Conclusion. The recommendations from initial audit were compared with the second audit, and whilst some of them were completed such as incorporating growth chart in the electronic records system, some ongoing challenges were identified. Positive and negative findings were both noted although the final conclusions lies in favour of good changes been made to service including the caseload becoming more ID specific in this age group.

If at First You Don't Succeed, Try, Try Again? Antipsychotic Trials and Clozapine Provision in Glasgow's Esteem (Early Intervention in Psychosis) Service

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Aims. To support evidence gathering for Esteem's RCPsych Early Intervention in Psychosis (EIP) network accreditation efforts, an audit was conducted to investigate compliance with EIPN's quality standards (QS) no. 33 and no. 36.

EIPN QS 33 = patients with first episode psychosis (FEP) are offered antipsychotic medication.

EIPN QS 36 = If the patient's illness does not respond to an adequate trial of two different antipsychotic medicines given sequentially, they are offered clozapine.

EIPN QS 36 is also specifically included in RCPsych's National Clinical Audit of Psychosis (NCAP) (listed as standard 4), but a more pragmatic definition is used, to factor in the issue of antipsychotic intolerance.

NCAP Standard 4 = People with FEP who have not responded adequately to or tolerated treatment with at least two antipsychotic drugs should be offered clozapine (NICE QS80).

This broader standard definition was used for this audit, to allow for results comparison with national data.

Methods. For EIPN QS 33, all patients on North East Esteem caseload (any primary diagnoses) for at least 6 months on 01/04/2023 were included.

For EIPN QS 36/NCAP Standard 4, the same inclusion criteria were used but refined to FEP cases only.

The electronic clinical records (EMIS) of such cases were reviewed manually by an ST5 and CT3 psychiatrist. Data on prescription history was collected then analysed in Microsoft Excel.

Results. EIPN QS 33: 58 patients with any primary diagnosis were initially identified as being on NE Esteem caseload > 6 months as of 01/04/23. 58 (100%) patients were offered antipsychotic medication · 1 (2%) patient was prescribed an antipsychotic but never took it · 21 (36%) patients were only ever prescribed one antipsychotic · 17 (29%) patients were prescribed two antipsychotics sequentially trialled · 11 (19%) patients were prescribed three antipsychotics sequentially trialled · The remainder, 8 (14%) patients, had four or more antipsychotics sequentially prescribed (with the maximum number of trials being eight).

EIPN QS 36 / NCAP Standard 4: 55 patients with FEP diagnosis were initially identified as being on NE Esteem caseload > 6 months as of 01/04/23. 16 (29%) of these patients had at least three or more trials of antipsychotic medication, i.e. patients eligible for clozapine. However, only 5 (31%) of these 16 patients had either been prescribed clozapine (3 patients, 19%) or offered/trialled clozapine (2 patients, 13%). This 31% figure compares with 85% in Wales, 52% in England, and 50% in Ireland (NCAP 2021–22).

Conclusion. EIPN QS 33: The standard that patients with first episode psychosis are offered antipsychotic medication was fully met. About a third of patients required only one antipsychotic trial. Less than a third required two antipsychotic trials. One in five required three antipsychotic trials, and approximately one in seven patients required more than three antipsychotic trials.

EIPN QS 36/NCAP Standard 4: The number of eligible patients being offered or prescribed clozapine for first episode psychosis under care of NE Esteem falls well below NCAP averages for Wales, England and Ireland.

Audit of the Use of Outcome Measures Within Child and Adolescent Mental Health Outpatient Services in Rotherham, Doncaster and South Humber NHS Foundation Trust

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Aims. Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) has 28 Promises as part of its Strategy.

Promise 16 is to: *Focus on collating, assessing and comparing the outcomes that our services deliver, which matter to local people, and investing in improving those outcomes year on year.*

This audit in November 2023 looked at the practice of using outcome measures for CAMHS patients in order to highlight areas of development for the service to work toward achieving the promise.

Methods. We wanted to understand if young people were having outcome measures completed and if so, when, what and how often. We achieved this by using a dip sample of five patients each across the three different localities (Rotherham, Doncaster and Scunthorpe).

A report was generated to include all patients discharged from CAMHS in the preceding three months to September 2023. Young people who had been with the service less than six months were excluded from the audit. Five patients were chosen randomly from each locality and their electronic patient record on System One was studied.

Information in the patient records was compared against the audit standards and recorded in Excel so the data could be analysed.

