appointments. An easy-read version was also sent to promote accessibility amongst the patient group. The data was collated and reviewed.

Results. Most common reasons for patients not attending their psychiatry outpatient clinic appointments under the CTPLDW team were identified:

2022: 35 patients DNA – 28.6% citing communication/correspondence issues.

2023: 30 patients DNA – 33.3% citing communication/correspondence issues.

Additional reasons for non-attendance included issues with residential homes, sickness and transport.

Conclusion. An anecdotally high number of DNAs were noted by CTPLDW. The data collected thus far has helped us to define and understand the issues. The main factors identified revolve around communication and correspondence of appointment times.

The next step in our quality improvement project is to trial text reminders for patients and carers to assist in remembering appointments, to assess whether this change idea helps to decrease the number of DNAs.

Future change ideas include development of resources to support attendance (e.g. adjusted appointment letters with QR codes for access/maps, reminder letters in easy-read format and video tours).

CTPLDW would like to offer a more personalised approach with a service that promotes reasonable adjustments and reduces barriers to access, thereby reducing the number of DNA appointments.

Benefits & Barriers: Improving Medical Handover in a Psychiatric Hospital

Dr Nina MacKenzie[1]*, Dr Callum Cruickshank[2], Dr Ewan Mahony[2], Dr Jessica Parker[2] and Dr Robyn Canham[2]

[1]NHS Education Scotland, Edinburgh, United Kingdom and [2]NHS Lothian, Edinburgh, United Kingdom

*Presenting author.

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Aims.

Background: Handover aims to achieve the efficient communication of clinical information when responsibility for patients is transferred. The Royal Edinburgh Hospital (REH), a specialist hospital serving the Lothians, has repeatedly received "red flags" (ranked in the bottom 2% of benchmarked areas) on the handover section of the Scottish training survey (STS) and GMC national training survey of doctors in training (DiT).

Aims:

- Survey DiT to understand their experience of handover.
- Introduce a new structured handover process.
- Re-audit parameters after intervention.

Methods. Data from REH DiT were extracted from an anonymised handover survey, disseminated to all psychiatry DiT in Scotland in January 2023. Multiple choice and free-text questions covered handover timings, format, structure, and attendance. The survey was repeated after intervention. In addition, data from the STS were analysed. The intervention consisted of altering shift times to include protected time for handover, introducing a dedicated room, training in the use of an electronic system to record tasks, involvement of senior doctors, and dissemination of the new changes to procedure.

Results. A total of 12 survey responses (25% response rate) pre-intervention (25% FY2s, 17% GPSTs, 58% core trainees) and 14 post-intervention (14% FY2s, 14% GPSTs, 71% core trainees) were analysed. The proportion of respondents reporting that handover always happened at times of shift change increased from 7% to 93% post-intervention. The proportion of those reporting that there was protected time for handover rose from 0% to 50%, and the use of a predetermined structure/format increased from 0% to 43%. After intervention, 86% of DiT felt adequately supported during handover (compared with 17% pre-intervention) and 93% of respondents felt handover 'allowed for the efficient and effective transfer of information to protect patient safety' (33% pre-intervention). Prior to the process change, 83% of DiT felt there was no clear senior leadership at handover; this fell to 21%. Post-intervention the use of WhatsApp/texts to hand over information fell by 100%. The new system was welcomed by trainees, but teething problems were identified.

Conclusion. The new process led to improvements in the frequency, consistency, format, recording, and senior support of handover. Issues with the use of video call software and electronic medical records systems have been identified, and work is ongoing to address these in an iterative quality improvement process. Good clinical handover benefits patients (fewer mistakes and increased safety, better continuity of care, improved satisfaction) and clinicians (improved communication skills, increased accountability, feel more informed, improved job satisfaction).

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.

Fitness to Drive Policy in Inpatient Setting: Findings of QI Project

Dr Sajid Mahmood*, Dr Heba Radwan, Dr Omotilewa Omotoso, Dr Waqqas Khokhar and Dr Nosheen Shams

Leicestershire Partnership NHS Trust, Leicester, United Kingdom

*Presenting author.

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Aims.

Background:

Nature and degree of mental illness can impair abilities of patients to drive safely which puts their own safety and safety of others at risk. There is also an ongoing concern of patients not being properly informed on their duty to inform the DVLA and potentially to stop driving for an extended period.

Aims:

1. To assess if risk assessment of patients in term of driving status was completed at time of admission, during their stay on ward, and if any advice regarding fitness to drive was given at time of discharge.
2. To improve patients being asked about driving status on admission to 100% of patients.
3. To improve rates of service users being informed of the DVLA guidance following a mental health illness to 100% of patients.

