13/20 staff questionnaires were completed. It showed most staff did not have formal training in managing comorbid ASC and ED, and confidence and skills varied in proportion to time and experience in the service. All staff members expressed they would like formal training, through sessions such as monthly training, weekly huddles, or psychoeducation.

Conclusion. A significant proportion of inpatients have comorbid ED and ASC. Therefore, awareness of potentially greater needs around communication, environment, and sensory hyper- or hyposensitivity is important. There is a risk of diagnostic overshadowing as both ED and ASC can mimic similar symptoms: cognitive rigidity, fixation on certain things etc. So while not straightforward it is important to differentiate which symptoms are due to ASC and which are due to ED. Leveraging resources from the PEACE pathway website, both staff and patients can enhance their understanding of this complex comorbidity.

A Clinical Audit of the Assessment and Management for Those Diagnosed With Young Onset Dementia Within the Shepway CMHSOP

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Aims. To audit the Shepway CMHSOP against the NICE guidelines in dementia and the Royal College of Psychiatrists recommendations for service provision in young onset dementia.

Methods. Data was collected retrospectively for all patients open to CMHSOP within the last 2 years with a diagnosis listed as dementia under the age of 65 years old.

Results. The work up prior to diagnosis met some standards but improvements could be made in other areas. Mood was considered in all patients. The majority of patients (89%) had young onset blood tests if there was a clinical indication. However physical examination was only carried out in 43% of patients. In addition to this where physical examination was completed it was often limited to a brief note about the patient's gait and tremor.

Imaging standards were met within the Shepway CMHSOP with all patients having a scan, some patients being referred for additional specialist scans where indicated. There is also a neuroimaging MDT in which scans can be discussed with a neuro-radiologist.

The follow up care and support was an area that needs further development within Shepway CMHSOP. There is no named lead for those diagnosed with young onset dementia. Furthermore, only half of patients received a named practitioner to support their care. In addition to this only 79% were offered cognitive stimulation therapy and post diagnostic support which incorporate education for the carers. It is difficult to know if these options were discussed and declined by the patients, but if this is the case it would have been good practice to document.

Conclusion. The time from referral to diagnosis was similar in those with a dementia with a well established and clear subtype (Down syndrome) to those diagnosed with other types of young onset dementia, 6 months and 5.5 months respectively.

My audit identified areas for improvement in the workup to diagnosis and the aftercare to support those diagnosed and their carers in order to meet NICE guidelines and the Royal College of Psychiatrists recommendations for service provision in young onset dementia.

Shepway CMHSOP will develop a young onset dementia pathway to ensure those diagnosed are offered the appropriate investigations and support following their diagnosis in line with these guidelines.

Outcome Measures in Mental Health – RCPsych Report and Working Group Survey

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Aims. Outcome measurement is central to transforming mental health care by quantifying change, enabling comparison and driving improvement. In recognition of this, the Royal College of Psychiatrists (RCPsych) has established a *working group on outcome measures*, led by an Associate Registrar.

To support routine outcome measurement capture in clinical services, RCPsych has developed the 'Outcome Measurement in Psychiatry' report.

The working group intends to launch a survey of Members to:

1) Understand psychiatrists' current use of outcome measures.
2) Understand psychiatrists' views on barriers and facilitators to the use of outcome measures.
3) Get feedback on the College Report.

Methods. The 'Outcome Measurement in Psychiatry' report was developed with input from all RCPsych Faculties and is scheduled for publication prior to the RCPsych International Congress.

Feedback will be sought on the 'Outcome Measurement in Psychiatry' report about whether the guiding principles are right, and if the College should be endorsing specific measures or advocating for the routine use of outcome measures. This will be used to guide future revisions of the report.

The working group believes the proposed survey will enable it to explore the facilitators and barriers to routine outcomes data capture both locally and nationally, including:

- how to consider organisational drivers and buy in of clinical staff
- digital enablement
- understanding time points in a chronic relapsing remitting condition in the community vs. episode of therapy or hospital admission
- clinical burden/benefit and buy in
- training.

An invitation to participate in the survey will be sent to all College members and advertised via social media, at the International Congress. Analysis will be via descriptive summary of quantitative data and a thematic summary of any free text data.

Results. The group intends to use the intelligence gather to inform, influence and shape policy that promotes routine outcome data capture and publish its findings for wider dissemination.

Conclusion. Outcome measurement is a top priority for the RCPsych. A new Associate Registrar and working group is

spearheading the College's work in this area, publishing guidance and conducting further research. Engagement and learning from our colleagues would provide critical intelligence to inform and influence future policy and strategy to enable routine outcome gathering embedded in mental health services.

