appointments. An easy-read version was also sent to promote accessibility amongst the patient group. The data was collated and reviewed.

Results. Most common reasons for patients not attending their psychiatry outpatient clinic appointments under the CTPLDW team were identified:

2022: 35 patients DNA – 28.6% citing communication/correspondence issues.

2023: 30 patients DNA – 33.3% citing communication/correspondence issues.

Additional reasons for non-attendance included issues with residential homes, sickness and transport.

Conclusion. An anecdotally high number of DNAs were noted by CTPLDW. The data collected thus far has helped us to define and understand the issues. The main factors identified revolve around communication and correspondence of appointment times.

The next step in our quality improvement project is to trial text reminders for patients and carers to assist in remembering appointments, to assess whether this change idea helps to decrease the number of DNAs.

Future change ideas include development of resources to support attendance (e.g. adjusted appointment letters with QR codes for access/maps, reminder letters in easy-read format and video tours).

CTPLDW would like to offer a more personalised approach with a service that promotes reasonable adjustments and reduces barriers to access, thereby reducing the number of DNA appointments.

Benefits & Barriers: Improving Medical Handover in a Psychiatric Hospital

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doi: 10.1192/bjo.2024.391

Aims.

Background: Handover aims to achieve the efficient communication of clinical information when responsibility for patients is transferred. The Royal Edinburgh Hospital (REH), a specialist hospital serving the Lothians, has repeatedly received "red flags" (ranked in the bottom 2% of benchmarked areas) on the handover section of the Scottish training survey (STS) and GMC national training survey of doctors in training (DiT).

Aims:

- Survey DiT to understand their experience of handover.
- Introduce a new structured handover process.
- Re-audit parameters after intervention.

Methods. Data from REH DiT were extracted from an anonymised handover survey, disseminated to all psychiatry DiT in Scotland in January 2023. Multiple choice and free-text questions covered handover timings, format, structure, and attendance. The survey was repeated after intervention. In addition, data from the STS were analysed. The intervention consisted of altering shift times to include protected time for handover, introducing a dedicated room, training in the use of an electronic system to record tasks, involvement of senior doctors, and dissemination of the new changes to procedure.

Results. A total of 12 survey responses (25% response rate) pre-intervention (25% FY2s, 17% GPSTs, 58% core trainees) and 14 post-intervention (14% FY2s, 14% GPSTs, 71% core trainees) were analysed. The proportion of respondents reporting that handover always happened at times of shift change increased from 7% to 93% post-intervention. The proportion of those reporting that there was protected time for handover rose from 0% to 50%, and the use of a predetermined structure/format increased from 0% to 43%. After intervention, 86% of DiT felt adequately supported during handover (compared with 17% pre-intervention) and 93% of respondents felt handover 'allowed for the efficient and effective transfer of information to protect patient safety' (33% pre-intervention). Prior to the process change, 83% of DiT felt there was no clear senior leadership at handover; this fell to 21%. Post-intervention the use of WhatsApp/texts to hand over information fell by 100%. The new system was welcomed by trainees, but teething problems were identified.

Conclusion. The new process led to improvements in the frequency, consistency, format, recording, and senior support of handover. Issues with the use of video call software and electronic medical records systems have been identified, and work is ongoing to address these in an iterative quality improvement process. Good clinical handover benefits patients (fewer mistakes and increased safety, better continuity of care, improved satisfaction) and clinicians (improved communication skills, increased accountability, feel more informed, improved job satisfaction).

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.

Fitness to Drive Policy in Inpatient Setting: Findings of QI Project

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doi: 10.1192/bjo.2024.392

Aims.

Background:

Nature and degree of mental illness can impair abilities of patients to drive safely which puts their own safety and safety of others at risk. There is also an ongoing concern of patients not being properly informed on their duty to inform the DVLA and potentially to stop driving for an extended period.

Aims:

1. To assess if risk assessment of patients in term of driving status was completed at time of admission, during their stay on ward, and if any advice regarding fitness to drive was given at time of discharge.
2. To improve patients being asked about driving status on admission to 100% of patients.
3. To improve rates of service users being informed of the DVLA guidance following a mental health illness to 100% of patients.

Methods. It is a Quality Improvement (QI) project. Baseline information on current practices were assessed against local fitness to drive policy of Leicestershire Partnership NHS Trust in