Conference Booklet

Contents	**Page**
General information	1-2
Conference programme	3-5
Speaker abstracts and biographies (Thursday 16 March 2023)	6-13
Speaker abstracts and biographies (Friday 17 March 2023)	14-21
Poster Abstracts	22-56

General information

This conference will be taking place via an online platform called EventsAir, this platform is accessible through your internet browser (ideally Google Chrome), where you can:

- watch the sessions
- interact with speakers via the discussion forum, live Q&A, and polling
- catch up with colleagues in the Meeting Hub
- view conference resources, posters and speaker presentations

Joining the webinar
We recommend that you log into the platform a day ahead of the conference taking place. When you first log into the platform you will be asked to confirm/edit some details about yourself. It is important that you select your time zone and choose what data you would like to share during the virtual event.

Once this is done, please click 'update and close' in the top right-hand corner. You will then be taken to the attendee portal where you will be able to view the conference agenda. For further information about each session click on the 'preview' button. The button will change from 'preview' to 'join' when the session is live and available to view.

Technology Requirements

- Access to a reliable internet connection – wired if possible
- A PC, laptop, tablet or phone
- Google Chrome or Microsoft Edge browser

Some users may experience difficulty joining the session due to security settings. If this is the case, we suggest you use a personal device rather than a work laptop/computer.

If you are having difficulty, please read our FAQs page or contact a member of the Events team via events@rcpsych.ac.uk

During the sessions
During the sessions you will be able to view the speakers as they present and any accompanying PowerPoint slides. You will **not** be visible to other attendees or speakers.

You can ask questions using the Q&A function on your screen and engage in conversation with other delegates via the discussion forum. The speakers will endeavour to answer as many questions as possible during the time period. There may be occasions when not all questions can be answered live, however we will try to answer any remaining questions offline, creating a Q&A resource sheet for all attendees.

If you lose connection during the webinar, please refresh your screen or try closing down browser and clicking the joining link again. Please ensure that all other tabs (including Microsoft Teams) are closed down.

Watching on demand
Once the conference has taken place you will receive an email informing you that all the sessions are now available to watch on demand. **Please be aware that the recordings will only be available for two months after the conference has taken place.** Please note that the recordings of the webinars and presentations are the intellectual property of the speaker and the College and any unauthorised broadcasting/copying of the material is strictly prohibited.

Accreditation
This conference is eligible for up to 6 CPD hours per day, subject to peer group approval.

Certificates
Certificates of attendance will be emailed to delegates after the meeting.

Feedback
Once the conference has taken place, please complete this feedback form. All comments received remain confidential and are viewed in an effort to improve future meetings.

Queries
Please email events@rcpsych.ac.uk if you require any assistance. We will try and respond to your email as soon as possible but please remember that all sessions will be recorded and available to watch on-demand for a period of two months post event. Please also take a look at our EventsAir FAQs which may be of assistance.

Social media
Please tweet us @rcpsychOldAge using the hashtag #OAPsych2023

Speaker presentations
Delegates will be able to access speaker presentations (where permission has been given) after the meeting. These can be accessed directly through the EventsAir platform.

Conference Programme

Thursday 16 March 2023	
	Session Chaired by Dr Mani Krishnan
9.00-9.15	**Welcome and introductions** Dr Mani Krishnan, Faculty Chair
9.15-9.25	**National Updates** Professor Alistair Burns, National Clinical Director for Dementia and Older People's Mental Health, NHS England and NHS Improvement
9.25 – 9.40	Dr Amanda Thompsell, National Specialty Advisor for Older People's Mental Health, NHS England and NHS Improvement
9.40 – 10.00	**Improving Joy in Work: Importance of Self Compassion** Dr Amit Ranjan Biswas
10.00 – 10.20	**Risk Factors for dementia** Professor Gill Livingston
10.20 -10.40	**Dementia Voices of hope: Living with Dementia in 2023** Afzal and Zohra Shaikh
10.40 – 10.50	**Q&A**
10.50-11.20	**Morning break and poster viewing**
	Session Chaired by Dr Mohan Bhat
11.20-11.40	**Complex Emotional Needs** Dr Ben Underwood & Natasha Treagust
11.40- 12.00	**Eating Disorders guidelines & outcome measures** Dr Suzanne Heywood Everett
12.00 – 12.20	**ADHD in old age & difficult diagnosis in old age dementia** Dr Conor Davidson
12.20 -12.30	**Q&A**
12:30-1.30	**Lunch break and poster viewing**
	Session Chaired by Dr Rashi Negi
1.30-1.50	**Is Problem Adaptation Therapy an effective treatment for depression in Alzheimer's Disease?** Professor Rob Howard
1.50 -2.10	**Recovery Colleges and social prescribing in dementia - what is it all about** Professor Chris Fox
2.10 – 2.30	**Maintaining someone well after diagnosis of dementia** Dr Jill Rasmussen
2.30 -2.40	**Q&A**

2.40-3.10	**Afternoon break and poster viewing**
3.10-3.55	**Parallel Sessions –** *a choice of 3*

3.10-3.55	**Embedding research into NHS practice: why bother and how to do it?** Dr Bob Barber, Dr Rashi Negi, and Professor Ramin Nilforooshan	**Neuroradiology scan interpretation** Dr Curtis Offiah	**Business Case Development: how you put a business case together** Dr Ben Underwood **How to articulate why older people matter** Dr Conor Barton

3.55-4.05	**Quick break**
	Session chaired by Dr Vivek Pattan
4.05– 4.25	**Mental health and older people in India** Dr Suvarna Kantipudi, overseas bursary prize winner
4.25- 4.45	**SIGN guidelines** Dr Vivek Patten
4.45–5.05	**The use of and future of psychedelics as treatment in older adult mental health** Dr Oliver Bashford
5.05 -5.15	**Q&A**
5:15-5:20	**Closing comments**

Friday 17 March 2023

	Session Chaired by Dr Josie Jenkinson
9.00-9.05	**Welcome and introductions** Dr Mani Krishnan, Faculty Chair
9.05 – 9.25	**Early diagnosis** Dr Vanessa Raymont
9.25 – 9.50	**New Therapies - Disease modifying treatments in Alzheimer's disease** Dr Bob Barber
9.50 – 10.00	**Q&A**
10.00 – 10.10	**Quick break**
10.10 -11.10	**Brain Health Clinics around the country** Brain Health Scotland – speaker to be confirmed Manchester & the North West – Dr Ross Dunne Newport and Wales – Dr Chineze Ivenso & Dr Marc Edwards Belfast and Northern Ireland – Prof Bernadette Mc Guinness Bristol and the Southwest – Dr Liz Coulthard Oxford and the TRC-D – Prof Clare Mackay London – Dr Chris Kalafatis
11.10-11.40	**Morning break and poster viewing**
11.40-12.10	**Session Chaired by Dr Chineze Ivenso** **Debate: Chaired by Dr Suhana Ahmed** **Should old age psychiatrists be involved in delivery of currently available Disease Modifying Treatments?** Prof Rob Howard – opposing

	Prof Ramin Nilforooshan – proposing
12.10-12.20	**Enhanced Care and Care Homes Model** Dr Amanda Thompsell
12.20 -12.40	**DiADeM (Diagnosing Advanced Dementia Mandate)** Dr Sara Humphrey
12.40 -1.00	**Falls and Deconditioning** Dr Amit Arora, Consultant Geriatrician
1.00 -1.50	**Lunch break and poster viewing**
	Chaired by Dr Sharmi Bhattacharyya
1.50-2.10	**Standards in dementia** Michaela Morris, Rebecca Hanmer and Professor Tony Bayer
2.10 -2.30	**Faculty Business Meeting** **Presentation of Lifetime Achievement Award to Professor Tom Dening**
2.40 – 3.10	**Afternoon break and poster viewing**
	Parallel Sessions – *a choice of 3*
3.10 – 3.55	**What can research offer to clinicians and patients? Lessons from experience (Panel Discussion)** Professor John O'Brien NIHR, Dr Chineze Ivenso, Dr Bob Barber, Dr Ross Dunne, Dr Rashi Negi, Dr Ben Underwood, Professor Tom Denning **ECT in Older Adults** Dr Richard Braithwaite **Why Data Matters II: reducing health inequalities of the local population** Dr Asif Bachlani
3.55-4.05	**Quick break**
	Chaired by Dr Conor Barton
4.05– 4.25	**Crisis/Virtual wards** Kerry Turner
4.25-4.45	**Impact of Acute Care Pathway Referrals Meeting on Waiting Time for Admission: One Year Study** Dr Raja Badrakalimuthu
4.45-4.55	**Q&A**
4.55-5.00	**Closing comments**

Speaker abstracts and biographies
(Thursday 16 March 2023)

National Update

Professor Alistair Burns, National Clinical Director for Dementia and Older People's Mental Health, NHS England and NHS Improvement.

National Update

Dr Amanda Thompsell, National Specialty Advisor for Older People's Mental Health, NHS England and NHS Improvement

This presentation will highlight some of the most important policy developments recently published by NHSE that affect services older adults' mental health. It will also reveal what else is in the pipeline.
It will include a focus on how NHSE is looking into implementing its new approach for allocating resources based on "Currencies" and how NHSE will look to measure outcomes for community mental health transformation. The presentation will include links to policy information and resources currently available and highlight what new resources are expected by the end of the year.

Dr Amanda Thompsell was a GP Principal before retraining in psychiatry and becoming an Old Age Psychiatrist She was a consultant for a multidisciplinary team supporting care homes with nursing and then an old age liaison service in an acute hospital before working in specialist care. She has previously led on the improving care in dementia work stream for London Dementia Strategic Clinical leadership group. She is a past Chair of the Faculty of Old Age Psychiatry at the Royal College of Psychiatrists. She currently works in a community team for older people with serious mental illnesses and is the National Specialty advisor in older adults' mental health NHSE .She is also a Medical member of First Tier Tribunal service and a non-executive director on Target Health care REIT.

Improving Joy in Work: Importance of Self Compassion

Dr Amit Ranjan Biswas

Risk Factors for dementia

Professor Gill Livingston

There has been a hugely welcome reduction in risk for dementia in some High-Income Countries. However, this has been restricted to those of higher income and more educated people. We have less information in some other countries, but it appears there is an increase in East Asian countries.

The first Lancet commission using worldwide figures found the estimated Population attributable fraction of 9 risk factors for dementia was 33%. Therefore, there was a potential reduction in the number of people with dementia of one third if these risks could be eliminated. These figures used all data available – which means that 80% was from white populations in high income countries. Considering the same risks using the 10/66 cross -sectional data we calculated that in most countries in Latin America the PAF is 56%, India 41% and China 40% -with more contribution from lack of education and hypertension and less from social isolation. The 2020 commission found a theoretical potential reduction worldwide of 40%. Since then, we have studied different ethnic groups in New Zealand and found Maori and Pacific peoples had a PAF of 51% -with a particularly high contribution from obesity and hearing loss. We have also examined dementia in different ethnic groups in Australia and in high- and low-income groups in Brazil. I will present these results. Overall, our findings make it clear that risk is not the same for everyone and therefore interventions have to be tailored for country, culture and individual. People often have little power to change their lives – it may be unsafe to walk and exercise outside, they may not be able to afford drugs for high blood pressure or hearing aids. In particular, we must target those who have not benefited to date. Groups who are underserved need the changes most and will derive the highest benefit.

Professor Gill Livingston is a clinical academic, working clinically with people with suspected or confirmed dementia and their families in Islington memory clinic. Her work is interdisciplinary and considers mechanisms through epidemiological and biopsychosocial enquiry, using them to co-design evidence-based interventions and test them. Professor Livingston leads the Lancet Standing Commission on Dementia Prevention, Intervention and Care, in 2017 and 2020 she produced new research and meta-analyses of life-course risk and an overview of current knowledge on interventions. These findings have substantial implications in preventing and delaying a significant proportion of dementia. They have resulted in changes in UK and US policy which aim to reduce dementia risk. Professor Livingston also researches interventions to improve the lives of people with dementia and their families and staff caring for them and particularly consider underserved and minority communities. START for family carers has long-lasting effects on depression and anxiety symptoms, increases quality of life, is cost-effective and might save money. Professor Livingston is in the final process of recruiting for DREAMS, a randomised controlled trial for sleep in dementia. It is led by Dr Penny Rapaport and Professor Livingston is co-Chief Investigator. Her work is as part of a team of investigators. Working, in particular with Penny Rapaport, Naaheed Mukadam, Andrew Sommerlad, Mika Kivimaki, Julie Barber, Louise Marston,. Sergi Costafreda, Rebecca Gould and Rob Howard (UCL).

Dementia Voices of hope: Living with Dementia in 2023

Afzal and Zohra Shaikh

Complex Emotional Needs

Dr Ben Underwood & Natasha Treagust

Complex emotional needs, sometimes also known as personality disorder, is a condition that is presumed to be lifelong. Despite this there is almost no literature on patients with personality disorder over the age of 65. We have completed the largest epidemiological study of older patients with a diagnosis of personality disorder. We found that the diagnosis was rare and that those patients with the diagnosis were significantly different to comparator groups in the general population, those aged under 65 with personality disorder and those of the same age but suffering from affective disorder. Most strikingly, we found that older patients with a diagnosis of personality disorder were much more likely to experience polypharmacy than any other group. We are now developing this work to see which drugs are prescribed, what patients think about the medicines that they receive and the clinical lessons from our research.

Dr Ben Underwood studied natural science at Oxford University and medicine in London. He completed his psychiatric training in Cambridge, including a PhD with Professor David Rubinsztein looking at autophagy up-regulating drugs as potential disease modifying agents in dementia. He is currently an assistant professor in applied and translational old age psychiatry at the University of Cambridge and honorary consultant psychiatrist at Cambridgeshire and Peterborough NHS Foundation Trust (CPFT). He is research and development director at CPFT, clinical lead for dementia in the East of England for the CRN, national CRN lead for stratified medicine in dementia, ARUK network co-ordinator for the East of England and co-organises the Cambridge Advance online course in translational medicine. He is clinical director of the Gnodde Goldman Sachs unit for translational neuroscience and the Windsor Unit at Fulbourn Hospital which seek to connect patients to the latest research and clinical trials.

Natasha Treagust is a 5th Year medical student studying at Gonville and Caius college at the University of Cambridge. As part of her student selected component in her 4th year she was given the opportunity to work with Dr Ben Underwood and the team at CPFT to gain a better understanding of the individuals who live in Cambridgeshire and Peterborough in secondary care with a diagnosis of personality disorder. This culminated in the publication of a paper in the International Journal of Geriatric Psychiatry.

Eating Disorders guidelines & outcome measures

Dr Suzanne Heywood Everett

ADHD in old age & difficult diagnosis in old age dementia

Dr Conor Davidson

Dr Davidson will present an update of the latest developments in autism relevant to psychiatrists. He will cover the changing demographic profile, challenges in service delivery, and policy issues such as the Oliver McGowan mandatory training. In the second half Dr Davidson will focus on autism in the speciality of Psychiatry of Old Age, including the under-recognition of autism in older people and the overlap between autism and mental health in later life.

