and care plan is crucial, as delays can significantly burden the NHS and adversely affect the long-term mental health of patients and their caregivers. According to the National Audit of Dementia for 2023/2024, wait times have risen sharply from 124 days in 2021 to 151 days, with only 10% of patients obtaining a diagnosis within six weeks of referral.

Methods: The audit was conducted over a four-week period from September 28 to October 28, 2024. A random sampling method was employed to select 149 patients referred to 15 memory services throughout the TEWV Trust. Data were collected through the analysis of referral letters, initial assessments, diagnostic appointments, case notes, and correspondence from CITO. Analysis was performed using a custom tool developed in Excel.

Results: The analysis yielded average access times, diagnostic wait times, and overall wait times ranging from 30 to 207 days, 3 to 147 days, and 92 to 323 days, respectively. Notably, none of the Mental Health Service for Older People (MHSOP) services within the TEWV Trust met the national benchmark for overall wait times of six weeks. Furthermore, only 25% of the services succeeded in providing a diagnosis within the 6 to 18-week timeframe, while the remaining 75% experienced wait times extending to 18-52 weeks. A comparative analysis revealed that the average wait times (access, diagnostic, and overall) within the Trust exceeded those of the National averages.

Conclusion: The audit underscored substantial discrepancies between the various memory services' performance and the National recommendations of a six-week wait. Among the services assessed, only one was marginally compliant with a 92-day mark, falling short of the National benchmark of 42 days. This evaluation not only identified critical challenges faced by the services but also presented a series of recommendations to address these gaps.

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From Fragmentation to Integration: Enhancing Staff Awareness and Signposting Capabilities via a Collaborative Digital Resource Directory

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Aims: The purpose of this audit was to evaluate and improve staff awareness and confidence in signposting patients to services both within and outside the NHS. It aimed to transition from a fragmented information landscape to an integrated "one-stop-shop" directory. By centralising resources into a sustainable, living database, the project sought to bridge knowledge gaps, foster Trust-wide collaboration, and ensure patients receive tailored support across all five boroughs.

Methods: A Trust-wide baseline survey was distributed to all staff, capturing data on professional roles and geographical boroughs to identify specific resource gaps. Targeted surveys were sent to medical staff to pinpoint clinical areas and service types where signposting confidence was lowest. Both quantitative and qualitative methods were used to gather initial baseline data and further suggestions to integrate resources better. This data informed the design of a Microsoft Lists database, prioritizing the most "under-resourced" areas and ensuring the platform met the practical needs of frontline staff.

Results: Baseline data confirmed a high demand for resources, with 71.5% of staff signposting patients at least weekly. Key barriers included unclear referral pathways (77.8%), poor service awareness (70.4%), and outdated information (59.3%). Pre-intervention, staff lacked confidence in signposting for housing (78.7%), employment (67%), and finances (57.1%), with significant unawareness regarding legal aid (89.3%) and food banks (67.9%). Internal service literacy was also low, with over half (60.7%) unaware of Trust rehabilitation services. Consequently, 60.7% of staff requested the interactive digital directory.

Post-intervention, confidence in signposting to employment, housing, and finance services all rose to above 56%. Staff reported marked increases in awareness for domestic abuse and carer support (both 93.8%), legal aid (75%), and debt advice (68.8%). While awareness of external resources improved, gaps persisted for internal rehabilitation (62.5% unaware) and forensic services (43.8% unaware). Qualitative feedback confirmed the directory successfully consolidated information, though staff recommended expanding the database through closer collaboration with community teams and social prescribers across all five boroughs.

Conclusion: The collaborative digital directory represents a low-cost, high-impact solution to streamline patient signposting. Future interventions will focus on expanding the project team and recruiting "resource champions" from various teams to ensure the directory remains dynamic and sustainable. This model serves as a scalable blueprint for enhancing health literacy of staff for services that exist both within and outside NHS services.

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Audit on Insomnia Management in In-Patient Psychiatric Unit

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Aims: - Evaluating the current practice for management of insomnia in inpatient settings.

- Assessment of the current use of CBT- Insomnia for the treatment of sleep disorders in inpatient settings.
- Comparing the current practice with the NICE guidelines.

Methods: A retrospective review of electronic medical records of 45 patients who were currently admitted in the inpatient unit over a period of two weeks of data collection.

For each patient, documentation was examined to determine:

- Whether insomnia was reported or observed
- Whether sleep difficulties were noted in clinical records
- Whether nonpharmacological interventions (e.g., sleep hygiene) were offered
- Whether behavioural therapy (CBTI), which is considered the first line of treatment.

treatment for chronic insomnia was offered or signposted

- Whether hypnotic medication was prescribed, and if so:

