out pre-intervention by two new members over 20 MDT meetings. Qualitative data were collected by identifying the key delays in MDT. Comparison of pre-intervention & post-intervention efficiency was established by quantifying the percentage of MDTs overrunning their allocated time. Satisfaction of the MDT members (n=10) with the new practise was also recorded via a questionnaire post-intervention. Our data collectors identified three main primary drivers: Systems, process & documentation.

Results. The interventions under process included a structured agenda, table of patients for discussion & allocating designated roles within MDT. The primary driver of System, focused on creating AccurX proformas as a way to ease the use of AccurX (an integrated software program in Rio for securely contacting patients) during MDT. MDT members were trained informally to use AccurX & Smartcard (NHS spine search for patient demographic details). Finally, a standardised documentation style was trialled by creating proformas with a streamlined set of options under each agenda.

Pre-intervention showed that >90% of MDTs were starting late & >50% were running over the allocated time. Post QI implementations, 80% of MDTs ran within allocated time. 90% of people found the MDT has increased efficiency, with 30% rating it as 'very efficient'.

Conclusion. The current CMHT MDT meetings have scope for more efficient practises. We should consider feasible modifications in the realm of system, process & documentation as a stepping stone to increase efficiency. This QI project suggests benefits for the wider implementation of such interventions to other CMHTs within the area.

Remembering Your Memory Appointment! a Quality Improvement Project Looking to Improve the Attendance of Memory Assessment Service (MAS) Appointments in the East North East Older Peoples Services (ENE-OPS) of Leeds, Through the Formalisation of a Pathway

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Aims. After experiencing disappointment due to numerous patients not turning up to their memory assessment service (MAS) appointments as well as the effect of losing man-hours due to this we decided to investigate how best to improve the attendance rates of our MAS patients. The initial frustration occurred when several patients for multiple team members were not attending their appointments. When followed up they stated that they had not received the required letters or follow up telephone calls prompting them to attend their appointments. This led to the initial hypotheses that a formal structure was required in part to aid in the delivery of this service and improve attendance.

Methods. We initially investigated the percentage of patient's that did not attend their appointments from the period of August 2022 to December 2022. This was achieved utilising the trust's data collection team. From these initial raw data we processed and calculated the delay between appointment allocation and a letter being sent out as well as basic percentages of patients not attending each month. What we realised was that there was no strict average and our admin team were not aware of any pathway that they could utilise as a guideline for the management of patient appointments. We therefore outlined the overall process of the appointment pathway and formed this. Upon this foundation we subsequently ironed out the optimal points of contact between our admin team and patients and when this could be accomplished and documented. The aims of these points of contact overall was to improve the rates of patients not attending their appointments and improving our target of appointment attendance. We subsequently re-evaluated our patient attendance five months after the formation of the posters, which were affixed in the admin and memory nurse rooms at our base.

Results. The results overall were quite promising and did appear to show a change based upon the formalisation of the MAS appointment pathway.

Conclusion. The results showed a positive improvement to the attendance rate of the MAS patients and also demonstrated the empowerment that a team can have when a formal pathway is in place. This fully completed audit cycle demonstrated the importance of such a pathway and how to address what is often a multi-faceted problem for many community based services. Our conclusion appears to support our hypotheses that a formal pathway can often improve the provision of a service.

Reinforcing Recovery and Relapse Prevention: Creation of a Junior Doctor Led Psychoeducation Course for Adolescent Inpatients With Psychosis

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Aims. The aim was to provide psychoeducation sessions to inpatients at a London adolescent mental health unit, admitted with first episode psychosis, at the recovery stage of admission. The COVID-19 pandemic-associated rise in admissions and clinical demand meant psychologists within the unit struggled to provide psychoeducation sessions; a deficit in care was identified and junior doctors established a psychoeducation group to meet this clinical need.

Methods. Course participants were three adolescent inpatients from black and ethnic minority backgrounds who were informal/voluntary patients approaching discharge. This ensured adequate insight into their mental health disorder and its impact on functioning, to effectively benefit from psychoeducation, and capacity to consent to this pilot programme.

Doctors liaised with psychologists, occupational therapists and nursing colleagues to create this holistic, patient-centred course, suited to patients' current psychosocial abilities with appropriate accommodations for age, developmental level and stage in recovery.

The team provided effectual, engaging content to deliver key messages while ensuring sessions were enjoyable for teenagers. Use of repetition accounted for residual effects of psychosis such as impaired concentration and memory. Patients actively participated with use of colourful visual aids, created interactively to consolidate learning. Peer discussion and personal reflection was supported, balanced with the need for patient confidentiality.