Dr Conor Davidson is a consultant psychiatrist in general adult psychiatry, and clinical lead of the Leeds Autism Diagnostic Service. He was appointed Autism Champion for the Royal College of Psychiatrists in May 2021. The focus of this work is on improving autism awareness and autism training for psychiatrists. He chairs the College cross-faculty autism group and sits on the NHS England national autism strategy steering group. Before joining LADS fulltime in 2020, Conor was autism lead for Tees, Esk & Wear Valley NHS trust. The TEWV autism project launched a large-scale training program and the autism Clinical Link Pathway; its achievements were recognised with a National Autistic Society award in 2019.

Conor has published a number of journal articles, blogs and book chapters with a particular focus on autism and mental health. Conor is a lifelong Leeds United supporter, which – after many years of disappointment – is finally starting to pay off.

Is Problem Adaptation Therapy an effective treatment for depression in Alzheimer's Disease?

Professor Rob Howard

Working with many colleagues from the Faculty, we have been conducting the PATHFINDER Trial, an RCT of problem adaptation therapy (PATH) in the treatment of depression in people with mild to moderate Alzheimer's disease. 346 participants were recruited, half of whom were randomised to PATH and treated with up to 8 sessions of therapy. The primary outcome was improvement in the Cornell Depression Scale at 6 months although participants were assessed for 12 months. The last participant had their final 12-month outcomes assessment on 28 February 2023, so I may not be able to present the full trial results by the time of the meeting. But I can present the story of the trial, characteristics of the participants and talk about the qualitative development of a PATH intervention that proved easy to deliver by memory service staff and was well received by patients and their carers.

Robert Howard is professor of old age psychiatry at UCL and honorary consultant psychiatrist at Camden and Islington NHS Trust.

Recovery Colleges and social prescribing in dementia - what is it all about

Professor Chris Fox

Recovery colleges have recently started to be develop from working age mental health for people with dementia. Underlining these colleges are the CHIME principals of Connectedness, Hope and optimism about future, Identity, Meaning in life and Empowerment dimensions. DISCOVERY is an NIHR programme blue printing what are the key considerations in recovery college.

Social prescribing has wide usage in long term conditions. How social prescribing works is still not completely clear? We now it engages people with new activities, supporting/setting new expectations of selves and care, enhancing trust, and reducing fear, all of which contribute to altered behaviour. For dementia and MCI these could provide enhanced cognitive reserve, cultivating skills and interests, assisting emotion regulation and reducing stress, depression and sedentary behaviours. SPLENDID is an NIHR programme developing precision social prescribing for people with dementia and carers utilising current social prescribing staff enhanced with digital systems inclusion health data and a digital dashboard to better offer tailored provision and an app. In this presentation I will highlight the potential benefits of recovery colleges and social prescribing and consider some of the post diagnostic pathway links.

Professor Chris Fox is an old age psychiatrist at the University of Exeter and runs a specialist memory service at Norfolk and Suffolk NHS foundation trust. He leads 4 NIHR programmes in dementia TIMES (Optimising sleep management in MCI and dementia) DISCOVERY (Blue printing recovery colleges in dementia) CARECOACH (Developing, adapting and evaluating an online hybrid self-efficacy intervention in dementia) and SPLENDID (UK development and trial of social prescribing in dementia).
He has worked on multiple medication and technology programmes in dementia in the previous 15 years. He has an interest in data and AI and is working on the MRC GEMINI programme in multi-morbidly. He has an interest in supporting Early career researchers and leads the NIHR PDG group which has this as a focus.

Maintaining someone well after diagnosis of dementia

Dr Jill Rasmussen

This presentation will consider all aspects of health and wellbeing to keep a person well after a diagnosis of dementia. A holistic approach that includes physical, psychological, and social aspects, impact of long-term conditions and health of family and carers.

Dr. Jill Rasmussen MBCHB, FRCGP, FFPM, Dip Ther. (Distinct) is a Primary Care Specialist in dementia, mental health and intellectual disability. Following an initial ten years in the NHS she spent the next ten years in both Europe and the USA where she held senior executive positions in the pharma industry and specialized in the development of new drugs for psychiatry and neurology. Since 1994, she has combined part-time clinical practice with her own independent research consultancy that specializes in

advising about the strategic development of new treatments for central nervous system disorders, and writing E-learning and other education materials for consultants and training psychiatrists, neurologists and community physicians. She is the Clinical Representative for Dementia for the Royal College of General Practice, and continues her clinical work in the new ICS system.

Embedding research into NHS practice: why bother and how to do it?

Professor John O'Brien NIHR, Dr Rashi Negi, and Professor Ramin Nilforooshan

A panel discussion to provide attendees with an awareness and knowledge of how and why to undertake research in the NHS and some "top tips".

Learning objectives:

1. To define the many ways in which clinicians can engage in research
2. To understand the benefits for clinicians and patients of clinical research
3. To be aware of some obstacles and how to overcome them

Embedding research in clinical practice has its challenges, but brings significant benefits for patients, clinicians and Trusts alike. This presentation will look at resources available to help clinicians take part in research, including support offered through the Clinical Research Network, including the Associate PI scheme, and e-learning and other resources to facilitate the conduct of studies, including research registers like Join Dementia Research to facilitate patient engagement and recruitment.

Professor John O'Brien is Professor of Old Age Psychiatry in the Department of Psychiatry at the University of Cambridge. He is a National Institute for Health Research (NIHR) Emeritus Senior Investigator and a Fellow of the UK Academy of Medical Sciences. He is the NIHR National Specialty Lead for Dementia. His main research interests are in the clinical and research application of imaging biomarkers in dementia, dementia with Lewy bodies and clinical trials. He has been a member of the National Institute for Health and Social Care Excellence (NICE), British Association of Psychopharmacology, European Federation of Neurological Sciences and European Stroke Association Dementia Guideline groups.

Ramin Nilforooshan is a Professor in Psychiatry at the University of Surrey (UK) and a Consultant Psychiatrist for older adults in Surrey and Borders Partnership NHS FT (SaBP). He is the Director for R&D in his organisation and is the Dementia Speciality Lead for Clinical Research Network in Kent Surrey and Sussex. He is also the Clinical Lead for Dementia Research Institute CR&T Imperial (UK).

Neuroradiology scan interpretation

Dr Curtis Offiah

Neuroimaging of cases for learning the facility and basic techniques and radiological diagnoses will be presented to provide an initial and hopefully useful guide in basic review of CT scans and MRI scans.

Dr Curtis Edward Offiah is a Consultant Neuroradiologist and an Honorary Senior Lecturer at Queen Mary University London. He studied medicine at University of Birmingham and holds the degrees of Bachelor of Science, Bachelor of Medicine and Bachelor of Surgery and is a Fellow of the Royal College of Radiologists and previously of the Royal College of Surgeons of Edinburgh. He has been employed as a full-time consultant at the Royal London Hospital and St Bartholomew's Hospital, which are part of Barts Health NHS Trust since 2006 . The Royal London Hospital and St. Bartholomew's Hospital are teaching hospitals associated with Queen Mary's University London and Barts and The London School of Medicine and Dentistry. Amongst Dr Offiah's specialist interests is neuroradiology pertaining to dementia and other neurodegenerative diseases and radiology pertaining to elderly care and elder abuse. He lectures at national, post-graduate and undergraduate levels and has lectured at the Royal Society of Medicine, Royal College of Radiologists Annual Scientific Meetings, British Institute of Radiology meetings, Faculty of Forensic and Legal Medicine, Royal College of Anaesthetists, Royal College of Surgeons of England and the British Association of Forensic Scientists. He has published peer-reviewed scientific research papers, reviews and textbook chapters. He is on the Editorial Board of the national journal of the Royal College of Radiologists (Clinical Radiology). He is an appointed Guideline Committee member of the National Institute for Health and Care Excellence (NICE). He is a member of the Faculty of Forensic and Legal Medicine. He is an appointed member of the Institute for Addressing Strangulation.

Business Case Development: how you put a business case together

Dr Ben Underwood

How to articulate why older people matter

Dr Connor Barton

Conor is a Consultant Old Age Psychiatrist and chair of the Old Age Faculty of RCPsych NI.

Mental health and older people in India

Dr Suvarna Kantipudi, overseas bursary prize winner

SIGN guidelines

Dr Vivek Patten

Presentation on development of Scottish guidelines on assessment, treatment and support for people with Dementia and their carers.

Dr Vivek Patten is a consultant old age psychiatrist working with Stirling community mental health team for older adults for the last 11 year. In the past Dr Patten has managed inpatient unit, acute hospital liaison and acted as clinical director for the department. Currently Dr Patten is the chair of Scottish old age psychiatry faculty and also has the role of clinical lead for Dementia portfolio in Health Improvement Scotland.

The use of and future of psychedelics as treatment in older adult mental health

Dr Oliver Bashford

This presentation will give an overview of the history of the therapeutic use of psychedelic drugs, from pre-industrial societies up to the recent explosion in clinical research that has been termed the

'psychedelic renaissance'. Findings from clinical trials and neuroscience will be presented with a discussion on their potential for use in the older adult population.

Dr Oliver Bashford is a consultant Older Adult psychiatrist working in a home treatment team in Surrey and Borders Partnership NHS Foundation Trust. During his training, he worked as an honorary clinical research fellow at Imperial College London where he worked on an early study of psilocybin (the active ingredient of 'magic mushrooms') for treatment-resistant depression, and is on the advisory board of Psycare UK, a charity that provides psychological support to individuals experiencing challenging drug-related experiences at music events.

Speaker abstracts and biographies
Friday 25 March 2022

Early diagnosis

Dr Vanessa Raymont

This talk will highlight initiatives in clinical practice around early and timely diagnosis, prevention and how clinical trials are supporting these.

Dr Vanessa Raymont is an academic old age psychiatrist working at the University of Oxford and Oxford Health NHS Foundation Trust with a long-standing interest in the late life cognitive effects of brain injury, as well as clinical trials in cognitive disorders and dementia. She is an associate director for Dementias Platforms UK (DPUK), leading on the Trials Delivery Framework, and R&D Director at Oxford Health NHS Foundation Trust.

Disease modifying treatments in Alzheimer's disease

Dr Bob Barber

This presentation will cover the current drug pipeline for Alzheimer's disease, the associated challenges and trends, and with an eye on the future, review the evidence relating to monoclonal antibody therapies.

Dr Bob Barber is an Old Age Psychiatrists based in Newcastle. He has been involved in delivery of non-commercial and commercial clinical trials since 2008. He is Speciality Lead for DeNDRoN in the North East and Cumbria and works with DeNDRoN nationally to support the delivery of Industry / commercial portfolio. He has worked a chief investigator for Roche on the Graduate study (gantenerumab) and previously has carried out ad hoc paid advisory roles for Roche and Biogen (nothing currently active).

Brain Health Clinics around the country

- Brain Health Scotland – Dr Catherine Pennington
- Manchester & the Northwest – Dr Ross Dunne
- Newport and Wales – Dr Chineze Ivenso & Dr Marc Edwards
- Bristol and the Southwest – Professor Liz Coulthard
- Oxford and the TRC-D – Prof Clare Mackay
- London – Dr Chris Kalafatis

Brain Health Manchester is a pilot clinic running since January 2022, which diverts GP referred patients without functional impairment to specialist assessment with the aim of 1) comprehensive risk assessment 2) timely diagnosis of prodromal disease 3) reducing barriers to research entry 4) personalised risk reduction plans.

South London & Maudsley NHS Foundation Trust (SLaM) has developed a remote Brain Health Clinic (BHC) under a pilot service development scheme of minimum twelve months. The clinic aims at enhancing the SLaM Memory pathway by delivering genuinely early diagnosis of Dementia AND therapeutic interventions. The BHC accepts referrals of patients diagnosed with Mild Cognitive Impairment (MCI) from all SLaM memory clinics.

Anticipating the advent of new disease-modifying therapies that will be indicated specifically to patients diagnosed early ie. those with MCI due to Alzheimer’s Disease, the clinic aims at providing timely, aetiological diagnosis of MCI and remote patient follow-up in view of objective monitoring for disease progression. The BHC is a virtual clinic that provides state-of-the-art diagnostics ie. digital clinical, functional and cognitive assessments, CSF biomarker (under a research protocol) testing and analysis and post-biomarker counselling. Patients are remotely followed-up at six-month intervals following an initial assessment and also reassures those who are less likely to develop Dementia. The BHC also provides psychosocial group interventions in order to reduce of risk of developing Dementia in the future and also manage ones’ symptoms and improve patients’ quality of life. The BHC has a strong interface with clinical research.

Dr Ross Dunne: In 2018 I became clinical director of the Greater Manchester Dementia Research Centre (GMDRC) where I'm a Principal Investigator on NIHR and industry-funded trials and cohort studies in dementia and depression. The GMDRC is now a member of the NIHR Dementia – Translational Research Collaboration (D-TRC). I am Greater Manchester NIHR Clinical Research Network (CRN) Division 4 lead for dementia and an Honorary Senior Lecturer at the University of Manchester. I am the Dementia theme lead for Health Innovation Manchester, Manchester's Academic Health Science Network, and a board member and dementia theme co-lead for the newly established Geoffrey Jefferson Brain Research Centre.

Dr Marc Edwards is a Neurology SpR studying across Wales with an interest in cognitive neurology. Dr Edwards has been working closely with Dr. Chineze Ivenso over the past couple of years in the memory service.

Dr Chris Kalafatis is a Consultant in Old Age Psychiatry at South London & Maudsley NHS Foundation Trust and Affiliate of King’s College London where he leads clinical research in translational and

cognitive Psychiatry. Chris has developed novel cognitive assessments, researches the diagnostics of neurodegeneration and leads on clinical trials in Dementia at the Institute of Psychiatry, Psychology & Neuroscience. Chris has developed clinical-academic NHS clinics with a focus on brain health and digital innovation at service level.

Professor Liz Coulthard is an associate professor in dementia neurology at the University of Bristol. She leads the ReMemBR group (Research into Memory, the Brain and Dementia) and runs a cognitive disorders clinic focusing on early, accurate diagnosis of dementia. Her research investigates sleep and memory in early Alzheimer's disease with a view to developing interventions to help prevent decline and improve quality of life in prodromal and established Alzheimer's.

Clare Mackay is a Professor of Imaging Neuroscience and leads the Translational Neuroimaging Group in the Department of Psychiatry. Her group use neuroimaging techniques to understand risk and develop markers for psychiatric and neurodegenerative disease. She trained in Psychology at the University of Liverpool, where she also studied for her PhD in quantitative MRI. Clare is a co-theme lead for the NIHR Oxford Health Biomedical Research Centre (Dementia), where she is leading the development of a new 'Brain Health Centre' for memory clinic patients. They will provide a very brief overview of their experience of setting up a Brain Health Clinic in Oxford. They see typical memory clinic patients in a clinical research setting where they offer high quality (MRI, clinical, cognitive) assessments as standard and research assessments as extra to all referrals.

Debate: Should old age psychiatrists be involved in delivery of currently available DMTs?

Prof Rob Howard – opposing

Prof Ramin Nilforooshan – proposing

Robert Howard is professor of old age psychiatry at UCL and honorary consultant psychiatrist at Camden and Islington NHS Trust.

Ramin Nilforooshan is a Professor in Psychiatry at the University of Surrey (UK) and a Consultant Psychiatrist for older adults in Surrey and Borders Partnership NHS FT (SaBP). He is the Director for R&D in his organisation and is the Dementia Speciality Lead for Clinical Research Network in Kent Surrey and Sussex. He is also the Clinical Lead for Dementia Research Institute CR&T Imperial (UK).

