creating aide-mémoire and relevant resources for staff and patients/carers.

Improving Attendance: Auditing Clinician's Adherence to 'Was Not Brought' (WNB) Policy in Dudley Child and Adolescent Mental Health Service (CAMHS)

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Aims: Non-attendance (DNA) at appointments wastes NHS resources and can indicate potential risk, making it essential for Trusts to have robust policies to safeguard young people and reduce recurrence. As part of the National Health Service (NHS) process, organisations are required to have a 'Was Not Brought' (WNB) policy to address situations where children are not seen. This audit aimed to assess Clinician's adherence with the Trust's DNA/WNB policy and reduce WNB rates.
Methods: The audit was conducted in two cycles, analysing retrospective data from 50 patient case notes (on RIO) using a pre-determined data tool based on the Trust's policy at each cycle.

Cycle 1 (August to October 2023) focused on DNA/WNB appointments and included an analysis of 8 patient survey responses, based on the policy 'Protocol for Managing DNA and Cancellations' in Dudley and Walsall CAMHS.

Following our recommendations, a new policy was drafted, adopted and shared across the Trust.

Cycle 2 (September to November 2024) audited DNA/WNB appointments and incorporated a staff survey (20 responses) based on the new policy 'CAMHS WNB Standard Operating Procedure'.
Results: Audit revealed moderate compliance (over 50%) in documenting DNA/WNB appointments, contacting families, and rescheduling appointments across both cycles.

However, compliance was poor (≤40%) in key areas, such as documenting risk assessments, reviewing case notes, attempting to engage with the child, completing lateral checks, sharing rescheduled appointments with GPs/referrers/other agencies, and obtaining SMS consent for appointment reminders.

WNB rates were 8.3% in Cycle 1 and 9% in Cycle 2.

The patient survey revealed that common reasons for WNB included forgetfulness, lack of awareness of the appointment, and illness. Respondents suggested SMS reminders 48 hours before appointments.

The staff survey showed that 45% were unaware of the updated WNB policy, and 30% did not know about the new messaging reminder system and so were not using it.
Conclusion: Overall, the Trust policy is generally followed for documenting DNA/WNB appointments and rescheduling; compliance remains poor in areas like risk assessments, engaging with the child, and sharing rescheduled appointments with other agencies.

There is a need for improved documentation and adherence to the WNB policy. The Trust should implement a reminder system to update clinicians on policy changes and prioritize messaging to families to improve appointment attendance.

An Audit on Substance Misuse Screening and Documentation in Acute Inpatient General Psychiatry Ward

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Aims: Scotland has the highest drug-related death rate in Europe, with 27.7 deaths per 100,000 people. The average age of drug-related deaths in Scotland has increased from 32 in 2000 to 44 in 2021, with a significant proportion involving multiple substances. According to NICE and Scottish Intercollegiate Guidelines Network (SIGN) guidelines, best practice management for inpatients with co-occurring substance misuse and mental health should involve: Screening and Identification of Substance Misuse, Integrated Dual Diagnosis Care, Pharmacological and Psychosocial Interventions, Harm Reduction Approaches in Acute Psychiatric Wards and Safe Discharge and Aftercare Planning. We have designed a closed-audit loop which has evolved into a quality improvement project to enhance the identification, management, and follow-up care of substance misuse among inpatients in general psychiatry ward at St John's Hospital, Livingston, Scotland. This project seeks to achieve an 80% compliance rate in substance use assessments, implement standardized protocols for managing active substance misuse, and develop a policy for handling patients under the influence, in possession, or distributing substances by December 2025. Data presented in this abstract is for the closed-loop audit part of a larger quality improvement project.
Methods: Data for the initial audit was collected from Trak, the electronic patient record (EPR) system, for patients admitted to and discharged from a mixed acute general adult ward at St John's Hospital, during the period from 13 February to 13 May 2024. Data was collected on documentation of previous substance misuse and substance misuse urine screening. As an intervention, our team introduced staff reminders for biological testing and incentivised staff, patients and carers to provide feedback on substance misuse history, substance misuse on the ward and testing. From 30 October till 30 January, a further cycle was conducted to assess for changes post-intervention.
Results: The closed-loop audit included 84 patients pre-intervention and 49 patients post-intervention. 35.3% had co-morbid schizophrenia/psychosis and a further 24.7% had combined depressive disorder and suicidality. Alcohol misuse was the highest reported substance misuse (33.33%), followed by cannabis (27.03%) and cocaine (11.71%). Post-intervention there was a 35.18% increase in biological testing compliance (post-intervention 57%) and 51.36% increase in substance misuse history documentation compliance (post-intervention 75%).
Conclusion: Substance misuse worsens prognosis for many patients with other mental health co-morbidities. We have identified that compliance is still low for documentation and testing. By identifying gaps in achieving compliance, this project seeks to guide better local