

lockdown and slight observable improvement in attendance rates during the lockdown. There was no statistical significance seen using t-test comparing attendance rates between video and telephone consultations including new patient virtual consultations.

Conclusion. The large sample size over this period suggests that the results are reliable and valid, we can therefore say virtual/telephone consultation does not affect attendance. It should be noted that the attendance rate may be a good indicator but we should also consider patient/clinician satisfaction, communication quality/effectiveness and other factors which could influence patient's compliance to outpatient follow-up. It is important to acknowledge the lack of a control group and the COVID-19 pandemic were major confounding factors. Mental health services should continue the use of virtual consultation post-pandemic and possibly integrate it with in person consultations (hybrid), this may help with attendance rate of patients with difficulty attending face-to-face appointments.

Audit on the Quality of Outpatient Letters From Cherrywood Clinic

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Aims. Letters between secondary and primary care are an integral part of continuity of patient care. It is crucial letters are comprehensible, focused and useful. The quality of letters can be of a variable standard, we aim to see if the letters sent from Cherrywood clinic are in line with the Royal College guidance.

Methods. Data were collected manually by 2 doctors using dictated clinic letters and patient notes, from the 3 community teams. 20 outpatient letters were sequentially selected from each team from the 1st to 31st of March 2017; 60 letters in total. The letters were divided equally between consultants and junior doctors. In the team where there were 2 Consultants; 5 letters of each were taken, and in the team where there was a junior doctor and a specialist registrar, 5 letters from each were taken. The data were collated onto an Excel spread sheet and analysed.

1. Demographic Details including Name, Date of Birth, Address and the Date of Appointment
2. Who was the patient been seen by; Consultant or Junior doctor (FY/GPST/CT/SPR)
3. Current diagnosis
4. Current medication including doses
5. Mental State Examination (MSE) findings
6. An update of the current problem(s)
7. Current/relevant Risks
8. Plan/recommendations
9. Follow-up plans

Results. Of the Consultant letters the diagnosis, medication and dosage was mentioned in 93%, 93% and 90% respectively. Mental state was found in 66%, risks in 83% and follow-up plans in 96%.

Most of the content derived from the registrar letters were unremarkable; with 80% in MSE in the 5 audited letters.

In the Junior doctor letters; the diagnosis was mentioned in 88% of letters, medication and dosage 76%, mental state 100%, risks 80%, follow-up 100%.

Conclusion. Our letters are largely meeting the Royal College standards, more than 85% of the data were up to the standard. The main areas to improve are;

- Documentation of the MSE.
- The medication and the dosages.
- Diagnosis.
- Risks should always be present.

The areas which require improvement are the areas which are essential for GPs to safely manage psychiatric patients in the community.

Improving Clinical Care in Tobacco and Smoking-Related Problems: A Report of Clinical Audit and Quality Improvement Project

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Aims. Around 40% of people with serious mental health problems smoke, which is significantly higher compared to the general population of the United Kingdom. The Welsh Government has set the target to reduce the overall prevalence of smoking in Wales to 16% from 19. In order to reduce the impact of smoking on the population, the first step is to identify the problem. Hence, a comprehensive history of smoking will help to identify the addiction-related problems. Hence, this combined clinical audit and quality improvement project (QIP) is aimed at the evaluation of the admission clerking around the assessment and management of smoking-related problems in an inpatient mental health unit.

Methods. This clinical audit was carried out at the local inpatient general adult mental health units in Wrexham. It was based on NICE smoking guidelines "Smoking: acute, maternity and mental health services". Clinically relevant information without personal identification information was collected based on a proforma. The first re-audit was repeated without a specific intervention to see any change in pattern and the need for intervention. This was followed by the first intervention, i.e., the sharing of a PowerPoint™ presentation discussing commonly utilised measurement tools in the assessment of smoking-related behaviours and the second re-audit.

Results. The first round of clinical audit involves 32 admissions, the first re-audit was 19 admissions, and the second re-audit was 37 admissions. The baseline showed 71.88% of inpatient admissions were asked about their smoking history, but only less than 10% of them were assessed in detail around the types and quantity of tobacco products, features of dependence and withdrawal, the motivation of the clients to quit smoking, and any help offered to the patients. The number of inpatient admissions which was assessed for their smoking-related behaviour dropped to 36.84% during the first re-audit, and less than 16% of them were assessed in detail. The number improved slightly to 57.14% after the first intervention, although less than 40% of the inpatient admissions were assessed in detail.

Conclusion. There is an inconsistent pattern of change in the percentage, and it seems that the intervention leads to minimal improvement of the assessment of smoking-related problems during admission clerking. The minimal change may be attributable to the change in posting around the intervention period. The