Enhanced Care and Care Homes Model

Dr Amanda Thompsell

This will be a brief run through the content of the newly updated Enhanced care in care homes policy document The presentation will outline what the core components of this model are expected to include.

Dr Amanda Thompsell was a GP Principal before retraining in psychiatry and becoming an Old Age Psychiatrist She was a consultant for a multidisciplinary team supporting care homes with nursing and then an old age liaison service in an acute hospital before working in specialist care. She has previously led on the improving care in dementia work stream for London Dementia Strategic Clinical leadership group. She is a past Chair of the Faculty of Old Age Psychiatry at the Royal College of Psychiatrists. She currently works in a community team for older people with serious mental illnesses and is the National Specialty advisor in older adults' mental health NHSE .She is also a Medical member of First Tier Tribunal service and a non-executive director on Target Health care REIT.

Diagnosing Advanced Dementia in Care Homes Mandate (DiADeM)

Dr Sara Humphrey

This presentation will cover:

- The background of the tool & when it should be used
- The presentation of the later stages of dementia
- Why a diagnosis of dementia is important
- Dying and dementia
- Consent
- How to use the tool
- How to access the tool

Dr Sara Humphrey is an Honorary Visiting Professor at the University of Bradford (2022-2025) and is the Clinical Lead for Y&H Older People Mental Health & Dementia Clinical Network, and she a member of the National Older People's Mental Health Expert Advisory Group. Sara provides local clinical leadership as the Associate Clinical Director for Frailty and Dementia for Bradford Health Care Partnership.

Sara started her career at Leeds Medical School in 1990 and following General Practice training joined Westcliffe Medical Centre (now Affinity Care) in 1995-2022 .Sara developed skills as a GP with an Extended Role in Older People and has worked for several local teams: including Bradford Hospital Intermediate Care, Bradford Care Trust PACT team and during COVID ,lead and worked in the Digital Care Hub 'Super Rota' remotely supporting care homes and their residents during the pandemic.

While in primary care Sara has lead a research unit at the Affinity Care PCN recruiting participants to a wide range of clinical trials with over 2137 people to 27 clinical trial in 21-22. Sara has also been involved

as a co-applicant with several trials involving frailty, dementia and medicines safety over the last 10 years. This includes PROSPER, EFI+ Sara has supported the Bradford Doctoral Training Centre Stakeholders Advisory Group since 2016 and worked with Bradford University on several studies. Sara continues to be a strong advocate for research in dementia, frailty and primary and brings an expertise in understanding how primary care can support and recruit to research trials

Falls and Deconditioning

Dr Amit Arora

Standards in dementia

Michaela Morris, Rebecca Hanmer and Professor Tony Bayer

Professor Antony Bayer is Emeritus Professor of Geriatric Medicine at Cardiff University. Until recently he was Clinical Lead of the Cardiff Memory Team.

Faculty Business Meeting

Presentation of Lifetime Achievement Award to Professor Tom Dening

What can research offer to clinicians and patients? Lessons from experience (Panel Discussion)

Professor John O'Brien NIHR, Dr Chineze Ivenso, Dr Bob Barber, Dr Ross Dunne, Dr Rashi Negi, Dr Ben Underwood, Professor Tom Dening

Professor John O'Brien is Professor of Old Age Psychiatry in the Department of Psychiatry at the University of Cambridge. He is a National Institute for Health Research (NIHR) Emeritus Senior Investigator and a Fellow of the UK Academy of Medical Sciences. He is the NIHR National Specialty Lead for Dementia. His main research interests are in the clinical and research application of imaging biomarkers in dementia, dementia with Lewy bodies and clinical trials. He has been a member of the National Institute for Health and Social Care Excellence (NICE), British Association of Psychopharmacology, European Federation of Neurological Sciences and European Stroke Association Dementia Guideline groups.

Dr Bob Barber is an Old Age Psychiatrists based in Newcastle. He has been involved in delivery of non-commercial and commercial clinical trials since 2008. He is Speciality Lead for DeNDRoN in the North East and Cumbria and works with DeNDRoN nationally to support the delivery of Industry / commercial portfolio. He has worked a chief investigator for Roche on the Graduate study (gantenerumab) and previously has carried out ad hoc paid advisory roles for Roche and Biogen (nothing currently active).

Dr Ross Dunne: In 2018 I became clinical director of the Greater Manchester Dementia Research Centre (GMDRC) where I'm a Principal Investigator on NIHR and industry-funded trials and cohort studies in dementia and depression. The GMDRC is now a member of the NIHR Dementia – Translational Research Collaboration (D-TRC). I am Greater Manchester NIHR Clinical Research Network (CRN) Division 4 lead for dementia and an Honorary Senior Lecturer at the University of Manchester. I am the Dementia theme lead for Health Innovation Manchester, Manchester's Academic Health Science Network, and a board member and dementia theme co-lead for the newly established Geoffrey Jefferson Brain Research Centre.

ECT in Older Adults

Dr Richard Braithwaite

Electroconvulsive therapy (ECT) is a very safe and highly effective medical treatment. It is particularly effective in the treatment of depressive episode and in older adults. Indeed, there is a steadily increasing body of evidence to guide its use in this population. Despite this, ECT is underused in all age groups in the UK. There are specific challenges to its use in older people but these are usually surmountable with individualised, multidisciplinary care.

Dr Richard Braithwaite completed dual training in General Adult and Old Age Psychiatry in 2010. He has since been employed as a Consultant Old Age Psychiatrist, first by Isle of Wight NHS Trust, during which he served as Clinical Tutor and as Lead Clinician, and currently by Sussex Partnership NHS Foundation Trust. He gained an interest in electroconvulsive therapy (ECT) at medical school, taking an active part in delivery of ECT during basic and higher psychiatric training. Alongside his work with patients and families affected by dementia, he is currently the Lead Consultant for Neuromodulation for West Sussex, Brighton & Hove, performing clinical sessions in repetitive transcranial magnetic stimulation (rTMS), as well as ECT.

He has chaired the Royal College's Special Committee for ECT & Related Treatments since September 2022, contributing to its work in key areas related to ECT practice and that of other physical treatments in psychiatry. Previously, he had served as Committee Vice Chair for four years. He has also served four years on the College Centre for Quality Improvement's ECT Accreditation Service (ECTAS) Advisory Group, helping shape national quality standards. He has long endeavoured to enhance the delivery of treatments in psychiatry for which a strong evidence base exists, whilst challenging the allocation of finite resources to those for which it does not. He questions the gradual extension of the borders of mental disorder into the realms of normal diversity, whilst upholding the rights of people with major mental illness to receive appropriate medical treatment and holistic support.

Why Data Matters II: reducing health inequalities of the local population

Dr Asif Bachlani

This is the 2nd of 'Why Data Matters' Talks which focuses on clinicians can use data sets to find out the needs of the local population and then address the local health inequalities.

In the talk, I will cover
• What data sets are available for clinicians to use to understand needs of local population.
• How to use nhs benchmarking data to get understanding of service gaps in their local area
• How to use a care pathway approach to develop new services
- The importance of clinical outcomes and how to use data to get services commissioned
• How to present data set and outcomes at ward/team level which are clinically meaningful.

Dr Asif Bachlani works as Consultant Psychiatrist and Clinical Lead for the ASD pathway at Priory Woking Hospital. Asif is also an Associate Non-Executive Director (NED) for Kent and Medway NHS and Social Care Partnership Trust with his portfolios being data and digital. Asif has held various managerial and digital positions in NHS and Independent sector including Clinical Director, Associate Medical Director, Clinical Lead for Mental Health Outcomes and Chief Clinical Information Officer.

In 2016 Dr Bachlani was awarded a Health Foundation QI award for his project 'Improving Physical Health care for patients with psychosis'. Asif was awarded the Fellowship of Royal College of Psychiatrists in 2019. Asif has been a member of the RCPsych General Adult Faculty for the past 10 years with his last role being Treasurer. Asif is also a committee member of the Digital Special Interest Group and the RCPsych Representative on the NHS Benchmarking Network, Mental Health Steering Group.

Asif was one of co-authors of the recent two-part series in RCPsych Advances (2022) on Digital literacy in contemporary mental healthcare. Asif has had an interest in clinical value of data and data literacy for clinicians. Asif set up 1st ever data events for clinicians initially regionally in 2018 and then nationally from 2019 via RCPsych Better Data, Better Care series of conferences which is now in its 4th year. Asif is the lead co-author of the RCPsych Data and Digital Literacy Competencies for Psychiatrists which is being launch in 2023.

Crisis/Virtual wards

Kerry Turner

Impact of Acute Care Pathway Referrals Meeting on Waiting Time for Admission: One Year Study

Dr Raja Badrakalimuthu

Aim & Hypothesis: To evaluate impact of waiting time for older adult inpatient admission by implementing daily acute care pathway referrals meeting.

Background: SABP NHS Foundation is in the lowest quartile for bed to older adult population and does not have dedicated crisis team for older adults. Clinically focused acute care pathway referrals daily meeting (12.30PM) including ward matrons, managers for community mental health teams and liaison managers was started in 2022 with clinicians attending this meeting to present their case to manage average waiting time of 2.32 days (2021). This project which commenced in January 2022 data collected data on age, gender, diagnosis, type of risk, type of accommodation (home v care home), support (living alone v with care/family), Mental Health Act status and referring service (CMHTOP/ Liaison). Odds ratio was calculated to understand impact of the variables on admission and waiting time.

Results: Of 291 referrals, 44% were under 75 and 42% were of male gender. Diagnostic rates of dementia and depression were 25% and 37% respectively. Risk rates for self-harm, self-neglect and aggression were 30%, 45% and 19% respectively. 48% lived alone and 54% were referred by CMHT.79% were admitted and off those 82% were detained. Average waiting time for admission was 1.34 days.
Liaison services referral predicted admission. Dementia and self-neglect predicted community treatment. Age 75+ trended to admission. Self-neglect predicted not having to wait for admission, with CMHT referral showing a trend to not having to wait. Dementia and liaison referrals showed a trend to waiting.

Clinicians feedback: ‘effective and solution-focused’, ‘learning for all of us’ ‘morale is up’.

Conclusion: Daily meeting of senior clinicians can cut down admission and waiting times whilst providing clinically appropriate alternative care plan.

Dr Raja Badrakalimuthu is a consultant old age psychiatrist in Surrey having worked in community, inpatient unit and acute hospital liaison teams. He has served as associate medical director, college tutor and foundation programme director. He has written fictional book ‘A Way With The Fairies’, story about an eight-year old who’s father is diagnosed with dementia.

Poster Abstracts

1. The Assessment and Management Of Fragility Fracture Risks In Older Adults Admitted To Highbury Hospital, Nottingham

Dr Nurul Nor Nazurah Abdul Wahid, Dr Sujata Das, Dr Asmaa Mahamed, Dr Laura McCormick, Dr Samreen Shah

Aims The primary objective of the audit is to assess the usage of the FRAX tool in identifying and evaluating fragility fracture risks in patients admitted into the Old Age Psychiatry wards. The secondary objective of the audit is to evaluate the management of patients that have been risk stratified accordingly.
Background Recent findings in a Serious Incident investigation found gaps in the documentation of FRAX assessment on Mental Health Services for Older People (MHSOP) wards. It is important that lessons are learned and by carrying out a clinical audit of our own practice we can better understand whether the systems currently in place within our clinical area are sufficiently robust.
Methods The NICE Clinical Knowledge Summary CKS Osteoporosis - Prevention of fragility fractures were used have been used to set the standards for this audit. Data was collected over a 3-month period between 1st January 2022, to 1st April 2022 - All patients admitted to Silver Birch ward (Old Age dementia ward) and Cherry ward (Old Age functional ward) in Highbury Hospital, Nottingham, who met inclusion criteria were included in the sample. Information was gathered about assessment and monitoring using electronic RiO records to complete Audit Tool 1. Patients who fell within the boundary of 2 risk stratification groups were allocated to the upper limit.
Results Overall, 65% FRAX assessments were completed during the study period. As anticipated, multiple risk factors were identified within the sample population. Amongst those that had FRAX assessments complete, 33% had risk stratification documented on electronic records. Sixty-nine percent of those who were risk stratified received the correct treatment plan accordingly.
Conclusions This audit successfully identified a potential patient safety issue but also highlighted likely gaps in junior doctor knowledge and poor documentation that can easily be rectified by simple measures.

2. Satisfaction survey of patients for telephone vs face-to-face reviews - a service evaluation project

Dr Busra Acar Sevim, Katherine Haworth, Tani Randhawa, Khan Kehkashan

Aims and hypothesis Remote assessment has positive impacts including: -improving access to care in remote areas/when local services cannot meet demand -for disabled patients Understanding the patient experience about remote assessments helps navigate decisions about future modes of consultation.
Background The Covid-19 pandemic necessitated major changes in clinical care, including remote patient contact. Havering Older Adults Mental Health Team and Memory Service (HOAMHT&MS) patients often fell within the vulnerable category for poorer outcomes with the SARS-CoV-2 virus, so remote contact was preferable during the pandemic. Telephone assessments were offered to replace face-to-face reviews for some patients. Feedback from patients and carers was collected to compare these modes of patient contact.
Methods This evaluation was organised in HOAMHT&MS. A Rio diary search was conducted for practitioners from 15/07/2020 to 15/10/2020. 75 questionnaires were sent from each clinic (OAMHT and Memory Service). We sent an equal number of questionnaires for telephone appointments and face-to-face reviews. Questionnaires were posted to patients with pre-paid envelopes to return responses.
Results We had a total return of 23 questionnaires from the Memory Service and 24 from the OAMHT clinic. Most questions were a likert scale from Poor(1) to Excellent(5). The overall satisfaction score out of 5(average of all the responses) for some of the responses: OAMHT: Patient/telephone:3.7(n=13) Patient/face-to-face:4.1(n=7) Memory Service: Carer/telephone:4.4(n=8) Carer/face-to-face:4.2(n=9) Conclusions OAMHT Responses: -Face-to-face feedback more positive -Patients experienced more distress- nature of illness (distress/crisis) compared to memory (usually gradual decline) -Telephone appointments seem less satisfactory- less likely to meet the emotional need of patient/carer Memory Service: -Generally positive feedback from carers and patients in all areas– able to take a meaningful history over telephone

3. Adding depression screening questions to the orthogeriatric review at the Bristol Royal Infirmary

Hani Akasheh, Dr Cannon Abigail

With no screening and psychological intervention for patients with hip fractures, the risk and impact of depression becomes inevitable. The aim of this quality improvement project is to help the ortho-geriatric team at the Bristol royal infirmary to detect baseline levels of depression and provide suggestions on sensitive questions within the Geriatric Depression Scale (GDS) and Patient health questionnaire (PHQ-9). This study identified that 38% of patients presenting with hip fractures experience or had experienced depression. An attempt at detecting sensitive questions within both questionnaires has been made with the intention of limiting the need for lengthy questionnaires during the admission process. We identified

questions related to poor sleep, helplessness, and a sense of boredom as correlates of underlying depression. The results of this study highlight an urgent requirement for improvement in the psychological intervention for patients with hip fractures however more research is needed on a larger population sample to identify optimal tools for screening.

