the steps laid out in the NICE Weight management guideline (NG246) during annual physical health assessments.
Methods: We assessed the documentation of all physical health assessments completed by the East Birmingham Early Intervention in Psychosis Service between August and November 2024. We then excluded any patients with a BMI under 30, providing a sample of 17 patients who would fit the criteria of the NICE Weight Management guideline. We then determined if they had previously received diet and exercise advice, if they or the clinician were concerned about their BMI, and finally if the clinician had documented advice to seek weight management support from their GP.
Results: We found that of the 17 patients with a BMI over 30, in 12 cases (71%) the patient or clinician had recorded concerns about their weight. Sixteen (94%) had been given diet and exercise advice in their most recent physical health review. Of the 12 (71%) for which concern had been documented, 6 (50%) had previously received diet and exercise advice at a previous review. Of the 17 patients with a BMI over 30, none (0%) had been directed to explore Weight Management tools beyond diet and exercise advice.
Conclusion: Patients under the care of secondary psychosis services were not advised to discuss further weight management options with their GP. Highlighting a vital missed opportunity to provide care that could have long-term impacts on patients.

This leaves us with the vital question: Could we do more to advocate for this patient group, who may not have the financial or social capital to seek the management that they are entitled to?

Combined Audit for depot/LAI (Long-Acting Injectable) Antipsychotic Medications Relapse Prevention and Side Effects for Older Adult Populations (Pan Trust Audit – Black Country Healthcare NHS Foundation Trust)

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Aims: This is an audit that combines the audit on relapse prevention and the audit on the side effects of the depot/LAI on cycle 2 with the aim of benchmarking the compliance of the clinicians' current clinical practice compared with the POMH-UK and NICE CG178.
Methods: The audit was completed with a retrospective electronic medical note review between Oct 2023 and Oct 2024, including patients who were above 65 and currently on depot/LAI. Total of 61 patients were identified, but only 59 patients were included (1 deceased and 1 duplication excluded). The audit was completed using pre-designed questionnaires based on POMH-UK (relapse prevention) and NICE CG 178 (side effect).
Results: For relapse prevention, most of the data from cycle 2 showed improvement compared with cycle 1, where the care plan included a crisis plan (89.7%); a plan to respond when defaulting from treatment (34.3%); the review of the therapeutic responses of the depot/LAI (90.7%); and involving patients in generating their own care plan (89.7%).

There were decrease in the percentage of accessibility of the care plan in the clinical record (98.3%), documentation of the relapse "signature" signs and symptoms (39.7%), and the annual review by the prescribing team (72.9%). The lack of documentation might be contributing to the low percentage for the review of relapse "signature" signs and symptoms.

Cycle 2 is a pan trust audit, which might have impacted the decrease in the percentage of the above questions, whereas the improvement in the small percentage also reflected the significant improvement of the clinical practice since cycle 1.

For the depot/LAI medications side effects assessment, there were minimal increases in the assessment of side effects over the last 12 months (76.2%). However, there was a decrease in the percentage where the side effects were identified and followed by the change of plan (90%). The one patient who did not have the changed plan was struggling with the side effects of sedation. The common side effect identified from this audit was EPSE (extrapyramidal side effect).
Conclusion: Although we are not achieving 100% on each component, there is evidence of improvement in good clinical practice as shown in the result compared with cycle 1.

There is still work that needs to be done in order to address the improvement of both completing and documenting the annual review of the care plan and side effects of the patients who are on depot/LAI antipsychotic medications.

Assessing the Recording of Adequate Care Plans in Child and Adolescent Mental Health Services: A Clinical Audit

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Aims: Care plans can be integral to community psychiatric services to evidence personalised care through shared decision-making. Black Country Healthcare NHS Foundation Trust (BCHFT) guidelines require a documented care plan for each patient, outlining their needs, goals and preferences. Additionally, the GMC advises doctors to keep contemporaneous records for children and young people. This maintains clarity with the patient, their family, GP, and the wider multidisciplinary team.