Results. The results showed that 11 of 15 young people had an outcome measure completed at some point during their episode of care. All five young people in Scunthorpe had an outcome measure recorded in their clinical records however this tended to only happen at the very start, meaning there was no basis for comparison. Four out of five patients in Doncaster had outcome measures in the clinical record and these were undertaken throughout the episodes of care. In Rotherham, two of five young people had outcome measures recorded in the clinical records.

The most frequently used outcome measure was the RCADS but the SDQ was also used.

Conclusion. There is work to be done to ensure the use of outcome measures becomes routine, and also to standardise both the type and frequency of use. The Trust is aiming to increase their use by utilising SystmOne's capabilities to interface with service user mobile devices to send out outcome measures to patients. There is also a plan to inform staff within the service about the expected use of outcome measures. This audit will be repeated in 2024 to see if the Trust are moving closer to delivering their promise.

An Audit on Telephone Referrals to Beechcroft, a Step 5 Regional Child and Adolescent Mental Health Inpatient Unit

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Aims. To audit telephone referrals to Beechcroft inpatient unit.

Beechcroft inpatient unit is a step 5 regional child and adolescent mental health inpatient unit in Belfast. It receives a large volume of referrals from across all five health and social care trusts in Northern Ireland. The process of referral to Beechcroft can vary between trusts and clinicians; the majority of admissions are emergency. The demand for beds has risen by 30% since 2019. Emergency admissions are commonly telephone referrals whilst others submit written referrals. The referrals process is managed by the ward sisters, as there is no bed manager post. Referrals are discussed with a consultant psychiatrist.

Referrals received often lack key clinical information, which makes decisions around appropriateness of admission or prioritising multiple referrals difficult. Furthermore, as the admitting doctor relies on this information, missing clinical information could result in patient safety issues.

Methods. 24 telephone referrals were recorded between August to December 2023. 5 referrals were excluded for either no request for a bed (3) or telephone update following previous written referral (2). 19 telephone referrals were analysed across 7 different criteria as below, based on necessary information.

Criteria 1 Patient identifiable information
Criteria 2 Source of referral/referrer details
Criteria 3 Current location of patient
Criteria 4 Legal status
Criteria 5 Presenting symptoms
Criteria 6 Working diagnosis
Criteria 7 Risks warranting admission

Results.	Yes	No	%Yes
Criteria 1	19	0	100
Criteria 2	19	0	100
Criteria 3	13	6	68
Criteria 4	14	5	74
Criteria 5	18	1	95
Criteria 6	2	17	11
Criteria 7	15	4	79
Total	**100**	**33**	**75.2**

Patient identifiable information and source was documented in all referrals. Only 10% of referrals included a working diagnosis. Location of patient, legal status and risks warranting admission were documented between 68 and 78%.

Conclusion. Crucial information such as working diagnosis was missing in 90%. Risks or legal status missing in up to a quarter of referrals. This has an impact on timely access, bed flow and potentially patient safety.

A need for improvement in receiving and documenting telephone referrals has been identified. To aid improvement in patient safety and flow, a bed manager for in hours has now been appointed. A standardised proforma for recording data will be developed by inpatient staff in collaboration with community staff to include the above criteria. A re-audit will be carried out following these service improvements.

Monitoring of Sodium Valproate Annual Risk Assessments Within Psychiatric Services

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Aims. To determine the number of patients within a service on sodium valproate for a psychiatric condition who have updated Annual Risk Acknowledgement forms in place.

Methods. It was firstly identified that within the NICE guidelines, it is recommended that all patients who are on sodium valproate should have an annual signed risk acknowledgement form in place. Following this, a list of patients was compiled who were currently prescribed this with the local area. Each patient was then checked to see if the valproate was prescribed by psychiatry or by neurology. This was then further divided into general adult and learning disability patients.

From this, a list of patients under the care of general adult psychiatry was compiled. The notes for these patients were obtained.

Data collection was then carried out. Each set of notes was reviewed by two individuals for the following:

1. To identify if an annual risk assessment form was carried out.
2. To check if this was within expiry date.
3. To identify patient diagnosis.
4. To identify the dose of sodium valproate.
5. To confirm if these patients were females of childbearing age.

Results. From the initial audit cycle, it was identified that 28 female patients who fell within the inclusion criteria were on valproate, and of these, 6 had forms in place. Of the 6 with forms in place, 50% had expired so needed to be replaced. 17 had no form in place, and for 4 patients it could not be certain if forms were present or not due to unavailability of records. Only 3 patients therefore had the correct form in place which were within expiry date. If we discount those with no data available, only 12% of patients had the correct annual risk acknowledgement form present and within expiry date.

Following the initial audit, two interventions were carried out:

1. The data from the above audit was presented at a consultant meeting, highlighting the importance of ensuring these forms are kept up to date.