4. Clozapine in the elderly: are we storing up problems?

Dr James Barclay, Dr Rahul Tomar

Aims and hypothesis We aimed to analyse data for patients in Hertfordshire aged 65 and older prescribed clozapine, assessing mental state stability, concomitant medication and side effect burden.
Background Clozapine is commonly prescribed and shows benefit in treatment-resistant schizophrenia. Side effects are commonly encountered. 18.6% of the UK is aged 65 or older: this is an increasing trend, and the number of older adults prescribed clozapine will likely increase accordingly. However, there is a lack of guidelines on prescribing in a cohort likely to encounter polypharmacy and a greater susceptibility to side effects. Co-prescribing of anti-hypertensives or benzodiazepines may contribute to falls, anticholinergic drugs to cognitive impairment and potentially fatal constipation, and hypersalivation to aspiration pneumonia.
Methods A retrospective analysis of electronic patient records was undertaken for the 42 patients over 65-year-olds currently prescribed clozapine within Hertfordshire Partnership NHS Foundation Trust (HPFT), out of 508 across all age groups.
Results Mean patient age was 70 and the most common diagnosis was schizophrenia (69%). 5% were prescribed clozapine for psychosis in Parkinson's disease. The majority (69%) of prescriptions were started before 65 years. 57% of patients had been stable for at least five years. 38% were co-prescribed an antidepressant, 29% an antihypertensive, 12% an additional antipsychotic and 12% a benzodiazepine/z-drug. 38% were prescribed at least three psychotropics. 90% of patients experienced side effects within the last year, most commonly constipation (60%), hypersalivation (41%) and falls (17%). Mean anticholinergic score was 4.3 (greater than 3 may increase cognitive impairment risk). In two further cases clozapine was discontinued as side effects outweighed benefits.
Conclusions The study demonstrates significant clozapine side effect burden and polypharmacy in an ageing patient group. This raises concerns about the incrementally increasing risk to physical health and how to best address risk-benefit discussions in the absence of clear guidelines.

5. Use of an information pack to improve family, friend and carer satisfaction with the admission process in an inpatient old age adult ward: a quality improvement project

Dr Luke Baxter, Tharun Zacharia

Aims and Hypothesis We performed a Quality Improvement Project in an inpatient Old Age Adult ward to increase patients' relatives, friends and carers' (RFCs') knowledge about important aspects of hospital admission, through the provision of an information pack. By increasing this knowledge, we aimed to improve RFC satisfaction surrounding the admission process.

Background Previously published evidence has shown that increasing the perception of involvement of RFCs in a patient's admission promotes greater satisfaction within this group. Adequate information provision is regarded as an important part of promoting perceived involvement; conversely, a lack of information provision and communication has been associated with dissatisfaction with hospital admissions among RFCs.

Methods Using a survey directed towards members (n=9) of the ward MDT, we identified several topics relating to hospital admission that were regarded as high priority for inclusion in an information pack. MDT members were also asked about their perception of RFC satisfaction in the admission process. RFCs (n=8) were asked how well-informed they felt about these topics with a separate survey, and their level of satisfaction with the admission process. An information pack was created based on the results of these surveys and distributed to RFCs. The RFC survey was then repeated to assess improvements in RFC knowledge and satisfaction.

Results Perceived RFC satisfaction among staff members prior to the publication of the information pack was lower than actual RFC satisfaction. RFC satisfaction with and knowledge about the admission process increased following the distribution of the care pack.

Conclusions Admission information packs can be used on inpatient old age wards to improve patient family, friend and carer knowledge and satisfaction.

6. Audit on interventions in dementia and its adherence to NICE guidelines

Dr Sachin Belur, Dr Rozita Zenhari, Dr Kapil Usgaokar

Aims and hypothesis To assess the interventions in dementia and its adherence to NICE guidelines.

Background Dementia management poses a great challenge, as it involves both pharmacological and non-pharmacological interventions which are used to promote cognition, independence, and well-being for people with mild to moderate dementia.

Methods An audit was performed on 50 patients who have completed their Level 2 assessments between June till August 2022. In this audit, we looked if the patients received at least one non-pharmacological intervention according to guidelines. The data was collated and analysed using Microsoft excel.

Results All the patients assessed by our service had a diagnosis, out of which 76% (38 patients) had a diagnosis of dementia. In terms of dementia subtypes and its pharmacological management, 39% of patients had mixed dementia, followed by 32% with Alzheimer's dementia and 5% having Lewy Body

dementia; and all three groups were prescribed anti-dementia medication according to the guidelines. 16% had unspecified dementia and out of which 83% were prescribed antidementia medication while 16% weren't as the clinician didn't see any benefit. 5% of patients with vascular dementia didn't receive antidementia medication according to guidelines. In terms of non-pharmacologic interventions, all patients diagnosed with dementia received at least one type of non-pharmacological intervention, including referral to Dementia advisor services from Alzheimer's society, and 5% were referred for occupational therapy input since they had mobility issues. None of the patients with Mild Cognitive Impairment or ruled-out dementia were offered antidementia medications.

Conclusion The results reflect the high quality of care that is being provided by our service adhering to the NICE guidelines in the management of both pharmacological and non-pharmacological management of dementia. Further recommendations involve tailor-made activities as psycho-social interventions for patients.

7. Adult family violence and old age psychiatry

Dr Susan-Mary Benbow, Sarmishtha Bhattacharyya, Susan-Mary Benbow, Paul Kingston

Aims To raise awareness of adult family violence as part of domestic abuse, and to consider ways of intervening when adult family violence is recognised.

Background The Domestic Abuse Act 2021 defines domestic abuse as follows: "Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if— (a) A and B are each aged 16 or over and are "personally connected" to each other, and (b) the behaviour is abusive." This definition includes both abuse between intimate partners (intimate partner abuse/ violence) and abuse between family members (adult family violence). The focus in terms of domestic abuse is often on intimate partners and families with children and adolescents: it might be argued that adult family violence is relatively neglected.

Method We carried out a narrative review of literature on adult family violence, and adult family homicide/ parricide, and re-examined our collection of domestic homicide review reports involving older adults.

Results Much of our knowledge comes from adult family homicide rather than adult family violence, most often involving mothers killed by adult sons. Common perpetrator themes include mental health issues (particularly psychosis), alcohol/ substance misuse, and criminality. A cross-cutting theme identified in various studies is care-giving responsibilities. The term 'parental proximity' is used to encompass cases where there is a dependent caring relationship between parent-victim and perpetrator with serious mental illness; a relationship which may involve the responsibilization and marginalization of an older parent caring for an adult-child with serious mental illness. Our previous research has identified two main

groups of adult family homicides: perpetrators with major psychotic illness, and victims-perpetrators in complex relational contexts.
Conclusions Old age psychiatrists need to be alert to adult family violence, particularly the potential risk to older parents caring for psychotic adult-children. We suggest practical ways forward for policy-makers, agencies/ organisations and practitioners.

8. Two outbreaks of Covid-19 on an older adult acute psychiatric in-patient ward

Dr Paul Boston, Gloria Abiola, Shane Donnelly

Aims and hypothesis
The study was a case report service evaluation of the rapid spread of Covid-19 spread on an elderly in-patient psychiatric ward with frail and vulnerable patients, many of whom had co-morbidities. The report aimed to inform infection control practice and to gain understanding of the spread of the virus on an in-patient ward.
Background Covid-19 is a highly infectious disorder which can be more severe in an elderly and vulnerable population. It arose as a new infection in early 2020 and rapidly reached pandemic status. It has the potential to spread rapidly in an in-patient environment. At the start of the pandemic, psychiatric wards had generally not been well set up for infection control procedure and there were few publications on experience in this area. The ward team had been unprepared for the rapid spread of the virus during the initial outbreak at the start of the pandemic.
Methods The study used retrospective case report data which are described and summarised from two outbreaks of the virus between March and April 2020 and between December 2020 and January 2021.
Results 12 patients with Covid-19 are described in the first outbreak and three in the second outbreak. Covid-19 spread rapidly in the first outbreak. Despite age, frailty and co-morbidities of the infected patients, no deaths occurred within 28 days of infection. However, in the first outbreak, two patients died within three months of infection.
Conclusions Experience gained enabled improvements in infection control on the ward. The use of asymptomatic testing for earlier case identification is discussed. Recognition that staff were probable vectors of infection especially in the second outbreak was important. No finance or sponsorship

9. Social connection in long-term care home residents (SONNET) study

Hannah Chapman, Andrew Sommerlad, Jennifer Bethell, Neha Dewan, Madalena Liougas

Aims: Our study aims to improve measurement of social connection in care homes by evaluating existing measures and developing a new measure. We aim to address: (1) What are the psychometric properties

of existing measures assessing social connection in care homes? (2) What do residents, staff and caregivers consider to be important elements of social connection? (3) Can a new measure adequately assess social connection?

Background: Social connection is important for physical and mental health, quality of life and care in care home residents so good measurement is crucial in supporting research evidence and contributing to improvements in policy and practice.

Methods: (1) Systematic review of studies examining psychometric properties of measures quantifying social connection in care home residents, using Consensus-based Standards for the selection of health Measurement Instruments (COSMIN). (2) Qualitative study of UK and Canadian care home residents, staff and caregivers, using thematic analysis to extract themes on important aspects of social connection. (3) Using previous results, we will develop and test a new measure in care home residents.

Results: We have identified 68 studies through the systematic review's literature search. Of the 35 separate measures on which they reported, the majority (18, 51.4%) were measures of quality of life with a subdomain on social connection, whilst only 10 (28.8%) specifically target social connection. We have conducted 32 qualitative interviews to date. Our initial thematic analysis reveals important themes relating to social connection, including the impact of complex needs, staff and resident relationships, and adjustment to life in LTC.

Conclusions: Our research so far suggests a lack of valid and reliable measures of social connection in care home settings. Improving measurement of social connection in care homes will help researchers, clinicians and care settings test the effects of interventions to improve social connection and evaluate quality of care.

10. **Culture-fair cognitive assessment tools for the diagnosis of cognitive impairment: A systematic review**

Dr Tamara Chithiramohan, Smrithi Santhosh, Grace Threlfall, Hari Subramaniam, Elizabeta Mukaetova-Ladinska, Lucy Beishon

Aims and hypothesis: This systematic review examines culture-fair cognitive assessment tools and evaluates their diagnostic accuracy, strengths and limitations.

Background: It is recognised that widely used cognitive assessment tools contain cultural biases and can lead to difficulty in accurately diagnosing patients of ethnic minorities. There have been multiple attempts to create culture-fair cognitive assessment tools.

Methods: Medline, Embase, PsychINFO and CINAHL were searched using a pre-defined search strategy. The protocol was registered on PROSPERO (CRD42021288776). We included studies using a culture fair or culture free cognitive tool to assess cognition in healthy adults or adults with dementia, from varying

ethnicities. Studies were excluded if they used translated versions, did not specify tools were culture fair and tools too long or too brief for the outpatient setting. Narrative synthesis was conducted.
Results: 24 studies were included. Eleven studies assessed the Rowland Universal Dementia Assessment (RUDAS). RUDAS was as accurate as the Mini Mental State Examination (MMSE), with a similar sensitivity and better specificity, and the Multicultural Cognitive Examination (MCE) had improved diagnostic accuracy compared to RUDAS alone. The remaining studies analysed the Community Screening Instrument for Dementia (CSI-D) (n=3), Visual Cognitive Assessment Test (VCAT) (n=2), Cross Cultural Dementia Screening Test (CCD), Dementia screening battery, Neuropsychological Evaluation Screening tool, Modified mini mental test, Iowa screening test, Cross-cultural cognitive examination and the Elderly Cognitive Assessment Questionnaire. VCAT had equivalent diagnostic accuracy to the MMSE and CCD had high predictive validity for dementia. The CSI-D, brief-CSI-D, CCD and VCAT were found to be culture-fair instruments with little effect of educational level.
Conclusions: The RUDAS and VCAT were found to be superior to MMSE in diagnosis of dementia in ethnically diverse minorities. Other tools also showed good diagnostic accuracy. Further research should be done to validate some of the tools in different populations.

11. The novel use of a Red/Amber/Green (RAG) rating in an older adult Hospital at Home (home treatment) team

Dr Rajiv Chudasama, Amelia Stephens, Tracy Draper

Aims/Hypothesis: The hospital at home team (HAHT) in Hereford and Worcestershire is a new service (and one of a handful of services across the country) set up in 2020 with the aim to prevent hospital admission and facilitate early discharge from acute inpatient wards exclusively in older adults (over 65). We aimed to develop a novel RAG rating system specifically designed to take into account needs of an older adult patient population.
Background: Home treatment teams for adults use RAG ratings to help ascertain and document risk but this model did not always map well onto an older adult population and often did not consider patient need as part of the assessment. During initial team set up and beginning to work with patients, it was clear a risk focused approach was often missing key elements of a patient's assessment including those with dementia. Our team also used a separate risk assessment tool.
Methods: The process of developing the new tool involved gathering the entire team and initially brainstorming ideas people had. Papers were put on the wall in the team office for team members to write down what each of the three ratings meant to them and the patient population served. Following this, common themes were summarised into each category and presented to the team.

Results: A RAG rating system was agreed upon by all team members and incorporated into daily clinical practice. This novel newly defined system enabled the team to better support an older adult population and identify patients requiring more intense support or those with greater needs. The ratings are reviewed and updated regularly to reflect ongoing assessments.

Conclusions: HAHT have developed a novel RAG rating system specifically tailored to older adults. We wanted to share how we developed this extremely useful tool which has a potential to be utilised and modified for other teams working with over 65s.

12. Improving Brent Older Adult Community Mental Health Team Referral Triage System, Central and North West London NHS Foundation Trust Quality Improvement Project 2022/2023

Dr Megan Clark, Dr Lakmini Ranasinghe, Dr Anand Ramakrishnan

Aims and hypothesis: This Quality Improvement Project (QIP) aims to improve the effectiveness and safety of the Brent Older Adult Community Mental Health Team (CMHT) triage process. It aims to develop a robust triage system which ensures patient referrals are not missed and are accurately assessed to improve patient care. We hypothesise with relevant training and service development it will mean the most appropriate clinician will review the referrals in the correct time frame. We started this QIP in 10th October 2022 with completion March 2023.

Background: The triage process is integral to ensure services are gatekept. The Brent Older Adult CMHT service caters a population of 44000 people over the age of 65 (2021 census) and receives approximately 600 referrals per year. Our service has finite resources and with the UK population ageing it is imperative to ensure patients are triaged appropriately to improve their care and wellbeing.

Methods: The QIP will use the principle of a PDSA (Plan, Do, Study, Act) cycle. The first stage will be to improve staff knowledge of the service's acceptance criteria and deliver training to all staff. Joint triaging sessions with senior colleagues will be implemented especially for challenging cases. To enhance the quality of triaging a new thorough proforma will be developed with the staff's quality and satisfaction surveyed.

Results: The results are expected March 2023, provisional data shows all patients are being triaged using the proforma with improved staff satisfaction.

Conclusions: Provisionally there has been a significant improvement in the triage process, previously patients had been lost to follow up which has not occurred since initiation of the QIP. The right professional is now being allocated to the patients based on the complexity of their illness and the thorough information gathered in the triage process.