This audit aimed to evaluate whether doctors' care plans at Sandwell CAMHS aligned with BCHFT guidelines, providing insight into their quality and completeness.
Methods: From the doctors' caseloads, 40 patients aged 18 and under were selected using a randomised generator. The data was collected retrospectively by reviewing the most recent outpatient clinic letters on electronic patient records from the past 12 months. The focus was identifying whether 5 key criteria from the local guidelines were covered in the care plans: 'My Medication and Treatment' (including psychological therapies); 'My Education/training'; 'My Physical Health'; and 'When I Need Urgent Support'.
Results: The majority of care plans included medication information (79%) when relevant, demonstrating good adherence to local guidelines. However, only few care plans included documentation

of physical health considerations (36%) and crisis planning (20%). 15% of letters did not have a clear 'Care Plan' subheading.
Conclusion: Care plans at Sandwell CAHMS do not currently fully comply with local guidelines across 5 criteria. Although care plans are by nature individualised, and hence subjective, we suggest implementing a standardised template for clinic letters that doctors could adjust according to the patient context. A specific subtitled section 'Care Plan' would help to make information clearer for the patient and other healthcare professionals. Local crisis contacts and safety netting information could be included as standard on every clinic letter. Re-audit following implementation of these recommendations will complete the audit cycle.

Re-Audit of Use of Psychotropic Medication in Children and Adolescents Attending Barnet's Service for Children and Adolescents With Neurodevelopmental Disorders (SCAN) Team

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Aims: This re-audit assessed whether Barnet's Service for Children and Adolescents with Neurodevelopmental disorders (SCAN) prescribing practices are in line with the National Institute for Care and Excellence (NICE) guidelines and the "Stopping Overuse of Medication in People with Learning Disability, Autism or both" (STOMP) and "Supporting Treatment and Appropriate Medication in Paediatrics" (STAMP) pledge. It also looked at whether psychotropic prescribing practices changed following the introduction of Positive Behavioural Support (PBS) Workshops in SCAN.
Methods: The sample consisted of 161 patients attending Barnet SCAN, Holly Oak Unit in Edgware Hospital as from January 2025. Electronic Patient Records via Rio were reviewed with data gathered on presence of LD and/or neurodevelopmental disorder, comorbid mental illness, documented use of therapeutic interventions and psychotropic medication prescribed.
Results: 88 out of 161 children and adolescents (55%) were on psychiatric medication. 48 of the children on psychotropic medication (55%) had a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD), whilst 68 had a diagnosis of Autism Spectrum Disorder (ASD) (77%). 40 children (45%) had a diagnosis of both ADHD and ASD.

The number of clients offered therapeutic interventions increased from 50% to 91%. There was a higher number of young people prescribed psychotropics despite a rise in nonpharmacological interventions (19% in 2020 vs 24%).
Conclusion: The rise in use of psychotropic medication could be secondary to the increasing acuity and complexity of cases presenting to the SCAN team post COVID pandemic. The initial audit took place during lockdown, during which fewer cases were being seen by mental health services. COVID-19 had a profound negative impact on children's mental health, behaviour, social skills and learning overall.

SCAN is working on pursuing further training in other therapeutic modalities including the 'Intensive Interaction' Course. SCAN will also continue promoting PBS through parenting programmes, individual sessions and psychoeducation.

Audit of Current Practise of Transfer of Care From Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services (AMHS) in Devon Partnership NHS Trust

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Aims: The transfer of care from CAMHS to AMHS is often poorly managed which is distressing for young people and their families. The implications of poor transition include disengagement from services and deterioration in young people's mental health.

In Devon Partnership NHS Trust (DPT) the transfer of care standard operating procedure (SOP) outlines 8 core standards of transition including clarification of clinical responsibilities, proposed timelines for task completion and documentation requirements. This audit compared DPT patient data against these core standards.

We aimed for 100% compliance between current practice in the transfer of care of patients from CAMHS to AMHS in North Devon and the recommended practice laid out in DPT's SOP.
Methods: Data was collected via retrospective review of electronic patient notes of 51 young people aged 18–25 years old that presented to North Devon Liaison or Home Treatment Teams between 01/05/2024–01/08/2024.

28 participants (55% of the original cohort) were formerly known to CAMHS. 12 participants (43% of the former CAMHS sub-cohort) underwent transfer of care to AMHS. Data was collected on these 12 participants comparing case notes to SOP transition standards.
Results: There were evident strengths of current transition practices demonstrated by 100% of CAMHS specialist service users at the time of transition securing AMHS input and 57% of those referred for transition were issued a care plan with a defined exit from CAMHS.

Weaker areas included only 14% of young people receiving explanation as to why services could not be offered and only 14% were allocated a doctor with medical responsibility on transfer. There was a disappointing lack of collaboration between services as only 29% had a documented joint meeting between CAMHS and AMHS.
Conclusion: There is certainly room for improvement in current transfer of care practices in DPT. Hopefully this audit generates discussions and reconsideration of current practices to initiate change at which point a re-audit could be conducted. Ultimately it is hoped to improve the level of care for young people at a vulnerable time of change in their care provision between CAMHS and AMHS.