Improving Outcomes in Alcohol Withdrawal; an Alcohol and Drug Liaison Outreach Approach

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Aims. This project's purpose was to improve the identification and management of patients at risk of or suffering from alcohol withdrawal at the point of admission. Ultimately aiming to prevent avoidable harm to patients and reduce the burden on local services within NHS Ayrshire & Arran.
Methods. The project began in August 2023 with Alcohol & Drug Liaison Nurses (ADLN) carrying out twice daily walkthroughs of the Emergency Department and Combined Assessment Unit. ADLNs were instructed to engage with these clinical teams, helping to identify those at risk, provide management advice and accept relevant referrals. A retrospective audit was completed covering patients referred to the alcohol and drug liaison team (ADLT) in July 2023 and a prospective audit covering October 2023. Quantitative data gathered included prescription of benzodiazepines & Pabrinex, time from admission to prescription and administration of treatments, any changes to treatment advised, and whether treatments administered correctly. Additional qualitative data was gathered through a short staff survey carried out in November 2023 asking if the project had been helpful in identifying patients, improving management, and making staff feel supported.
Results. There was a 33% increase in referrals from July (n = 15) to October (n = 20), with a slightly greater proportion coming from ED (80% vs 85%). The average time from admission to benzodiazepine prescription fell by 2hrs and to administration by 8hrs. However, changes were advised to benzodiazepines prescriptions more frequently (12% increase).

Pabrinex prescriptions were being completed overall for patients both before (92%) and after (100%) the project. Average time from admission to pabrinex prescription fell by 2hrs but to administration increased by 0.5hrs. Additionally, cases of incorrect pabrinex administration increased from 31% to 47% between the two periods.

Staff feedback was very positive; project was very (45%) or somewhat (35%) helpful in identifying patients at risk, very (30%) or somewhat (50%) helpful in managing alcohol withdrawal, and very (55%) or somewhat (20%) helpful in making staff feel more supported with this patient group.
Conclusion. This project demonstrated that additional support can improve identification of patients, speed of initial management decisions, and staff confidence. However, it also showed a significant knowledge/skills gap across both departments leading to continued problems with patients receiving timely and appropriate treatment. ADLN ward input cannot be continuous, as such practical changes are required to help maximize Liaison input. Following this project's recommendation, work has begun to develop an Alcohol Withdrawal Bundle and associated staff training.

Cambridgeshire Lifespan Autism Spectrum Service Clinic: Managing Demand, Capacity and Flow of Referrals for Adult Autism Assessment

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Aims. Referrals for adult autism assessment to the Cambridgeshire Lifespan Autism Spectrum Service (CLASS) have increased from 430 in 2019 to 887 in 2023, with demand exceeding capacity. The team enrolled in the Royal College of Psychiatrists' Quality Improvement (QI) Demand, Capacity and Flow (DCF) Collaborative. The agreed aim was to increase the number of diagnostic assessments by 51% per month.
Methods. Participants included the CLASS multi-disciplinary team (MDT), referrers, the provider improvement advisor and an autistic adult. Using the NHS Quality Service Improvement and Redesign (QSIR) six-step approach, a process map identified five key stages of the CLASS pathway. A project driver diagram was then used to identify change ideas in the referral, screening, pre-assessment, assessment and post-diagnostic stages.

Change ideas in the screening and assessment stages were prioritised and two Plan-Do-Study-Act (PDSA) cycles designed: PDSA 1) To reduce screening time by removing the first screening of referrals; PDSA 2) To increase the number of assessments conducted and completed in a single face-to-face appointment.

Data collected for PDSA 1 included: number of working days from date of referral to date added to waiting list and total screening time (minutes) per referral. Data were compared in a sample of 133 referrals from the two-stage screening process and 68 referrals from the one-stage process. Data collected for PDSA 2 included: average assessment time (minutes), average duration of open assessments, and the number of assessments completed within the same month. The data at Time 1 (before introducing PDSA 2) were compared with Time 2 (after PDSA 2) in a sample of 10 and nine referrals, respectively.
Results. PDSA 1) Statistical Process Control (SPC) charts show a reduction in mean working days from 160 to 30 working days. The mean screening time per referral reduced from 33 minutes to 23 minutes. PDSA 2) SPC charts show that between Time 1 and Time 2 there was (i) a reduction in clinician time in minutes per assessment (m = 236.8 to m = 210), (ii) a reduction in working days assessment remained open (m = 39.4 to m = 6.4), (iii) a reduction in number of assessments involving multiple appointments (6 of 10 to 3 of 9), (iv) an increase in the number of assessments completed in the same month (3 of 10 to 7 of 9).
Conclusion. These results show promise towards increasing DCF across the pathway, but further PDSAs (e.g., digitalising reporting, refining the post-diagnostic pathway) need to be implemented to achieve the overall aim.