

13/20 staff questionnaires were completed. It showed most staff did not have formal training in managing comorbid ASC and ED, and confidence and skills varied in proportion to time and experience in the service. All staff members expressed they would like formal training, through sessions such as monthly training, weekly huddles, or psychoeducation.

Conclusion. A significant proportion of inpatients have comorbid ED and ASC. Therefore, awareness of potentially greater needs around communication, environment, and sensory hyper- or hyposensitivity is important. There is a risk of diagnostic overshadowing as both ED and ASC can mimic similar symptoms: cognitive rigidity, fixation on certain things etc. So while not straightforward it is important to differentiate which symptoms are due to ASC and which are due to ED. Leveraging resources from the PEACE pathway website, both staff and patients can enhance their understanding of this complex comorbidity.

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A Clinical Audit of the Assessment and Management for Those Diagnosed With Young Onset Dementia Within the Shepway CMHSOP

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Aims. To audit the Shepway CMHSOP against the NICE guidelines in dementia and the Royal College of Psychiatrists recommendations for service provision in young onset dementia.

Methods. Data was collected retrospectively for all patients open to CMHSOP within the last 2 years with a diagnosis listed as dementia under the age of 65 years old.

Results. The work up prior to diagnosis met some standards but improvements could be made in other areas. Mood was considered in all patients. The majority of patients (89%) had young onset blood tests if there was a clinical indication. However physical examination was only carried out in 43% of patients. In addition to this where physical examination was completed it was often limited to a brief note about the patient's gait and tremor.

Imaging standards were met within the Shepway CMHSOP with all patients having a scan, some patients being referred for additional specialist scans where indicated. There is also a neuroimaging MDT in which scans can be discussed with a neuro-radiologist.

The follow up care and support was an area that needs further development within Shepway CMHSOP. There is no named lead for those diagnosed with young onset dementia. Furthermore, only half of patients received a named practitioner to support their care. In addition to this only 79% were offered cognitive stimulation therapy and post diagnostic support which incorporate education for the carers. It is difficult to know if these options were discussed and declined by the patients, but if this is the case it would have been good practice to document.

Conclusion. The time from referral to diagnosis was similar in those with a dementia with a well established and clear subtype (Down syndrome) to those diagnosed with other types of young onset dementia, 6 months and 5.5 months respectively.

My audit identified areas for improvement in the workup to diagnosis and the aftercare to support those diagnosed and their carers in order to meet NICE guidelines and the Royal College of Psychiatrists recommendations for service provision in young onset dementia.

Shepway CMHSOP will develop a young onset dementia pathway to ensure those diagnosed are offered the appropriate investigations and support following their diagnosis in line with these guidelines.

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Outcome Measures in Mental Health – RCPsych Report and Working Group Survey

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Aims. Outcome measurement is central to transforming mental health care by quantifying change, enabling comparison and driving improvement. In recognition of this, the Royal College of Psychiatrists (RCPsych) has established a *working group on outcome measures*, led by an Associate Registrar.

To support routine outcome measurement capture in clinical services, RCPsych has developed the 'Outcome Measurement in Psychiatry' report.

The working group intends to launch a survey of Members to:

- 1) Understand psychiatrists' current use of outcome measures.
- 2) Understand psychiatrists' views on barriers and facilitators to the use of outcome measures.
- 3) Get feedback on the College Report.

Methods. The 'Outcome Measurement in Psychiatry' report was developed with input from all RCPsych Faculties and is scheduled for publication prior to the RCPsych International Congress.

Feedback will be sought on the 'Outcome Measurement in Psychiatry' report about whether the guiding principles are right, and if the College should be endorsing specific measures or advocating for the routine use of outcome measures. This will be used to guide future revisions of the report.

The working group believes the proposed survey will enable it to explore the facilitators and barriers to routine outcomes data capture both locally and nationally, including:

- how to consider organisational drivers and buy in of clinical staff
- digital enablement
- understanding time points in a chronic relapsing remitting condition in the community vs. episode of therapy or hospital admission
- clinical burden/benefit and buy in
- training.

An invitation to participate in the survey will be sent to all College members and advertised via social media, at the International Congress. Analysis will be via descriptive summary of quantitative data and a thematic summary of any free text data.

Results. The group intends to use the intelligence gather to inform, influence and shape policy that promotes routine outcome data capture and publish its findings for wider dissemination.

Conclusion. Outcome measurement is a top priority for the RCPsych. A new Associate Registrar and working group is