- 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

appropriate health professional(s) in the timeliest way and that we communicate with their referrer in a timely and helpful manner. We aim to deliver a service that is safe, effective and helpful to patients, carers and their referrers. The purpose of this study is to understand the referrers' experience of our communications with them when they refer to the T&AT.

Methods. A pre-intervention survey was sent out in November 2022 to GPs who work and are part of the Brompton and South Kensington primary care networks (PCNs).

We received an equal number of responses from Brompton and South Kensington GPs respectively. Quantitative and qualitative data were both collected. We had a cross section of respondents including trainees, salaried GPs and partners.

Results. From the quantitative data, the majority of respondents reported they were reasonably satisfied with our communication with respect to timeliness, clarity and clinical relevance of our communication.

Respondents were less satisfied with the balance struck between clinical detail on the one hand and recommendations for the mental health shared care plan.

A qualitative analysis of respondents all free text comments and identified three main themes: the local referral pathway, the use of SystmOne computer software programme, and recommendations for improving communications between GPs and the T&AT at CMHT.

Conclusion. We have acknowledged concerns about the complex mental health referral pathway together with suggestions about improving the functionality of SystmOne across the GP and CMHT interface into the regular discussions we have with our respective PCNs.

The Triage and Assessment Team are designing improvements to the consistency, timeliness and relevance of our GP communications.

Once these improvements have been implemented, we will send out a post-intervention survey to GPs and reassess their satisfaction levels with our new mode of communication.

A Re-Audit of the Assessment and Management of Patients With Alcohol Use Disorders Following Admission to the General Adult Inpatient Wards in Mersey Care NHS Foundation Trust

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Aims. This re-audit aimed to determine the level of performance in the assessment and management of patients with alcohol use disorders following admission to one of the general adult inpatient wards in Mersey Care NHS Foundation Trust and to determine whether the level of performance has improved compared to the original audit done in 2021 and whether recommendations that were implemented following the original audit have been effective.

Methods. A list of all inpatients on each of the eight general adult inpatient wards in the Trust was obtained. The electronic patient record (on RiO) and electronic prescription card (on EPMA) for each inpatient was scrutinised to obtain the required data. All data were collected retrospectively.

Results. A total of 149 inpatients were identified on the eight general adult inpatient wards. Using specific inclusion and exclusion criteria, 56 of the 149 inpatients formed the final sample. Of the 56 inpatients, 58% were male, 42% were female. An alcohol history was documented in 81% of the 56 inpatients, representing an improvement on the 45% in the original audit in 2021. An average weekly quantity of alcohol for the inpatient was documented in only 8% of cases, a drop from 22% in the original audit in 2021. There was minor improvement in documentation of a CIWA-R score for the inpatient on admission to the ward - an increase from 0.7% in 2021 to 4.0% in 2022. There were improvements on gamma GT and serum Magnesium level being checked on admission for the 2022 audit cohort compared with the 2021 audit cohort. There was also an improvement on referral of the inpatient to community alcohol services - 3% in the 2021 audit vs 7% in the 2022 audit.

Conclusion. The findings from this re-audit indicate an improved level of performance in assessment and management of patients with alcohol use disorders following admission to the general adult inpatient ward since the original audit in 2021. Recommendations from this re-audit are: ensuring that taking and documenting a thorough alcohol history is included in the induction for junior trainees, the provision of education and training to both medical and nursing staff on the wards in using the CIWA-R to assess level of alcohol withdrawal and producing a flow chart on the assessment and management of alcohol use in patients following admission to the ward that can be displayed in the Treatment Room on each ward and in the Junior Doctors' office.

Antipsychotic Dose Reduction for Patients With Behavioural and Psychological Symptoms of Dementia in the Well-being Clinic of a Community Mental Health Team for Older People

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Aims. To evaluate the usefulness of the "Well-being Clinic", a specialized service aimed at reducing the dose of antipsychotic medication prescribed for patients with behavioural and psychological symptoms of dementia (BPSD). The aim of the service was to have a sustained reduction of at least 50% of the antipsychotic dose in at least 50% of the sample size.

Methods. A retrospective quantitative study was performed, looking at the 6 month period between August 2022 and January 2023. Two data parameters were obtained. One, the percentage of reduction of the antipsychotic dose for each patient. Two, the number of reviews done for each patient over the specified time period.

Results. Out of a sample size of 21 patients prescribed antipsychotics for BPSD, only 1 (5%) had a sustained reduction of at least 50% of the antipsychotic dose. 2 (10%) had a dose reduction of less than 50%, 14 (67%) had no change and 4 (19%) had a dose increase.

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