- To follow up on amber results and to identify if the data captured from the previous audit has improved.
- This clinical audit project also reviewed how often community mental health teams and service users met during a patient's inpatient stay.

Methods.

- The audit was conducted at West Park Hospital, Darlington. Information was collated from a consecutive group of female inpatients that were discharged from Elm Ward between 01/02/2021 and 23/03/2021. The audit data collection was performed between 01/05/2021 and 31/05/2021.
- Data were collected retrospectively and was obtained from the inpatient medical records system (PARIS), and input into a designated audit tool.
- Medical records were reviewed for the duration of each inpatient episode, and the criteria and standards above were applied.

Results.

- The data demonstrate that in the vast majority of cases, the ward invited the community team to the relevant meetings during the patient admission (96%) which indicates the improvement in compliance with virtual meetings
- In 100% of cases, there were contacts between the community team through MS Teams or directly through phone or face to face (the number of contacts depends on the length of admission, shown in the figure below)
- The percentage of patients that were offered a written copy of the care plan was observed to have increased when this is compared to the original Audit
- The percentage of patients whose GP doctor was informed also increased to 20%, however, that is still at red remarks

Conclusion.

- An amber compliance rating was assigned to this clinical audit report. High compliance was achieved for evidence of the reason for admission, anticipated risks, and capacity communicated to the ward by the care coordinator/crisis team.
- There is evidence of inviting the care coordinator/crisis team staff to the initial formulation meeting and review/MDT meetings. However, some elements of the Admission, Transfer, and Discharge policy required improvements, particularly in relation to information about expected length of stay communicated to the ward by care coordinators/crisis team staff
- It should be clear who should be responsible to inform the patient's GP within 24 hours of admission
- Still, compliance with offering patients a written copy of the care plan (care document/ intervention plan), is low.

An Audit of Planned Follow-Up Following Discharge From Four Black Country CRHT's

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Aims. It is well established in the evidence base that mortality and suicide risk increases following discharge from an inpatient admission, leading to the national implementation of '72 hour follow-up'. However, there is little data examining outcomes following discharge from an admission to a Crisis Resolution & Home Treatment Team. Following a number of noted Serious Untoward Incidents at a trust level, we sought to examine the standard of follow up post discharge from all four Black Country CRHT's (Dudley, Walsall, Sandwell and Wolverhampton) in order to improve policy and thus patient outcomes.
Methods. The caseloads for all four CRHT's for the period of 1st-31st December 2021 were obtained. The clinical notes system RIO was searched and scrutinised for each patient to determine when the patient's next planned follow-up following discharge from that particular spell in CRHT took place. This was compared to the audits standard: all patients discharged from CRHT should receive some form of planned follow-up in the 3 month period post discharge.
Results. All of the patients discharged from Wolverhampton CRHT received 72 hour follow-up as conducted by members of their own team, however despite this 12% of the total caseload were either lost to long term follow-up or went into crisis before planned follow-up could take place. With regard to Dudley and Sandwell, only 51% and 47% of patients respectively were routinely followed-up within 3 months. A total of 30 patients across all 4 CRHT's went into crisis before planned follow-up took place. One patient ended their life 4 months following discharge from the CRHT; no planned follow-up took place. All of Walsall CRHT's patients were followed up on discharge unless they were discharged directly back to their GP.
Conclusion. Timely, regular and robust follow-up embedded in the community mental health team is paramount to the provision of safe psychiatric care. This audit has also uncovered the need for follow-up for patients discharged from CRHT to their GP, as this cohort of patients is sizeable. However we argue that a one off '72 hour/7 day follow-up' is insufficient when reducing morbidity and mortality, and robust long term care plans and regular follow-up should instead be a feature of longer term community mental health care.

How Satisfied Are Local General Practitioners, Who Are Part of the Brompton and South Kensington Primary Care Networks, With Communications About Patients Referred to the Mental Health Triage and Assessment Team?

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Aims. The Triage and Assessment Team (T&AT) at South Kensington and Chelsea Mental Health Centre have conducted a research project to assess our written communication with General Practitioners (GPs) in primary care. We are responsible for screening and assessing new patients referred by GPs to the South Kensington and Chelsea Mental Health Centre community mental health team (CMHT) department.The aim is to ensure all patients referred from primary care, receive care from the most