Type of medication
Documentation of indication
Presence of review or stop dates

Results: Out of the 45 current in-patients audited during the initial assessment of electronic records, 26 (58%) complained of sleeping difficulties; an additional 4 patients were observed to have sleeping

difficulties according to the records. This makes the totalprevalence of insomnia 30 (66.6%). Of these patients, 23 (76.6%) had proper documentation of insomnia in their notes. As management, non-pharmacological interventions such as sleep hygiene discussion were done in 11 out of 30 (36.6%), and no patients (0%) were offered or signposted towards CBT-I. Pharmacological interventions of offering hypnotic medications were offered to 26 out of 30 (86.6%). The hypnotic medications offered included Z-drugs and/or in combination with benzodiazepine and antihistamines. None of the patients (0%) adhered to all criteria of NICE guidelines and Local Trust Policy (classifying insomnia according to duration of symptoms, trial of non-pharmacological intervention before using medications, clear indication documented before starting hypnotics, periodic review and documentation of stop date for said medications)

Conclusion: This audit highlights the need for a structured and consistent approach to managing insomnia across the hospital. Establishing a simple, standardized care pathway–prioritizing non-pharmacological strategies and applying a cautious, clearly justified approach to hypnotic prescribing–has the potential to enhance patient safety, minimize the risk of hypnotic dependence, and promote higher-quality clinical care. Ensuring insomnia is managed systematically and in line with NICE recommendations will support more effective and sustainable outcomes for our patients.

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An Audit of Patient- and System-Level Factors Related to Prolonged Length of Stay on a Female Inpatient Ward

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Aims: Prolonged length of stay (LoS) on acute psychiatric inpatient wards is associated with increased clinical risk, poorer patient experience, reduced patient flow, and higher healthcare costs. National monitoring frameworks focus on average LoS and the proportion of admissions exceeding defined long-stay thresholds. NHS England policy outlines an ambition for average acute adult mental health inpatient stays of approximately 32 days. A UK-focused systematic review identified factors associated with longer psychiatric inpatient stays, including involuntary admission, psychotic diagnosis, older age, and ethnic minority status. Individual studies have also highlighted systemic and social contributors to prolonged LoS, such as out-of-area placements and accommodation-related discharge delays, alongside clinical factors including psychotropic polypharmacy. Local, service-level analyses using routinely collected clinical data can identify patient- and system-level predictors of prolonged LoS, enabling the development of targeted quality improvement initiatives to reduce avoidable extended inpatient admissions.

Methods: All inpatient admissions to a female acute ward over a 12-month period (January–December 2025) were analysed, with readmissions included as separate episodes. A multivariable logistic regression was conducted examining factors associated with prolonged LoS (≥32 days, in line with current NHS mental health policy and performance monitoring frameworks, vs <32 days). Data was extracted from electronic health records: age, ethnicity, local vs. out-of-area placement, primary discharge diagnosis, detention under the Mental Health Act, presence of incidents during admission, discharge destination, safeguarding processes raised, and psychotropic polypharmacy (≥2 concurrent antipsychotics or ≥2 psychotropic medications on discharge)

Results: 161 records were included in the analysis. Mean LoS was 29.76 days (SD=29.71). Median LoS was 17 days (IQR 9-31). Forty admissions (24.8%) met criteria for prolonged LoS (≥32 days). Adjusting for all other factors included in the model, prolonged LoS was independently associated with detention under the Mental Health Act (aOR 6.07, 95% CI 2.06–17.88; p=0.001), schizophrenia, schizotypal and delusional disorders (aOR 5.55, 95% CI 1.14–27.00; p=0.034), and mood disorders (aOR 4.77, 95% CI 1.01–22.52; p=0.049). Incidents, safeguarding, polypharmacy, out-of-area placement, discharge destination, ethnicity, and age were not significantly associated with prolonged LoS after adjustment (all p>0.05)

Conclusion: Prolonged inpatient length of stay was independently associated with detention under the Mental Health Act and diagnoses of schizophrenia-spectrum and mood disorders. No other patient- or system-level variables remained significant following multivariable adjustment. Targeted early intervention and proactive care planning for high-risk groups may help reduce avoidable prolonged inpatient stays while maintaining patient safety

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Compliance With NICE-Recommended Physical Health Monitoring for Children and Young People Prescribed Antipsychotic Medication Within Nottinghamshire CAHMS Head-to-Head Community Service: A Retrospective Audit

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Aims: Antipsychotic medications are widely prescribed in child and adolescent mental health services (CAHMS) and carry recognised metabolic and cardiovascular risks. National Institute for Health and Care Excellence (NICE) guidance outlines minimum standards for physical health monitoring before and during antipsychotic treatment. This audit aimed to assess compliance with NICE-recommended physical health monitoring for children and young people prescribed antipsychotic medication within a CAHMS Head-to-Head (H2H) community service.

Methods: A retrospective audit of electronic patient records (Rio) was conducted. All patients under the CAHMS H2H team prescribed antipsychotic medication were identified. Physical health monitoring was assessed at baseline, six weeks, twelve weeks, and at six-monthly intervals thereafter. Six-monthly monitoring was analysed per eligible monitoring window, recognising that patients commenced treatment at different times. Patients admitted to inpatient wards when monitoring was due were excluded. Patients who had not yet reached eligibility for six-monthly monitoring were excluded from six-monthly denominators. Monitoring performed during medication titration or switching was outside the scope of this audit. Descriptive statistics were used to calculate completion rates.

Results: Eleven patients were identified; two were excluded, leaving a final audit cohort of nine patients aged 15–18 years. Complete