affray. Diagnoses included learning disability, delusional disorder, paranoid schizophrenia, bipolar affective disorder, alcohol dependence, personality disorder and depressive disorder.

Patients had multiple comorbidities such as diabetes, COPD, hypertension, coronary artery disease and musculoskeletal problems. Out of the nine admitted patients, only six had an ACE with an average score of 70.83. Five patients had brain imaging, with two normal results and the others showing some degree of atrophy and ischemic changes.

Discharge destinations included medium secure units, low secure unit and prison. One patient unfortunately died during admission and four are still inpatients.

A staff survey conducted showed their perspective on the challenges in managing elderly patients and whether Wathwood Hospital had the appropriate resources for them to work with elderly offenders in their area of work. All results will be explained through tables and graphs.

Conclusion. It's evident that there are challenges in managing elderly patients in units not specifically designed to manage them. This is also due to the lack of geriatric training and resources available to allied health care professionals to carry out their respective work. It's therefore crucial we formulate more inclusive strategies to address these challenges.

The use of antipsychotic polypharmacy at Ravenswood House Medium Secure Unit: the extent of use and reporting of outcomes

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Aims. To evaluate the use of antipsychotic polypharmacy in Ravenswood House Medium Secure Hospital. We also aimed to review the reporting of the outcomes of their use.

Background. The use of antipsychotic polypharmacy (APP) continues to be practised within forensic psychiatric inpatient settings yet there is a lack of robust evidence for the benefits of doing so. The practice is also associated with the use of higher total antipsychotic doses beyond the recommended BNF maximum. Such prescribing is associated with an increased side effect burden. Doctors have a duty to justify the ongoing use of antipsychotic polypharmacy and to avoid potentially ineffective and/or harmful use.

Method. A cross-sectional review of the medication cards for 51 in-patients at Ravenswood House Hospital was completed. Demographic data and data pertaining to diagnoses and medication was also gathered from the electronic patient records.

Result. 23 patients (45%) in Ravenswood House Hospital were prescribed antipsychotic polypharmacy. 87% of those prescribed antipsychotic polypharmacy had a primary diagnosis of either schizophrenia or schizoaffective disorder. 19 patients (37%) had two regular antipsychotics prescribed. 74% of these prescriptions were above the recommended BNF maximum. 62% were also prescribed a regular benzodiazepine. The vast majority of indications documented for APP were chronic behavioural disturbance and treatment resistant schizophrenia. The majority of these patients were on a T3. There was a significant under reporting of the rationale of prescribing APP. It could be surmised that at least 11 combinations were in part to mitigate side effects, but only 3 had this documented. There was also a lack of documentation or use of rating scales regarding the clinical outcomes and side effects of APP.

Conclusion. Prescription of antipsychotic polypharmacy is an important issue in secure forensic hospital settings. The lack of clear documentation of clinical effectiveness and side effect burden remains a concern. Wider study is required to establish the benefits of such prescribing to justify its ongoing use.

Capacity and consent to treatment – how well did we do?

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Aims. An audit on capacity assessment and consent to treatment on inpatient visits to Atherleigh Park Hospital was performed using the Mental Health Act Code of Practice as a framework. Six standards were evaluated:

1) documentation of capacity assessment in patient care records
2) documentation of patients who display a lack of capacity
3) completion of a Section 58 and/or 62 for detained patients
4) documentation of medicines on T2/T3 form and if they match with the patient's prescription chart
5) evidence of medication concordance and monitoring of adverse side effects
6) patient education on medicines prescribed for them

Method. Inclusion criteria included patients who were detained under Sections 2, 3 and informal admissions, who were admitted for 72 hours or more, between October and December 2019. This gave a total sample size of 75. Data were collected by looking at patients' care records and if applicable, their Section paperwork to identify any documentations related to the standards evaluated as above. Data collected were transcribed to a web link, downloaded and analysed.

Result. In standard 1), it was found that 77% of the capacity assessment and consent to treatment forms were recorded in patient care records. Of these, 100% of were completed by a medic and 99% of all sections in the form were completed. However, only 57% of patients were re-assessed when their capacity and consent changed during admission. In standards 2), 3) and 4), documentation of patients who lacked capacity, completion of a Section 58 or 62 form and charting of medications on the T2/T3 forms were fully compliant. In standards 5) and 6), 76% of medication concordance were documented in patients' records. Only 39% of adverse effects from medications were documented but monitoring compliance was 100%. Medication counselling was done infrequently, with 47% of patients given a leaflet and 28% educated on their side effects.

Conclusion. Action plans were identified. Firstly, to link the capacity assessment form with patient electronic ward round notes to ensure clinicians complete it at the end of a review. In order to monitor adverse effects from medications, physical examination, blood tests and ECG are to be done following a new prescription, and to be repeated if indicated. Information leaflets on common psychiatric medications are to be made readily available for patients. The findings from this service evaluation and the actions plans were shared with doctors. A re-audit is vital to re-evaluate the hospital's compliance.