13. Improving Memory Assessment Service Initial Assessment Service electronic documentation within Huntingdon Community Mental Health Team

Dr Felix Clay, Alison Skea

Aims and hypothesis: To identify the process and clinician time required for completing Memory Assessment Service (MAS) Initial Assessment electronic documentation within Huntingdon Community Team. Work with team members to agree standards, improve consistency and efficiency. We predicted that by understanding better and then standardising electronic documentation we will save clinician time and this may contribute to other improvements.

Background: Local clinicians completing MAS Initial Assessment documentation reported multiple different ways they complete the same process and have noted frustration with the perceived complexity and time taken to complete administration.

Methods: In Autumn 2021 we completed process mapping of existing systems and met with clinicians to discuss their experiences. We measured experience and time spent completing different aspects of electronic documentation before and after roll out of a new template designed to simplify and standardise the process. This was in accordance with clinicians' feedback and later integrated MSNAP best practice guidelines.

Results: 7 clinicians completed initial survey compared to 5 completing follow up after 9 months. Frustrations were noted with lack of a standard documentation process in the initial survey with marked variation in how documentation was completed. Users commented on the benefits of a template on follow up and variation in documentation was reduced. Overall time to documents assessments stayed the same (median 60-90 mins) but time to create and format letters was decreased (median 10-20 minutes□5-10 minutes). Explanatory template videos and appendices were highly rated by new starters and trainees. Subsequently MSNAP standards have been included in the template.

Conclusions: Standardising the electronic template for MAS Initial Assessments has saved limited time in documentation but has offered benefits in supporting induction, clarifying standards and provided clear guidance for how integrated templates can be improved. Next steps are service user feedback, wider roll out and updating integrated templates.

14. The "Lesley Marcus" Family Communication Update - a QIP to improve communication with relatives

Dr Ekaterina Doukova, Dr Dilyana Andonova, Dr Jade Wright

Aims and hypothesis · to improve the quality and frequency of communication with relatives · to standardize communication with relatives · to improve the involvement and understanding of

relatives in the care of their family member on the ward •to reduce telephone request for updates from relatives thus freeing up more clinician time to deliver care

Background Following admission, relatives are often not fully satisfied with communication and updates received. Relatives would often contact the ward for updates, however due to the dynamic and acute environment, the information provided would vary in detail and accuracy.

Methods • A questionnaire was designed to gather feedback from relatives about their experience. • A template was created to provide relatives with written feedback. • Communication forms were then distributed fortnightly for up to a maximum of 8 patients per week. • A follow up questionnaire was designed and used to gather feedback from the relatives. • Feedback was gathered from staff. • Three PDSA cycles were completed and the project was then implemented into standard care on the ward.

Results We received very positive qualitative feedback from relatives about this project and the written communication updates that they received. Average rating scores (out of 5) increased from just over 4 at the start to 5 at the end of the project.

Conclusions • The implementation of a fortnightly written feedback form to relatives has had a significant positive impact • Relatives have given overwhelmingly positive feedback regarding the quality of the feedback they receive and have also felt more involved in their family member's care •Staff have fed back that this QIP has also reduced the frequency of telephone calls and hence given them more time to spend with patients on the ward. • This QIP has now become part of the standard care on our ward.

15. Vascular risk factors and cognitive training in older adults: a longitudinal study of UK residents

Dr Rebecca Fitton, Thomas French, Ugochukwu Aghaji, Anne Corbett, Helen Brooker, Clive Ballard, Dag Aarsland, Petroula Proitsi, Latha Velayudhan

Objectives: To establish the benefit of cognitive training (CT) in people with vascular risk factors (VRF) compared to those without.

Methods: 12-month open, non-randomised study of 5574 participants from the Platform for Research Online to investigate Cognition and Genetics in Ageing (PROTECT) who were willing to take part in CT via an online platform. Participants completed baseline cognitive assessments and questionnaires reporting medical diagnoses, demographic information and depressive symptoms. The number of CT sessions completed was recorded. Cognitive assessments were repeated at 12 months. Linear regression models with number of CT sessions and each self-reported VRF diagnosis (diabetes, smoking, heart disease, hypertension, hypercholesterolaemia, obesity) as independent variables. Interaction terms were added to test for interaction between each VRF and number of CT sessions. Relevant demographic variables and depression scores were also included in each model.

Results: Increasing number of CT sessions was associated with improved cognitive performance for all cognitive outcomes (digit span $\beta=0.037$, 95% CI 0.009-0.065, $p=0.009$, paired associate learning $\beta=0.040$ 95% CI 0.022-0.058, $p<0.001$, verbal reasoning $\beta=0.635$ 95% CI 0.460-0.810, $p<0.001$, self-ordered search $\beta=0.144$ 95% CI 0.099-0.189 $p<0.001$). Heart disease showed a significant negative interaction effect with CT for verbal reasoning ($p=0.028$) and hypertension showed a significant negative interaction effect for paired associate learning ($p=0.029$), suggesting a reduced benefit of CT in these groups.
Conclusion: Increased sessions of CT resulted in greater improvement in cognition. Cognitive training appears less effective in participants with heart disease and hypertension, but the presence of other VRF do not modify the effect of cognitive training

16. Structured Board Rounds; Improving patient safety through effective handover on the Older Adult Psychiatry Wards in Leicester Partnership Trust

Dr Sanah Ghafoor, Dr Sujaen Ravii, Dr Ada Ugochukwu, Dr Christina Evans, Rachael Beasley

Aims and hypothesis To create a standardised template document for daily board rounds to improve patient handover on Older Adult Psychiatry wards in the Leicester Partnership Trust.
Background Handover of patients between multi-disciplinary team (MDT) members occurs during a daily morning board round. It is led by the nurse in charge and attended by junior doctors, nurses, and allied healthcare professionals. Areas of concern identified by ward management included quality of communication documented from the board round, which included lack of consistency and poor documentation leading to failure of task completion.
Methods Quantitative data on board round template pre- intervention was collected retrospectively. Amendments to the template were made based on the areas of deficiency highlighted in data collection in the first cycle. The results were fed back to the team and a new board round template rolled out. Post-intervention quantitative data was collected on the board round template. Results Parameters relating to demographics (patient name, date of birth, consultant, legal status, current medication, and mental state etc) had good compliance (100%) pre and post intervention. There was an improvement in documentation of physical health (42% vs 71%), Bloods (48% vs 91%), ECG (46% vs 84%), Capacity (26% vs 76%), ward round plan (11% vs 80%) post intervention. Improvement in job task completion (doctors 20% vs 25%) was noted. No compliance on documentation of discharge plan post-intervention.
Conclusions Modifying the board round template improved compliance with documentation across a range of parameters. However, there remains room for improvement with regards to documentation of discharge planning if we are to aim to introduce a standard board round template across all wards within the Older Adult Service.

17. **Audit of Hypnotic Medication Use in the Treatment of Insomnia Among Elderly Patients on the Bryngolau Ward in Prince Philip Hospital**

Dr Padmavathy Gopinath, Dr Kingsley Nnamah, Dr Graham O Connor

Background Insomnia is a common disorder that can have a significant impact on daytime functioning and quality of life Hypnotic medications can be useful for the short-term management of insomnia, but they should be used with caution due to potential side effects and dependence Careful consideration should be given to the use of hypnotic medications in elderly patients, including following evidence-based guidelines and considering alternative treatment options Regular reviews of prescribing practices can help to identify any deficits and improve the quality of care for patients with insomnia

Objectives: The aim of this audit was to assess the use of hypnotic medications, specifically "Z" drugs and short-acting benzodiazepines, in the treatment of insomnia among elderly patients on the Bryngolau ward. The audit sought to compare the prescribing practices with NICE guidelines and the British Association for Psychopharmacology's consensus statement on the evidence-based treatment of insomnia, and to identify any deficits in order to improve care for these patients.

Methods: The audit took place over a three-month period and involved a review of medical records and the use of a collection tool to gather data on the prescribing practices and outcomes for 20 patients meeting the inclusion criteria. Data was collected on the indications for prescribing these medications, the duration of treatment, and any adverse effects experienced by the patients.

Results: The results of the audit showed that the majority of the patients (16 out of 20) were prescribed a "Z" drug, with Zopiclone being the most commonly used. Most of these patients (14 out of 16) were also prescribed a benzodiazepine for use as needed. However, the prescribing practices for these medications did not consistently follow NICE guidelines and the British Association for Psychopharmacology's consensus statement. In particular, the audit found that the indications for prescribing these medications were not always clearly documented and that the duration of treatment was often longer than recommended. Some patients also experienced adverse effects, including dizziness and falls.

Conclusions: The findings of this audit suggest that there may be room for improvement in the prescribing practices for hypnotic medications on the Bryngolau ward. It is important to ensure that these medications are used appropriately and only when indicated, and to carefully consider the risks and benefits in elderly patients. Further efforts should be made to follow evidence-based guidelines and to consider alternative treatment options, such as non-pharmacological approaches or the use of other types of medications, in order to optimize care for these patients. Regular reviews of prescribing practices can help to identify any deficits and ensure that the quality of care for patients with insomnia is improved

18. **An Audit into the practice of brain imaging in memory clinics initial assessments in Merseycare.**

Dr Nourgeihan Hashem, Dr. Rosie Conroy, Dr. Sudip Sikdar, Dr. Jolanta Webb

Aims: Investigate indications of imaging during initial assessments of cognitive impairment against NICE guideline 97. Secondary aims were to review the quality of radiology reports as well as impact of imaging on diagnosis and treatments.

Background: Currently, there are ~900,000 people with dementia in the UK. Focus on early referral but delays in imaging can delay diagnosis and management. As such we compared imaging practice to current NICE guidelines.

Methods: All CT Brain imaging requested by memory clinics from October2022-March2021 and undertaken at Liverpool University Hospitals Foundation Trust were collected. 204 patients identified and data collected from CT reports and psychiatry documentation system (Rio). Proforma containing 11-psychiatry-based and 11-Radiology-based questions was utilized. Master set data created in Excel which was used for analysis.

Results: CT scan indications for 204 patients, 55.4 % (113) were Routine, 29.4% (60) were to classify subtype of dementia, 6.4% (13) were to rule out reversible causes and 8.8% (18) were to differentiate Dementia from Mild Cognitive impairment. CT scan's impact on diagnosis and treatment were reviewed. 28%(58) didn't have a provisional diagnosis ,40%(82) had it confirmed, 19%(38) had it changed, 8%(16) we were unable to comment and 5%(10) had it for other indications. 50% (102) had no treatment change, 38% (77) had dementia medications started, 5% (10) had other treatment changes and we were unable to comment on 7% (15). Review of radiology reports showed that 57% (117) had all qualitive scores, 38% (78) had some scores and 5% (9) were qualitative.

Conclusions: Pertaining to the indications of scanning, 36% (73) were compliant with NICE guidelines (an estimate of £19,037/year) and 64% were non-compliant (131). 57% of radiology reports were compliant, 38% had some compliance and 5% had no compliance.

19. **Literature review on the use of orexin receptor antagonists in Alzheimer's dementia**

Dr Su Mon Hein, Dr Anne M. Bonnici Mallia, Dr Genevieve Hirsz

Aims and Hypothesis: We reviewed the literature to understand the safety and efficacy of orexin receptor antagonists in individuals with Alzheimer's disease (AD). This will help us consider whether orexin receptor antagonists are safe in this group.

Background: Irregular sleep pattern disorder and insomnia are common in patients with AD. Orexin receptor antagonists are a new class of medications for the treatment of insomnia. Suvorexant was

approved in the United States in 2014 and Lemborexant in 2019. Most hypnotics have significant side effects including increased risk of falls and worse cognitive function when used in individuals with AD.
Methods: Peer reviewed articles were identified in Medline, Embase and PsychInfo from inception until 1st January 2023. Search terms included: "irregular sleep wake rhythm disorder", “insomnia”, “suvorexant”, “lemborexant”, “orexin receptor antagonist”, "orexin antagonist", “dementia” and “Alzheimer”. Three original trials and a case series were identified and included in this literature review.
Result: Moline et al. describe a randomised multicentre double-blind study with 62 subjects with AD. This provided preliminary evidence of significant improvements with Lemborexant 5mg and 15mg compared to placebo. [1]. In this study, Lemborexant was well tolerated with no serious adverse events or worsening of cognitive function. Herring et al describe a randomized controlled clinical polysomnography trial of suvorexant for treating insomnia in patients with AD. Suvorexant was effective and generally well-tolerated for treating insomnia in patients with AD. [2] A case series reported that Suvorexant improves sleep-wake cycle disturbances due to delirium in patients with AD. [3]. A Japanese clinical trial with six patients also indicate that suvorexant has adequate efficacy for the treatment of insomnia in patients with AD.[4]
Conclusions: The orexin receptor antagonists show promising results and safety profile in individuals with AD. They appear to be well tolerated with minimal side effects. More studies are required.

20. Trail-making Test A helps to differentiate MCI-LB from MCI-AD

Dr Muhammad-Kazim Kanani, Alan Thomas, Calum Hamilton, Joanna Ciafone, Rory Durcan, Sarah Lawley, N A Barnett, Kirsty Olsen, Michael Firbank, Gemma Roberts, Louise Allan, Ian McKeith, John O'Brien, John-Paul Taylor, Paul Donaghy

Aim To determine if expanded scoring of visuospatial tests could differentiate between mild cognitive impairment with Lewy bodies (MCI-LB) compared with MCI due to Alzheimer’s disease (MCI-AD).
Background MCI-LB is associated with greater visuospatial and executive dysfunction compared with MCI-AD. However, standard neuropsychological tests do not accurately discriminate between the two diseases. More detailed methods of scoring standard cognitive tests can help to distinguish between dementia with Lewy bodies and Alzheimer’s dementia. We sought to determine if these methods could be used to differentiate between MCI-LB and MCI-AD.
Methods MCI participants from memory clinics were recruited and underwent comprehensive neuropsychological testing including pentagon-copying, cube-copying, clock drawing and Trail-making Tests A and B. Clinical diagnosis was made according to consensus criteria. Two raters independently re-scored the cognitive tests above blind to diagnoses, recording specific errors made in detail using expanded scoring systems from the literature.

Results Using expanded scoring systems for pentagon-copying, cube-copying, clock drawing and Trails B did not to help to distinguish between MCI-LB and MCI-AD. MCI-LB were more likely to make any error on Trail-making test A compared to MCI-AD (18/43 (42%) of MCI-LB vs. 1/21 (5%) of MCI-AD; likelihood ratio (LR) 8.8; p=0.003).   To validate this finding Trail-making Test A and B were similarly re-scored on an independent cohort of MCI subjects. Those with MCI-LB were again more likely to make an error with Trail-making Test Part A (7/28 (25%) of MCI-LB vs. 1/25 (4%) of MCI-AD; LR 6.3; p=0.05).
Conclusions The presence of MCI-LB should be considered in anyone with MCI who makes an error on the Trail-making Test A test. The Trail-making Test A could form part of a battery of simple screening tests to help to identify subjects with MCI-LB in clinical and research settings, particularly considering its ease of administration.