Methods. It is a Quality Improvement (QI) project. Baseline information on current practices were assessed against local fitness to drive policy of Leicestershire Partnership NHS Trust in

May 2023. Data was collected from 10 inpatient (6 general adult & 4 old age) wards. All patients who were discharged in the month of January 2023 were included for audit. Information was collected about driving status of patients at time of admission, during their stay on ward, and if any advice regarding fitness to drive was given at time of discharge. Data was recorded anonymously. Results are reported in percentages for descriptive statistics.

Results. Risk assessment was completed in 95% of patients on admission. About 12% (15/128) of the patients were driving at the time of admission, 80% of them were female. Assessment of driving risk during admission only took place in 11.7% (13/128) of cases. Advice on fitness to drive at time of discharge was given only in 12.5% (16/128) of cases. About ¼ of patients who were driving at time of admission, did not receive advice on fitness to drive at time of discharge from hospital.

Conclusion. There is a huge gap in clinical practice regarding compliance with fitness to drive policy. There is an urgent need to improve awareness among mental health teams that they have a role with regard to assessment of their patients' risks and fitness to drive. An educational training video will be prepared and shared with clinicians in December 2023 to fill gaps in the service. Further information will be collected on practices related to fitness to drive policy in March 2024 for further evaluation of services.

Thematic Analysis of Coroners' Prevention of Future Deaths (PFDs) Reports in Mental Health Related Suicide

Dr Dean Manning[1,2]* and Dr Shweta Mittal[1]

[1]Nottinghamshire Healthcare NHS Foundation Trust, Nottingham, United Kingdom and [2]Sheffield Health and Social Care NHS Foundation Trust, Sheffield, United Kingdom
*Presenting author.

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Aims. To identify professional and organisational-related themes in Coroners' PFDs reports which contributed to mental health related suicide.

Methods. We reviewed Coroners' PFDs reports via the UK Judiciary website. We filtered reports by those which were mental health related deaths and included the keyword 'suicide'. 100 reports were reviewed starting with the most recent which was August 2023. We reviewed which Coroner's area the reports originated from and the age and gender of the deceased. Then, we examined the contents of the PFDs reports including the inquest conclusion, circumstances of death and concerns raised by the coroner. Themes were identified and grouped into patient-related, professional-related, and organisational-related factors that may have contributed to the death by suicide.

Results. Reports were reviewed from across the UK. The highest number of reports were from the coroner area of Manchester South (12%).

From those reports whereby the deceased's age was mentioned, the mean age was 36 with an age range of 14–81 years (35% of reports did not include the deceased's age).

61% of reports were of males and 39% females.

The main professional-related factors identified from thematic analysis of the PFDs reports were issues around risk assessment and management (45%), lack of interprofessional communication and collaboration (33%), inadequate clinical queries/assessment (25%), lack of consultation of family/carers (17%) and lack of treatment/follow up plan following discharge (11%).

The main organisational-related factors were inadequate service provision for the population covered (20%), inadequate training/knowledge (18%), inadequate staffing or reliance on agency staff (15%), poor systems in place including information technology (13%) and lack of audit or evidence of learning from prior investigations & events (11%).

Patient-related factors were less commonly identified but included lack of engagement with services, denying suicidality and autistic spectrum disorder.

Conclusion. The commonest theme was issues around risk assessment and management which was identified in 45% of suicides. It is hoped by highlighting common themes arising from PFDs reports across the UK this analysis could inform targeted improvements in practice that will lead to reductions in mental health related suicide which is the need of the hour.

Using a Systems Wide Approach to Improve Medical Emergencies in a High Secure Forensic Psychiatry Setting

Dr Brooke Marron* and Dr Cormac Maguire

The State Hospital, Carstairs, United Kingdom
*Presenting author.

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Aims. Patients with severe mental illness are at a significantly higher risk of poor physical health outcomes than the general population and die on average 15–20 years earlier. The Royal College of Psychiatrists has published extensively on how to improve routine physical health monitoring in this cohort. Despite this, there is little data or guidance on improving emergency medical care for this cohort. We aimed to analyse and optimise the process of patients being sent to general hospital on an emergency basis.

Methods. A review was undertaken of the clinical notes for medical emergencies over a 12 month period by two core psychiatry trainees. Site visits and interviews with local A&E department clinicians, the covering General Practitioner and pharmacy were completed. A questionnaire was distributed to all nursing staff to gather their perspective on the considerations for emergency medical transfers out of The State Hospital.

Results. On review of the case notes, 44/44 emergency outings were deemed to be clinically necessary for investigations/interventions that would not have been possible on-site. Qualitative methodology highlighted a disconnect amongst staff groups and stake holders regarding thresholds for transfers relating to medical emergencies leading to a high level of staff dissatisfaction.

Conclusion. The interface between psychiatric and medical services is an area of risk to patients. Levels of staff confidence, knowledge and available resources all contribute to the risk of transfer. Further work is required to explore other aspects of patient care and treatment which can be impacted as a consequence of emergency transfers.