Experiences of psychiatrists assessing under 18s on an "all age" rota. An evaluation of the current service

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Aims. Gloucestershire Health Care Trust operates an "all age" out of hours on-call rota, staffed by Registrars and Consultants who cross-cover all psychiatric sub-specialities. Our aim was to understand the challenges faced by psychiatrists of different professional backgrounds when assessing under 18 year olds in a health-based Place of Safety (POS).
Method. We circulated a survey to all psychiatrists on the on-call rota, to gather quantitative and qualitative information on the challenges posed by assessments of under-18s in a POS and assess whether an under-18 specific policy was needed.
Result. Out of the 50 psychiatrists invited, 27 completed this survey (during February 2021). 33.3% of respondents reported that they had completed a POS assessment of an under 18-year-old when a Consultant Child and Adolescent Psychiatrist/Registrar was not available to join. 33.3% of respondents had been asked to complete such an assessment as the sole psychiatrist joining the AMHP, with 24% of those respondents reporting feeling uncomfortable doing these assessments without a second doctor present, and an additional 24% feeling comfortable only sometimes. 48.1% of the doctors surveyed did not invite parents or carers to take part in the assessment, despite this being considered best practice, citing reasons such as: being unaware that this was a possibility, assessments conducted at unsociable hours, safeguarding concerns involving the parents, and social distancing in the context of COVID-19. 41% of respondents had assessed vulnerable young people (children looked after or with a diagnosis of an autism spectrum condition) in the POS and reported that these assessments posed significant challenges to safe discharge planning and identifying appropriate placements. 81.5% felt that a tailored policy for young people was needed. Qualitative findings suggest psychiatrists think such a policy should include clear procedures (flowcharts), potential outcome scenarios/options for safe discharge, referral criteria for CAMHS, contact details for key staff members, a handover protocol. Respondents felt a shared policy with all stakeholders (AMHP service, Mental Health Services, police) was required.
Conclusion. Our survey highlights the challenges for non-CAMHS specialists assessing under 18s in a health-based POS and the need for an under-18 policy to support safe practice. Major themes will be further explored in a focus group to guide policy development.

Assessing DNA rates within first time psychiatric referrals and the extent to which DNA rates are reduced by an SMS reminder service

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Aims. 1) To assess the average wait time for patients to be offered an appointment and to establish any correlations between longer waiting times and 'Did not attend (DNA)' rates 2) To assess the number of patients who have opted into the text message appointment reminder service and whether this had an effect on DNA rates.
Background. Research has indicated that the Did Not Attend (DNA) rate in Psychiatry is estimated at 20%, twice that of other medical specialties (1). With NHS Digital estimating that DNAs cost the NHS £1 Billion per annum, there has been much interest in reducing the rate of DNAs within Psychiatry (2). Findings have shown that short waiting times are associated with higher rates of attendance (3). In addition, poor appointment attendance within Psychiatry is also associated with increased disease severity and higher rates of hospital admission (4).
Method. We conducted retrospective data collection on 99 patients referred to Professor Oyebode between January 2018 and August 2019. Our data collection involved assessing time the referral was received, time to first appointment and the patient's communication preference (e.g. whether they opted in to the SMS alert service). All data collection was conducted through use of RIO and coded/ammonized into a Excel spreadsheet. No sampling methods were employed and our population only consisted of first-time referrals to Professor Oyebodes clinic.
Result. 1) We found no correlation between a longer waiting time to first appointment and an increased DNA rate.

2) All patient waiting times between 1st January - 31st August were within the maximum limit set by national guidelines

3) Opting into the text messaging service remains severely low. Of the patients audited, 95% had not completed a communication preference form. Overall, it is still unclear whether the text messaging service has a positive impact on DNA rates.
Conclusion. Our data have shown no significant correlation between a longer waiting time and an increased DNA rate for first time Psychiatry appointments. Secondly, we have concluded that between the audited period, waiting times were still within the maximum 18 week wait set by the Mental Health Standards. Finally, we can conclude that uptake of the text messaging service remains very low at 4%. Due to a limited sample size of only 4 patients, it is still unclear from this audit whether opting into the text messaging services will have a positive decrease on the number of DNA's.

'Foreseeing well-being': developing a physical health strategic vision across a large mental health trust 'foreseeing well-being': developing a physical health strategic vision across a large mental health trust

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Aims. Statistically, suicide is less than half as deadly as poor physical health for people with severe mental illnesses (SMI). For every 1000 SMI patients, diseases such as diabetes cause 10-20,000 'years of life lost' compared to 4,000 'years of life lost' to suicide. National charity Rethink dubbed the failure of the NHS to act on this as tantamount to "lethal discrimination".

We aim to reform the physical health care provision for service users under the care of Avon and Wiltshire Mental Health Partnership NHS Trust (AWP).
Method. To evaluate the current service within AWP, we combined data from a comprehensive audit of 106 inpatients, local Quality Improvement (QI) Projects, and qualitative feedback from a pilot Medical-Psychiatric Liaison Service (MPLS).