21. Cognitive functioning and physical health among elderly population in urban senior citizen homes in South India-a cross-sectional study

Suvarna Kantipudi

Introduction: Aging is a process involving many physical, psychological, and cognitive changes. There is a steep rise in the elderly population in the world is estimated to increase to 1.4 billion by 2030 and 2.4 billion by 2050 (WHO 2021). The elderly population is at risk for physical ill health and cognitive decline and our study aimed to evaluate them in elderly residing in urban senior citizen homes.
Methods: Individuals aged more than 60 years and staying in the same residence for at least six months were included. Those with severe physical illnesses, hearing loss, visual impairment, and bedridden status were excluded.432 patients fulfilled the inclusion criteria and 402 consented to participate in the study. Data was collected by the trained interviewers after obtaining ethics approval. A semi-structured socio-demographic proforma was used to collect basic sociodemographic and medical history, Montreal Cognitive Assessment (MoCA) or Rowland Universal Dementia Assessment Screen(RUDAS) was used to assess cognitive function, and the Subjective Memory Complaint Questionnaire (SMCQ), for self-reported memory problems in general and daily living.
Results: 149(37.1%) were diagnosed with diabetes mellitus and 95(23.4%) with hypertension.210(52.24%) had scores less than the cut-off score of 26 on MOCA or 23 on RUDAS suggesting cognitive impairment. The mean MOCA score was 23.65(S.D:3.33) and the RUDAS score was 23.96(S.D:4.12). 376(93.5%) had reported at least 1 subjective complaint with SMCQ.
Discussion: There is significant morbidity of cognitive decline in the elderly and its occurrence is higher than comorbid physical conditions like Diabetes or Hypertension. Subjective memory complaints are present in most of the elderly(93.5%). Higher educational attainment is associated with better cognition. Interventions to prevent the dementia epidemic should focus on screening and early effective intervention to prevent further decline in cognition.

22. Ethnicity, Cardiovascular Disease & the Risk of Alzheimer's Disease and related Dementias (ADRD). A national observational study

Anita Kulatilake

Aims: This study explored whether the Black and South Asian ethnic groups are at greater risk of developing dementia that the White ethnic group in the United Kingdom, using the Clinical Practice Datalink (CPRD) database.

Background: South Asian and Black minority ethnic groups, in the United Kingdom, are known to have a higher incidence and prevalence of cardiovascular disease and it is thought that this may in turn place these ethnic groups at a greater risk of developing dementia.

Methods: All eligible participants over 50 years of age from the CPRD database, that were free from a diagnosis of dementia at time of entry to the study, and with an ethnic coding were followed between 1996 and 2016. 1,091,242 individuals were included in the analytical sample. Cardiovascular Disease and available lifestyle risk factor data relating to the development of dementia were also captured.

Results: There was a total of 174,546 (16.3%) cases of ascertained dementia. The white ethnic group had a higher mean age of dementia onset 81.8 years (SD 8.6) and the lowest mean age of dementia onset seen in the Black ethnic group 76.3 years (SD 9.4). The fully adjusted Cox regression model (adjusting for all covariates including, socioeconomic status and education) revealed a lower risk of incident dementia in the Black [HR 0.83 (95% I 0.74-0.93)] and South Asian ethnic groups [HR 0.55 (95% CI 0.49-0.61)] when compared with the White and East Asian ethnic groups.

Conclusion: The lower incidence of dementia seen in the Black and South Asian groups may be due to case under ascertainment, particularly in view of their higher risk of cardiovascular disease. Understanding the differences for ethnic variation in dementia rates is not only vital for aetiological research but also for the development of prevention strategies, health service planning and resource allocation.

23. An Audit on HbA1c & plasma glucose blood tests done on admission to an inpatient older adult ward

Dr Loui Kyriacou, Anthony Conganige, Bansal Saakshi, Abba Abdul-Rahman, Albert Michael

Aims and Hypothesis The aim was to determine what proportion of patients recently admitted to an Older Adult Ward, Wren Ward, had a fasting blood glucose and HbA1c blood test. It was hypothesised that the majority of patients would have these tests done.

Background People with severe mental illness have a reduced life expectancy. This is largely due to the greater burden of physical health diseases, such as diabetes and heart disease. As such, as per trust policy, patients admitted to the older adult ward, Wren Ward, undergo a physical health assessment on admission that includes a physical examination, ECG and blood test. The blood test includes a fasting blood glucose and HbA1c.

Methods A sample of 40 patients who were most recently discharged from Wren Ward were included in the audit. Four authors each independently reviewed 10 patient case notes and blood results. An Audit Collection Tool was produced and data logged for each patient. The data collected was reviewed by all authors.

Results 57.5% (23) of the study population had admission blood tests that included a HBA1c level. Only 2.5% (1) had a plasma glucose test. 42.5% (17) of the study population did not have their plasma glucose or HBA1c level checked.

Conclusions There was poor overall compliance with Trust policy related to admission blood tests. Fasting plasma glucose tests on admission are logistically difficult to obtain and rarely done so the team propose that this be removed from the panel of blood tests done on admission. The team also propose changes to the clerking proforma to emphasise the need for completing a HbA1c test.

24. Could a virtual clinic improve the quality of physical health monitoring for safe antipsychotic prescribing in an older adult community mental health team (CMHT)? Encouraging preliminary results from a CMHT in Wales

Dr Andreas S. Lappas, Dr Anna Searle, Dr Sophie Chalinder, Dr Divya Vikraman Chandrika, Dr Ata Anane-Adusei, Dr Samantha Moynes, Dr Danika Rafferty, Dr Hannah Willoughby, Dr Ceri Evans

Aims and hypothesis This is a Quality Improvement Project on physical health monitoring (PHM) for safe antipsychotic prescribing in an older adult (OA) CMHT. Baseline data, a virtual clinic model and preliminary results of the first Plan-Do-Study-Act cycle are presented.

Background Antipsychotics are linked to increased cardiometabolic risk. Guidance on PHM is available to mitigate this. Both risks and guidance are age-blind, and very relevant to OAs (age-related increased cardiovascular risk). The COVID-19 pandemic boosted digital healthcare, which remains relevant due to rocketing demand and stretched services.

Methods An audit was conducted (06/21–12/21), with continuous prospective data collection thereafter. A scoping exercise was conducted to establish available resources. A local protocol/operational framework was developed. Education interventions (03/2022-on-going) and a junior-doctor-led virtual PHM clinic (10/2022-on-going) were designed and implemented.

Results Baseline (06/21-09/22): completed lifestyle advice=0%, physical observations=3%, blood tests=3%, ECG=3% of eligible patients. Mean overall compliance with guidance/patient=9%. Pareto chart: no clear

pathway and lack of prescriber awareness main reasons (>95%) for poor performance. Scoping exercise: No Health-Board/Trust-wide approach for OAs, PHM problematic in all localities. GP-leads assertive regarding no responsibility to deliver PHM. Geriatric teams, district nurses, general adult teams stretched and unable to support. Care home staff lack training and resources. Phlebotomy/ECG departments of local hospitals could support but no pathway. First PDSA cycle (preliminary): Change idea 1: staff education – clear shift (04/2022-onwards). Proportion of trained staff reached 100% in December 2022. Change idea 2: virtual clinic – mean overall compliance with guidance/patient (10/22-12/22)=57% (vs. 9% baseline). 58% patient response rate. Change idea 3: phlebotomy/ECG pathways – proportion of patients with bloods/ECG reached 75% and 25% respectively in December 2022.
Conclusions Preliminary data suggest an emerging trend for continuous improvement and may indicate effectiveness of this model of a PHM virtual clinic. More data are required to draw safe conclusions.

25. Monitoring Of Delirium Risk Factors In Older Adults Admitted To An Acute Geriatric Ward

Lianne Leung, Dr Kapila Abeysuriya, Dr Madeline Rogers-Seeley

Aims and Hypothesis: This study aimed to evaluate rates of delirium risk factor monitoring in older adult inpatients. It is hypothesised that rates of monitoring would vary depending on relevance to presentation, but overall low.
Background: Delirium is a common hospital-acquired complication associated with significant clinical morbidity and economic burden. Addressing modifiable risk factors can prevent delirium and is especially important in acutely unwell older adults.
Methods: A single-centre retrospective study was conducted, looking at patients admitted to the acute geriatric ward at a tertiary hospital over a two-week period. Medical records were reviewed to see if modifiable delirium risk factors were monitored during medical ward rounds as per local delirium prevention guidelines. Factors included patient's hydration, nutrition, bowels, urine output, infection, invasive lines, medications, and pain. Basic demographic data (age, previous diagnoses of dementia, depression or cognitive impairment) was collected to identify patients' risk of delirium and whether they were delirious upon admission.
Results: Fifty-nine patients were reviewed across 175 ward rounds, making an average of 2.9(±1.8) ward round reviews per patient. Rates of monitoring were best for infection (93%), medications (74%), pain (47%), bowels (45%), and worst for invasive lines (10%), nutrition (8%), urine output (8%) and hydration (6%). Monitoring was not significantly different for patients who had a documented diagnosis of dementia, depression or cognitive impairment ($p=0.40$), nor for whether patients were delirious upon admission ($p=0.84$).

Conclusions: Monitoring of modifiable delirium risk factors is generally low. Low rates may be due to true issues in monitoring or due to inaccurate documentation. Education and cultural change may improve monitoring, while templates are currently being trialled to improve documentation.

26. The influence of ethnicity on accessing memory services and outcomes

Thomas Mayne, Sara Soames, Thomas Dixon, Krishnaveni Vedavanam

Aims and hypothesis Parity of access to memory assessment services, timely diagnosis of dementia and treatment are vital for all ethnicities. We hypothesised that minority ethnic communities were more likely to face reduced access. A literature review was conducted to identify barriers to accessing memory services and evaluate the role of social determinants, including ethnicity. An audit of referrals to Wandsworth Memory Service (WMAS) was then undertaken, examining ethnicity data and type of cognitive testing used.

Background Literature search identified 2 main categories of barriers: at community level affecting referral to the service , and at service level reducing diagnosis due to testing bias. Community-level barriers, eg culture and education, cause significant inequity in access to memory services. Lack of provision for ethnic minority elders in their native tongue is a particular factor, associated with low referral rates and presentation at a more advanced stage. Service level barriers include cognitive testing bias, affecting ethnic minorities disproportionally compared to their white-British counterparts, leading to incorrect test results, potentially delaying diagnosis

Methods A chi-square test was conducted on access data from Wandsworth memory assessment service (WMAS) , acting as a case study for the barriers identified.

Results No statistical difference was found between 2011 census demographic data and access rates for different ethnicities.

Conclusions: Services must address both community and service-level barriers to access. Our analysis indicated that ethnicity did not appear to be a barrier to accessing WMAS, and suggest that the service is enabling access to underserved communities. In addition there was no cognitive testing bias relating to ethnicity The reasons for this success merit further exploration, as they could have potential in informing policy. Future direction for WMAS could be to focus on enhancing appropriate post-diagnostic support, eg provision of materials in languages other than English via their website.

27. Identifying symptoms of dementia with Lewy bodies through natural language processing

Dr Christoph Mueller, Annabel Price, Rudolf Cardinal, John O'Brien, Robert Stewart

Aims and hypothesis: The aim of this project was to apply a range of natural language processing (NLP) applications to detect core symptoms of dementia with Lewy bodies (DLB) and to determine their prevalence in patients with DLB and Alzheimer's disease (AD).
Background: Electronic health records can be used to assemble cohorts of patients who are difficult to recruit for prospective studies, as patients with DLB. DLB is underdiagnosed in routine clinical services, but the information extracted from electronic health records can be enriched using NLP.
Methods: For a large dementia care database in Southeast London, NLP applications were developed to capture core symptoms of DLB. We ascertained prevalence in a cohort of patients with DLB or AD both around the first presentation to specialist services and across the whole patient record.
Results: Of 14,329 patients identified, 4.3% had a recorded diagnosis of DLB and 95.7% a recorded diagnosis of AD. All core symptoms were significantly more common in patients with DLB versus AD. At the time of first presentation the proportion of the core symptoms in patients with DLB were: 57.2% with visual hallucinations, 43.3% with fluctuations, 35.2% with Parkinsonism, and 12.3% with REM sleep behaviour disorder. Core symptoms of DLB were also detected in a considerable proportion of patients with AD. Of the 13,712 patients diagnosed with AD 5.7% met criteria for probable DLB at the time of first presentation and 18.7% if considering their whole electronic health record.
Conclusions: NLP applications can identify typical DLB symptoms in routinely collected data and potentially validate DLB diagnoses. The relatively frequent occurrence of DLB core symptoms in patients with AD suggests that some of these patients might have undiagnosed DLB. NLP may be helpful to identify patients who fulfil criteria for DLB but have not yet been diagnosed.

28. A Quality Improvement project to improve the effectiveness of the referral pathway to secondary dementia care services across East Staffordshire

Dr Sambavi Navaratnarajah, Dr Prasanna Gowrishankar, Dr Rashi Negi

Background Dementia is a progressive neurodegenerative condition currently affecting approximately 900,000 people in the UK. With the ever increasing ageing population, the Alzheimer's society projects cases to reach 1.6 million by 2040. As a service, we have noticed an increase in incomplete referrals across East Staffordshire. This has not only delayed assessment but also in some cases we have not been the appropriate service for patients to be referred to.
Aims The project aims to look at current referral pathways and improve clinical outcomes for both patients and the service.
Methods This was a retrospective study looking at all the dementia referrals from August to September 2022 (N=285). This involved reviewing online referral forms to ensure that the referral pro-forma had been filled in completely. This had to include results of dementia screening assessments, reasons for referral, recent blood tests, and past medical history (including medications).

Results Analysis of the data showed that only 22% of referrals were completed in full thus meeting referral criteria. Approximately 50% of referrals contained information about an initial screening tool for dementia being utilised with only 32% including a full complement of required screening bloods completed within the preceding 3 months. Almost three quarters of all referrals included reasons for referral and contained information on medical history and medications.

Conclusion It is clear from the results that currently the dementia pathway is receiving a large number of incomplete referrals. This has a significant impact on the service in terms of consultation time and cost effectiveness when managing patient care. It causes delays in assessing, diagnosing and commencing treatment where appropriate in patient's who have an underlying dementia. The findings of this QI project will be used to educate local services about criteria for referral but also improve the triaging of referrals within our service.

29. Hyperosteosis Frontalis Interna and neuropsychiatric symptoms A case report

Dr Kingsley Nnamah, Padmavathy S Gopinath, Myles Dyer

Hyperostosis frontalis interna (HFI) is a rare condition characterized by the thickening of the inner table of the frontal bone. It is usually bilateral and symmetrical, and may extend to involve the parietal bone. The exact cause of HFI is unknown, but some theories include a genetic predisposition, the presence of vascular anastomoses on the calvaria, and the influence of estrogen. HFI is more common in women over the age of 65, with 87% of severe cases occurring in this age group. This poster presents a case of a 75-year-old woman with HFI who was also diagnosed with schizophrenia and depression. The patient had a history of mental health issues and was being treated with a combination of medications, including venlafaxine, Depakote, and Olanzapine. After a recent episode of distress, she was admitted to the hospital informally and later placed on a section of the mental health act. Upon admission, she displayed suspicious behavior and was preoccupied with thoughts of infection and money problems. A CT head was ordered and showed cerebral atrophy and HFI. The patient was initially treated with Olanzapine, but showed poor response. She was then switched to Quetiapine, which led to significant improvement in her symptoms. Despite this improvement, she experienced a relapse and underwent electroconvulsive therapy (ECT). Since the ECT, she has shown further improvement and is awaiting discharge home. Neurology consultation was also obtained, and the patient will be followed up as an outpatient in clinic. This case highlights the potential relationship between HFI and neuropsychiatric symptoms, including schizophrenia. It also demonstrates the importance of considering HFI in the differential diagnosis of patients with mental health issues and the potential effectiveness of Quetiapine in the treatment of HFI-associated schizophrenia. Further research is needed to fully understand the relationship between HFI and mental health conditions and to determine the most effective treatment options for patients with HFI. In conclusion, this case report highlights the complex relationship between HFI and mental health

conditions, and the importance of considering HFI in the differential diagnosis of patients with neuropsychiatric symptoms. Further research is needed to better understand the underlying causes of HFI and to determine the most effective treatment options for patients with this condition.

30. Can we improve physical health observations by using a digital platform?

Dr Patience Otaniyen, Nicholas Rhodes, Andrew Donaldson

Aims and hypothesis: To assess how well we monitor patients' physical health observations and investigate the impact of our recent adoption of a digital observation recording programme.
Background: It is well established that psychiatry inpatients are at an increased risks of physical health complications. Our local guidance requires patients have their physical health observations (oxygen saturations, respiratory rate, blood pressure, heart rate, temperature and brief neurological observations) monitored and a National Early Warning Score (NEWS) calculated at least daily. Previous audits have shown that observations are often not recorded and errors are regularly made when calculating NEWS scores. We have recently adopted Patientrack, a digital platform to record and monitor physical health observations.
Method: We collected data from all of the old age psychiatry inpatient units in North Lanarkshire and looked retrospectively at whether they had observations recorded and NEWS scores calculated correctly over a seven-day period. We then ran a period of re-education to familiarise staff with the new system and encourage engagement.
Results were then compared to data collected prior to the introduction of the electronic recording programme. Results: Prior to the introduction of electronic recording, NEWS scores were recorded on 70-86% of the minimum required occasions. Of these recordings, 16-20% were incomplete or had incorrectly calculated NEWS scores. After the introduction of electronic recording and monitoring, 95% of patients had their physical health observations carried out at least daily and all observations sets were complete with NEWS scores correctly calculated.
Conclusions: The introduction of a digital physical health observation recording and monitoring programme has led to significant improvements in our assessment and management of our patients' physical health.

31. Audit of documentation of DNACPR decisions on inpatient old-age Psychiatry wards

Dr Chanel Parmar, Dr Nuzhat Sultana. Dr Parvez

Introduction: Decisions surrounding cardiopulmonary resuscitation (CPR) must always be made in accordance with legal requirements, good clinical practice and local policy. Once a decision has been

made, it must be recorded including information regarding background to the decision, reasons for the decision, those involved and an explanation of the process.
Aim: To audit whether unified Do Not Attempt CPR (uDNACPR) discussions with patients or their legal proxies/families/those close to them are taking place and clearly documented.
Methods: All inpatients on the old age psychiatry wards at Tameside and Stockport were screened for eligibility. The inclusion criteria were an inpatient on old age psychiatry ward with a uDNACPR in place. Patients were excluded if the uDNACPR was not put in place by the inpatient psychiatric team during this admission. Patient's case notes and paper DNACPR forms were then reviewed retrospectively using a data collection proforma.
Results: Only 1 (11%) of the 9 patients had sufficient documentation of the DNACPR discussion. 3 (33%) had insufficient documentation and 5 (56%) had no documentation. None of the patients were included in DNACPR discussions. 5 (56%) of the patients had a reason documented why they weren't included in discussions. 8 (89%) of patients had those close to them informed of the decision.
Conclusion: Current practice does not meet the standards outlined by local and national guidance. Our documentation of DNACPR decisions and discussions needs to improve by clearly documenting reasons for the decision and an explanation of the implications of the decision. Documentation also needs to include who was involved in discussions and if the patient or those close to the patient were not involved, it should be clearly documented why.

32. An Audit cycle investigating physical healthcare assessments of patients admitted to mental helath services for older persons functional wards at Leicestershire Partnership NHS Trust

Dr Mohammed Qureshi, Dr Charlotte Messer, Dr Jon Turvey, Dr Taofeeq Elias, Dr Olaomopo Ikuforiji, Dr Logan Windell

Aim: To investigate whether appropriate and timely physical healthcare assessments are occurring for patients admitted to older persons mental health wards.
Background: Individuals with serious mental illness are at higher risk of poor physical health, due to difficulties accessing mainstream health services, effects of psychotropic medication and lifestyle choices. Being an older adult increases this risk further. A mental health hospital admission presents us with an opportunity to comprehensively review physical health.
Methods: A team of junior doctors retrospectively collected data in both the initial audit (May 2020) and the re-audit (September 2022). For patients randomly selected from two functional wards, notes were reviewed using relevant electronic records. An audit tool was constructed for the first audit and was utilised again in the re-audit, through completing it for each identified patient. The sample size for the initial audit was 60 and, in the re-audit, was 50.

Results: Following the interventions enacted after the initial audit, compliance improved for physical examinations completed during the admission (92% vs 87%), bloods completed within 24 hours of admission (78% vs 73%), bloods completed at any stage of admission (98% vs 93%), ECG completed within 24 hours of admission (58% to 45%), ECG completed at any stage of admission (84% vs 75%) and VTE risk assessments completed (100% vs 98%). However, if physical examination, bloods or ECG were not completed within 24 hours of admission, the compliance for reattempts within the next 24 hours was poor (47%, 42% and 50% respectively).

Conclusions: Subsequent to the initial audit, interventions included posters placed in doctors' offices on the ward as a reminder to conduct physical healthcare checks, and presentations delivered to junior doctors and nurses working on the relevant wards. Re-audit results indicated improved compliance in a multitude of different physical healthcare domains.

33. Aftershock: An audit to assess ECT monitoring standards in older age and adult inpatient psychiatry wards

Dr Ardra Radhalakshmi, Georgina O'Callaghan, Jane McNulty

Aims and hypothesis This project aimed to determine if monitoring requirements were consistently met in accordance with ECTAS (ECT Accreditation Service) and Trust policies before, during and after an acute course of electroconvulsive therapy (ECT) during inpatient admission.

Background ECT is currently used for treatment-resistant or life-threatening depression, mania, schizophrenia, or catatonia. Monitoring cognition and symptoms are paramount in evaluating treatment efficacy. Local and national policies recommend monitoring of patients during ECT courses and specify testing is required for baseline comparison.

Methods Cognitive and symptom monitoring data was collected from all patients within Mill View Hospital that had received an acute course of ECT from September 2021 - November 2022. We accessed individual electronic patient records then collated tabular data on Excel for further analysis.

Results A total of 19 patients fulfilled our inclusion criteria; 11 received correct cognitive testing (CT) and 3 received correct depression scale monitoring (DS) for their entire course. Compliance to standards was 95% when initially commenced and fell to 72% CT and 61% DS by course completion. For CT, the Montreal Cognitive Assessment (MOCA) was used for all patients and for DS, the Hamilton Depression (HAM-D) Scale. For 89%, consistent scales were used to monitor both cognition and symptoms. Tests were performed at incorrect intervals in 5 patients and excess testing for 4 patients.

Conclusions Our ECT monitoring does not meet standards, falling short largely in intra and post-ECT. Compliance decreased as the ECT course progressed, particularly for depression scale monitoring. Key barriers to compliance were time constraints, no formal tracking system and lack of knowledge from junior colleagues who largely perform this task documentation. To improve, we have designed and

implemented ward-based tracking spreadsheets. This project has been shared trust-wide, received positive feedback, and included in induction materials for incoming junior colleagues. We will re-audit to assess long-term impact.

34. Service evaluation project of Nurse led Delirium Clinic in MHSOP Liaison service in Durham & Darlington

Kayleigh Heathcote, Jayne Turnbull, Dr Girish Rao

Aims and Hypothesis: The purpose of the project is to ensure Presenting with an episode of delirium where there is evidence, or a suggestion of, chronic cognitive impairment should benefit from further assessment/investigation once delirium resolved

Background: The purpose of the project is to determine if transfer to CMHT for diagnosis/dementia pathway is appropriate once delirium is resolved which will prevent unnecessary referrals to CMHT. In addition, service will aim to promote early detection of dementia and prevent patients presenting with evidence of chronic cognitive changes being missed by services.

Method: Patients referred to Delirium clinic will be offered telephone contact in 6 weeks post discharge from Hospital to determine if delirium is resolved or there is further need for mental health assessment, which will be offered at 12 weeks post discharge from Hospital. Patient will have detailed mental health review and cognitive assessment at 12 weeks and possible referral to CMHT will be considered or patient will be discharged back to GP.

Results: Total number of patients referred to Delirium clinic across Durham & Darlington Hospital over 3 months period was 41 patients. 27 patients out of 41, which equates to 66% had delirium resolved within 6 weeks period & did not require any further CMHT support. 10 out of 41 patients, which equates to 24% required CMHT support. Amongst remaining 4 patients out of 41, equating to 10% ,1 required admission ,1patient was deceased & 2 patients required Crisis support.

Conclusion Data suggests that follow up in Delirium Clinic service not only promotes early detection of dementia & prevents patients presenting with evidence of chronic cognitive changes being missed by services. It also prevents and reduces unnecessary referrals to CMHT's.

35. Audit of the documentation of ReSPECT forms within the inpatient Older Adult Population in Leeds

Dr Benjamin Rutt, Harriet Winder-Rhodes, Sophie Dawe

Aims and hypothesis Recommendation Summary Plan for Emergency Care and Treatment (ReSPECT) forms promote discussion and shared decision making between patients and clinicians with regards to

recommendations for emergency treatment. We completed an audit to assess the documentation of ReSPECT decisions in patients presenting to the Older Person's Inpatient Service in Leeds between 01.08.2021 and 30.11.2021.

Background Members of the medical team expressed concern regarding the lack of formally documented advanced care decisions in patients admitted to inpatient services. This could lead to the commencement of unwanted treatment up to, and including, cardiopulmonary resuscitation (CPR). Treatment preferences are of particular importance to patients presenting with cognitive decline.

Methods We used the Standard Operating Procedure: Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) including Cardiopulmonary Resuscitation (Adults) as our audit standard. This suggests completing a ReSPECT form in any patient wishing to record preferences or treatment recommendations even if they do not have a significant medical condition. We also collected data on the patient population using Clinical Records, the Clinical Frailty Score (CFS) and Charlson Comorbidity Index (CCI).

Results In total, 37.7% [26] of the 69 patients admitted to the Older Persons Inpatient Service between 01.08.2021 and 30.11.2021 had a completed ReSPECT form. 38.1% [8/21] of patients with mild frailty (CFS 5), 58.3% [7/12] with moderate frailty (CFS 6), and 50% [6/12] with severe frailty (CFS 7) had a completed ReSPECT form. The only very severely frail patient had a completed ReSPECT form.

Conclusions Patients with significant clinical frailty and comorbidity had clearly documented decisions, however overall documentation was lacking. Clinical staff require further training and awareness of ReSPECT forms within the trust. Recommendations include the inclusion of ReSPECT status on admission, and MDT proformas, to prompt conversations between patients, staff, and families about advanced care decisions and preferences.

36. Lockdown: What was the impact of deliberate self harm [DSH] on older adults? A service evaluation comparing Liaison Psychiatry Referrals before and During the Covid 19 Lockdown of March 2020

Dr Tristan Sawle, Dr Rogin Deylami, Dr Kehinde Junaid, Lori Edwards Suarez

Aims and Hypothesis We examined the impact of the Covid Lockdown on DSH presentations in older adults. We investigated whether the number of DSH presentations changed, and if any factors could be identified.

Background Part of National Project across 6 trusts examining the same service evaluation locally. We evaluated our local data with the above aims and objectives.

Methods Retrospective review of routine collected data of DSH presentations to liaison psychiatry within the Nottinghamshire Healthcare NHS Foundation Trust. Presentations evaluated were between 22/3/2019 to 21/3/2020 and between 22/3/2020 and 21/3 2021. 255 referrals were evaluated in total.

Results Results were not tested for statistical significance. Nonetheless a slight increase in referrals (124 to 133) and percentage that were DSH related was observed. Basic demographics and PMH [past medical history] remained largely the same. The percentage living alone decreased (57% to 54%). However, the percentage married decreased (44% to 38%). There was a slight decrease in those known to services (42% to 39%). There was a trending increase in IMD deprivation scores - patients attending on average were from slightly less deprived areas. Over 90% patients presented with at least one physical health co-morbidity. The highest incidence of psychiatric disorder throughout was mood disorder. Overdose was by far the most common method in both periods. However, a slight increase in presentations due to cutting/stabbing was observed.

Conclusions DSH in older adults, especially in those with a mood disorder, still constitutes a valid presentation for this service group. Services need to be commissioned to be able to tackle this. Suicide in the context of a Psychiatric disorder still occurs in older adults and as clinicians we need to be aware of this when performing our risk assessments and developing management plans.

37. A quality improvement project – monitoring patients on lithium under the care of an older person's CMHT in Hampshire

Dr Gemma Smith, Dr Filipa Teixeira, Dr Makomborero Kasipo

Aims and hypothesis • To review physical health monitoring in patients prescribed lithium under the care of an older person's mental health (OPMH) team. • To improve monitoring through an effective intervention in 2022.

Background Lithium is an effective treatment for bipolar affective disorder and treatment-resistant depression. Disadvantages include the narrow therapeutic window and endocrine effects, necessitating regular monitoring. This is important in old age given physiological changes and higher rates of comorbidities and polypharmacy.

Methods • Monitoring standards were based on NICE guideline CG185. • Data was collected using electronic patient records, blood results, and GP records. • All patients who had been under the OPMH team in the past 3 months and were prescribed lithium at the time of data collection were investigated. • Initial data from 2020 reviewing 15 patients showed monitoring was below that recommended. In 2021, a re-audit of 13 patients showed that suggested changes had not been implemented. • A proforma template was reintroduced in June 2022 alongside a 'lithium monitoring' education session to the team. Data was then collected in October 2022 from 12 patients.

Results Six-monthly monitoring of renal function decreased from 100% to 54% between 2020 and 2021, but increased to 92% in 2022. Monitoring of thyroid function decreased between 2020 and 2021 from 87% to 62%, increasing to 92% in 2022. Calcium level monitoring improved from 40% in 2020, 54% in 2021, to

83% in 2022. Three-monthly monitoring of lithium levels showed a downward trend between 2020 and 2022, from 93%, to 69%, to 67%. Overall usage of a proforma was low.
Conclusions The monitoring of renal function, thyroid function and calcium levels is improving, whereas lithium level monitoring has been declining. The implementation of a proforma was previously recommended, but the data shows that this has not been effective in improving monitoring rates.

38. Clinical Audit on the Measurement of Antipsychotic Side Effects using rating scales (GASS, LUNSERS, and SESCAM) in community settings

Dr Olusegun Sodiya, Adewole Adegoke, Geanina Ilinoiu, Clare Morgans

Aim: This clinical audit aimed to assess if monitoring of side effect of antipsychotics is adhered to using the Trust and National institute of clinical excellence (NICE) guidelines.
Background: One of the determinants of prognosis in schizophrenia is compliance to medications. Several patients during episodes of relapse have reported that experience of side effects were their main reasons for defaulting on their medications. This underpins the importance to monitor patients' tolerability of side effects when prescribed antipsychotics. Recommended monitoring scales are Glasgow antipsychotic scale, Liverpool University neuroleptic side effect rating scale, and Side effects scale for antipsychotic medication.
Method: 1st cycle of the audit was conducted from March 30th to April 30th, 2021, and 2nd cycle was done between 4th October and 28th October 2022. In both cycles random sampling was used to select 50 patients on the caseloads of two community mental health teams. The data was collected with a tool designed using NICE guidelines and the Trust policy on monitoring of psychotropic medications.
Results: For all selected patients in 1st cycle, no rating scales were used to assess side effects at three months or after one year of commencement of antipsychotics. Although, there was documented review of side effects written on electronic case notes in 96% of patients. EPSE was the most documented of the side effects. The re-audit saw an improvement of 24% in the use of an objective rating scale.
Conclusion: Although, there was an improvement in the use of rating scales of up to 24% as compared to 0%, the uptake was still far from the ideal. There is a need for the Trust and NICE guidelines to be adhered to in the monitoring of side effects of antipsychotics as this is likely to have a positive impact on compliance to medications by patients.

39. A Case of Sporadic Creutzfeldt-Jacob Disease (sCJD) Detected with Real-Time Quaking-Induced Conversion (RT-QuIC)

Dr Waseem Sultan, Dr Josie Jenkinson

Background Sporadic Creutzfeldt-Jacob Disease (sCJD) is the most common form of transmissible spongiform encephalopathies (TSEs). It is of particular importance to psychiatrists due to the neuropsychiatric presentation seen. Historically a range of investigations have been employed to support the diagnosis of sCJD. However, limitations exist relating to the sensitivity and specificity of these tests as they cannot directly detect misfolded prion protein (MPrP). To aid in diagnosis protein amplification techniques have been developed that exploit the ability of MPrP to induce a conformational change in normal prion protein (PrP), allowing a small amount of MPrP to be amplified and detected. Real-Time Quaking-Induced Conversion (RT-QuIC) represents one such technique. It is a rapid, low-cost, non-invasive test with a high degree of sensitivity and specificity. Here we present a diagnostically challenging case of sCJD detected with the use of RT-QuIC.

Case Report A 71-year-old female patient presented to hospital following a rapid decline in her cognitive functioning. Other notable symptoms included anxiety, paranoia and visual hallucinations. Collateral revealed a decline in cognition over the last 9 months and a diagnosis in the community of pseudodementia. Joint reviews were conducted by psychiatry and neurology and multiple investigations requested. Extensive blood workup and electroencephalogram were normal. Brain magnetic resonance imaging revealed increased caudate and putamen brightness, prompting an RT-QuIC test. This yielded a positive result a few days later confirming sCJD. The patient was managed symptomatically and transferred to the palliative care team. She was discharged to a 24-hour supported care home of her family's choosing.

Conclusion This case demonstrates the collaborative approach employed and the utility of RT-QuIC in diagnosing sCJD. It is the only non-invasive test that can detect the presence of MPrP antemortem and with a very high sensitivity and specificity its use in clinical practice will likely increase over time.

40. Transition between General Adult to Older adult

Dr Nuzhat Sultana, Dr J Palle

Aim: To identify established standards for transition between General Adult and Older Adult services. To develop new referral protocols. We looked at the royal college of psychiatry reports:CR218 bridges not walls, CR153 Links not bridges and trust protocol 2009. Standards:1-Documentation of patients' needs must be included at the time of referral to OA teams.2-written copy of care plan should be produced and shared in line within cared programme approach policy.3-Appropriate investigation must be included in all clinical correspondence.4-Written communications must be made between General Adult and Older Adult consultants.

Methodology: All referrals to Single Point of Access from General Adult between February 2020-February 2021.All patients under 65 were included, 20 above 65 were randomly chosen. Patient's paper-notes/clinic letters used to obtain information. Inclusion criteria outlined that the patients should under General Adult

Community mental health team in Oldham hospital. New referrals from General Practitioner 's/other services were excluded.
Results:48 patients Aged between 31-77 were referred to Single Point of Access from General Adult services.28 under 65.20 above 65. Average age was between 35-77.4 were under section 117 were referred by General Practitioner. All were on one or a combination of psychotropic medications.17 appropriate referrals,30 was rejected.1 was accepted for review.10 patients needs were clearly documented.3 were under cared programme approach. only 1 care plan was handed over by trust cared programme approach policy.12 had appropriate investigations,36 did not. In15 patients, written and verbal communication took place between the consultants. Junior doctors referred 25 patients.16 patients had no communications.
Conclusion: NICE and Royal college of psychiatrist suggest there should be safe transfer between the teams, the policy should be more transparent. Currently, standards are sparse. This can be achieved by improving transfer pathways. Includes outlining clear performance and protocols.

41. The epidemiology and clinical features of personality disorders in later life; a study of secondary care data

Natasha Treagust, Benjamin R Underwood, Emad Sidhom, Jonathan Lewis, Chess Denman, Olivia Knutson

Aims and hypothesis We aimed to characterise patients with a diagnosis of personality disorder over 65 who are receiving secondary care from an NHS mental health trust. We hypothesise they have features which make them a distinct group.
Background Personality disorders are conceptualised as impacting individuals throughout their life. However, there has been almost no study in those older than 65.
Methods The data from all patients >65 with a diagnosis of personality disorder was extracted (n=217) along with two comparison groups (n=2170); patients <65 with a diagnosis of personality disorder and patients >65 with a diagnosis other than a personality disorder or dementia.
Results Compared to younger patients with a personality disorder, older patients were more likely to be male, married, have a mixed disorder, and live in less deprived areas. Compared to patients >65 with diagnoses other than personality disorder, older patients with personality disorders were more likely to be female, single, or divorced and had a higher level of social deprivation. Older patients with personality disorders were also more likely to experience polypharmacy compared to both groups. A mean of 18.48 different drugs had been prescribed over their lifetime, compared to 9.51 for patients >65 without a diagnosis of personality disorder.
Discussion Our study demonstrates >65s with a diagnosis of personality disorder are a distinct patient group. This is especially important as our patient population was far smaller than expected which suggests the possibility of unmet need. However, our most important finding was the high levels of

polypharmacy. Further research should concentrate on establishing to what extent this is appropriate and whether simple interventions can rationalise prescribing to maximise benefit and minimise harm.
Conclusion Here we present the largest ever description of this group of patients and provide insights that could inform clinical practice and future research.

42. SLAM Image Bank – a real world diverse London memory cohort linking MRI to clinical records for the development of clinical decision support tools using artificial intelligence

Dr Ashwin Venkataraman, Steve C.R. Williams, Robert Stewart, Dag Aarsland

Rapid developments are occurring in artificial intelligence (AI) and machine learning (ML) applied to neuroimaging. To date advances in this space have largely been limited to research cohorts with little real world translation that is clinically meaningful for patients with dementia and associated neuropsychiatric symptoms. Translation has been limited primarily by the lack of large real world linked datasets combining MRI imaging, clinical variables and biomarkers within more representative ethnically diverse populations with multiple neuropsychiatric and systemic co-morbidities alongside the right infrastructure to do so. We therefore linked MRI scans in South London and Maudsley (SLAM) NHS Trust with linked clinical data for 5672 patients from multiple clinical sites in South London harnessing the Clinical Record Interactive Search database (CRIS) from 2008-2021. This will form the basis to which new memory and brain health clinic linked data and MRI data will be added in order to grow this cohort alongside potential additions of additional biomarkers and patient groups in the future. SLAM Image Bank is an exceptionally rich real world cohort with linked MRI and clinical data reflecting the diversity of the population of South London that provides a unique platform for testing automated decision support tools that may identify unique signatures of dementia and neuropsychiatric symptom subtype, markers of prognosis, and stratification for interventions or trials that are clinically meaningful.

43. Importance of recognising and treating the neuropsychiatric effect of a stroke

Courtney Weir

Aims To highlight the impact that a stroke can have on a patient's mental health and identify potential changes to improve patient care.
Background Post stroke psychiatric symptoms are common and result in higher mortality and lower quality of life for patients. However, they remain under recognised and underdiagnosed. Appropriate recognition and treatment of these conditions would benefit our holistic treatment.
Method To use a case study of a stroke patient to frame a review of existing literature on how a stroke can affect the psychiatry of patient, together with its implications on post stroke patient care.

Case Description A seventy-two-year-old male suffered two major strokes in May and December 2021. The patient continues to have lasting profound disability since the stroke and the psychiatric impact has meant the patient suffers from post stroke depression (PSD) and emotional incontinence (PSEI), for which he is prescribed fluoxetine.

Results and Discussion Age is a non-modifiable risk factor for stroke, therefore, the well-recognised association between strokes and neuropsychiatric disorders including PSD, PSEI anxiety and psychosis is of relevance to old age psychiatry. PSD occurs in approximately 30% of stroke patients and rates of PSEI are estimated at 10%. This is clinically significant as mortality rate within ten years of stroke in patients with PSD is three times higher than those without. Thus, the inclusion of robust guidelines regarding psychological wellbeing in stroke wards should be enforced. Furthermore, consideration should be given to the prospect of ongoing psychological assessment as part of the standard care for all stroke patients.

Conclusions An element of post stroke care which is poorly executed, is that of post stroke neuropsychiatric care. Changes must be made in education to change the professional narrative, additionally, further research and education regarding preventative measures, recognition and management of these conditions is necessary.

44. Patterns and Risks for Cognitive Impairment in Multiple Sclerosis: a UK Biobank study

Dr Victoria Whitford, Sheena Waters, Benjamin Jacobs, Lucie Burgess, Pooja Tank, Charles Marshall, Ruth Dobson

Aims/Hypothesis 1. To determine patterns of cognitive impairment in MS 2. To assess the role of dementia risk factors in MS-associated cognitive impairment

Background Cognitive dysfunction is common in people with Multiple Sclerosis (MS). It is unclear whether MS preferentially affects specific cognitive domains, or to what extent risk factors for cognitive impairment in the general population (e.g. depression, loneliness, hearing loss) overlap with those in MS.

Methods We obtained linked healthcare records, demographic data and cognitive test outcomes for 2500 people with MS (pwMS) and 10000 age and sex-matched healthy controls without neurological disease from UK Biobank (ages 40-69). We evaluated the effect of MS on cognitive test outcomes using linear regression models, adjusted for age, sex, ethnicity and deprivation, then adjusted further for dementia risk factors described by the Lancet Commission 2020.

Results The study population had a mean age of 55 (SD 7.7) and was predominantly female (73%). MS was associated with a specific pattern of cognitive impairment, characterised by diminished processing speed and executive function. Working, short-term and episodic memory were relatively preserved. MS was independently associated with increased (slower) reaction time (mean difference MD in reaction time between pwMS and controls +35.97ms, $p<0.005$). The individual effects of dementia risk factors on

reaction time were small compared with the effect of MS. BMI, air pollution and hearing loss had no significant effect on reaction time. Depression (MD +7.75ms), diabetes (MD +7.87ms), hypertension (MD +4.89ms), loneliness (MD +6.02ms) and fewer years of full time education (MD +1.44ms) were independently associated ($p<0.05$) with longer reaction times.

Conclusion Using a large cohort of deeply-phenotyped UK older adults, we observed a distinct pattern of cognitive impairment among people with MS compared to healthy controls. Longer reaction time was independently associated with MS even after adjusting for conventional dementia risk factors.

45. Audit of Patient Transfer to General Hospital from Old Age Psychiatry Wards

Dr Nurul Yahya, Dr Suzanna Rongpi, Dr Krishan Patel- Smith

Aims and hypothesis We aim to improve the experience of the hospital transfer process for the doctors and nursing team at both sites of hospitals.

Background This audit was initiated in response to issues highlighted by the psychiatry ward (Juniper Centre) regarding hospital transfer of patients to Queen Elizabeth Hospital (QEHB) and Moseley Hall Hospital (MHH). Some of these issues included: · Difficulty contacting general hospitals · Problems with transfer information for the receiving hospital · Logistical transfer issues · Not receiving discharge paperwork Overcoming these issues was proving time consuming for the team and affecting patient care.

Methods Retrospective data collection of all transfers (46) in three wards over a 6-month period. Many aspects were considered including: · Who assessed the patient and reason for transfer · Whether the bed manager and covering doctor were contactable · Bed availability and logistical issues · Changes to transfer destination and why · Transfer documentation · Total transfer time · Adequate discharge paperwork being available within 24hrs (as per GN27 for general practice)

Results Most cases were transferred within the guideline of 4 hours, which was in line with the standard. This audit showed that we had a very poor response from the general hospital in having a discharge summary, where the numbers were merely 40%. We should reach the aim for 100% of transfer information written up by doctors prior to hospital transfer, however this only happen in 41% of the cases.

Conclusions Better communication with the general hospital will need to be made for getting a good discharge summary so that any plan and recommendation made in general hospital can be follow up quickly. To improve these, we plan to raise awareness of the findings of the audit and to provide training and education on best practice.

46. A New Brain Scanning Technique to Aid Diagnosis of Dementia

Dr Rui Zheng, Dr Chineze Ivenso, Prof Chris Marshall, Dr Brian Huey, Dr Patrick Fielding

Aims: Use of FDG-PET to aid diagnosis of dementia in those with diagnostic uncertainty.
Background: Key aspiration for the Dementia Action Plan Wales is to increase number of people formally diagnosed with dementia by 3% points annually to improve early diagnosis and timely interventions. NICE Guidelines for Dementia 2018 recommend, if diagnosis is uncertain and Alzheimer's Disease is suspected, to consider FDG-PET (or perfusion SPECT if FDG-PET is unavailable) or examining CSF.
Methods: Aneurin Bevan University Health Board (ABUHB) Older Adult Mental Health Directorate works with ABUHB Radiology Directorate in partnership with Wales Research and Diagnostic Positron Emission Tomography Imaging Centre (PETIC) and Royal College of Psychiatrists in Wales. Gwent Regional Partnership Board commissioned review of Dementia Services 2019 identified commissioning priorities, included priority around improved diagnostic pathway and rate. We were granted £100,269 of Integrated Care Fund for 60 FDG-PET scans and 20 Amyloid PET scans.
Results: The project showed that use of FDG-PET led to a change in the pre-test clinical diagnosis in 61% of cases. 91% of patients had their clinical management changed. 100% of clinicians reported an increased confidence in their diagnosis following receiving FDG-PET results. These findings compare favourably with the results obtained by R Ossenkoppele et al (R Ossenkoppele, 2013).
Conclusions: The project demonstrates the huge clinical utility of FDG-PET imaging in selected patients with difficult to diagnose dementia. We trained psychiatrists, neurologists and geriatricians around the neuroimaging needed for diagnosis of early or uncertain dementia. The project was presented with Royal College of Psychiatrists in Wales and Welsh Health Specialised Services Committee. As a result, use of FDG-PET in aiding diagnosis of dementia has been committed nationally in Wales.