to plan and deliver their projects, including support to generate insights based on data, staff and community engagement, carry out assets mapping, develop the project's aim and key drivers organisations need to work towards, identify measures, generate change ideas to be tested, and sustain successful changes.

Members of organisations taking part also attend quarterly learning sets where they come together to network, share challenges and ideas, and learn from each other.

Results. Populations identified by organisations include children and young people; Black, Asian and Ethnic minority men aged 18+ years; carer population; neurodivergent individuals with comorbid mental health diagnoses; Muslim women/Black women; refugees and forced migrants; women military veterans in Greater Manchester and Lancashire; Bangladeshi and Pakistani men and women in Oldham; Traveller community in Somerset. A number of initiatives are being tested by teams to improve access, experience and outcomes of mental health care, support, and treatment for these populations, such as offering mental health awareness sessions for refugees in a range of languages.

Conclusion. Addressing inequality in mental health care is a long and complex process. The AMHE collaborative is supporting teams to take an innovative approach to tackle this issue, by ensuring their projects are fully co-produced with those affected by inequality. This includes engaging representatives from the communities they are trying to improve access, experience and outcomes for in all aspects of their quality improvement projects; from design to generating ideas to test, and ensuring they measure what is important to these communities to determine whether improvements have been made.

Trainee Led Quality Improvement Addressing Lack of Transparency in Referral Processes for Psychiatric Reviews in the Maudsley Adolescent Mental Health Service

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Aims. The Specialist Adolescent Mental Health Service at the Maudsley Hospital provides multi-disciplinary mental health care to adolescents in London. There is currently no policy by which non-medical members of the multi-disciplinary team can request a psychiatric review for their patients. Staff feedback revealed problems with the medical review referral process to be a lack of clarity on how to make referrals, and a lack of transparency (e.g. referral outcome, approximate waiting time).This projected aimed to improve the clarity of the process for requesting psychiatric reviews and to develop skills in leadership as a future child psychiatrist.

Methods. We designed and introduced a referral form and integrated waiting list. Next we developed a policy document for making referrals. Finally we modified the referral form so that when submitted, it automatically updated the integrated waiting list. At the outset and after each intervention we resurveyed the staff.

Results. At the outset 71% of staff reported finding the process somewhat unclear, while 29% reported finding the referral process neither clear nor unclear. Following the final change 100% staff each reported finding the process very clear or somewhat clear.

Conclusion. The changes we implemented resulted in a clearer and more transparent referral process for medical reviews. We anticipate that this improved staff satisfaction will equally translate into some benefits for patient care, such as more clarity around when a medical review can be expected and what it might entail.

Postgraduate Teaching Programme in Psychiatry in North Wales- a Regional Quality Improvement Project 2022-2023

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Aims. We aimed to arrange the local Postgraduate teaching in psychiatry as per the Deanery requirement/ HEIW requirement. We aim to achieve a better target with regard to local teaching as noted from the previous year's GMC trainee survey

Methods. The project started in 2019. 3 sets of audits and PDSA's were done- one each year, before the final PDSA. During these 3 audits, only non-consultants were participants.

During the 4th PDSA, in 2022-2023, a purposive sample was selected to provide the best information possible for the audit. It included Consultant Psychiatrists from all three sites in North Wales, Trainees(Junior/ Senior), SHO, speciality doctors, FY2, GP trainees and Clinical fellows. The criteria for participation were that the doctors should be working in Psychiatry and should have attended the local postgraduate programme. Access to the internet and appropriate device was mandatory as an add-on availability.

An online questionnaire was emailed to the participants. There were only 3 questions for the Consultants and 5 for the non Consultants' group. 2 weeks window was offered to fill out the forms.

Results. The 3 audits done initially revealed that consistent formal teaching was not provided. The candidates also found the current programme not fulfilling the criteria laid by the deanery and that their educational needs were neglected. The summary of the old audits suggested that the teaching had worsened eventually.

The final PDSA was done in 2022-2023. The overall time to fill out the form was 1.43 minutes. An equal number of Consultants and Non-consultants filled out the form. 31 Consultants rated the new programme as 4.23 for 5. The 31 non-consultants rated the programme 3.68 out of 4 and 95% identified that the new postgraduate programme covered the core trainees' requirements as per the MRCPsych Handbook from the Deanery.

Conclusion. Prioritisation of the most important facilitators and identification of 'easy wins' are important steps in this process.

The purpose of this study was to develop a national expert group consensus amongst a range of relevant stakeholders; senior doctors, residents, patients, allied healthcare professionals and healthcare managers allowing us to;

1. identify important barriers and facilitators of learning in clinical environments and

2. indicate priority areas for improvement. Our overarching objective was to provide information to guide policymakers and those tasked with the delivery of graduate medical education in tackling the provision of high-quality clinical learning environments in challenging time

Getting a Handle on Handover: Improving the E-Handover Process for Duty Doctors in Psychiatry

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Aims. Effective handover is a vital aspect of patient safety and continuity of care. On-call junior doctors (the Duty Doctor) in psychiatry inpatient wards in University Hospital Hairmyres (UHH) and University Hospital Wishaw (UHW) use an electronic handover tool (e-handover) to supplement handover. This lists outstanding jobs and information to be aware of. This project aimed to improve the handover process by making amendments to the e-handover.

Methods. A Plan, Do, See, Act (PDSA) cycle structured the project. An electronic survey was sent to all 30 Duty Doctors. This contained a Likert scale, 1 being negative and 10 being positive, to rate the handover process, alongside space for free text comments to be given. Thematic analysis identified common themes within these comments.

Changes were implemented in response to the survey findings. Space was added to the e-handover for each patient's care team (parent team), as well as their contact details. The Duty Doctors were informed of the changes and a post-intervention survey was sent six weeks later.

Results. There was a total of 22 responses (73.3%) to the pre-intervention survey. Themes identified from the free text comments included: Organisation of tasks; Ease of use; Reliability; Inappropriate use; Technical issues; Handover update; Task information and Ward information. The most common theme was inappropriate use of e-handover. It was identified that tasks were being added to the e-handover that would be more appropriately actioned by the parent team.

There was a total of 12 responses (40%) to the post-intervention survey. A demonstrable improvement in the rating of the handover process was found. Free text comments showed that the changes made were helpful. Common themes were identified from the comments. One theme was 'Missing information', which included a lack of clarity on the date a job was added to the e-handover. Future changes could include adding space to the e-handover for this information.

Conclusion. Following the adjustments made to the e-handover there was an improvement in the satisfaction amongst the Duty Doctors.

One limitation identified was the lower response rate for the post intervention survey. We postulated that this was due to the survey being distributed when junior doctors changed clinical rotations and left the Duty Doctor role. This could be considered for future improvement cycles.

Additionally, free text comments from the post intervention survey could be utilised to inform future improvements.

Assessment of Cardiovascular Disease Risk in Adults With Severe Mental Illness Admitted to Acute Psychiatric Unit Using QRISK-3 Assessment Tool: A Quality Improvement Project

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Aims. The purpose of this QI project was to assess risk of CVD (cardiovascular disease) in adults with SMI (severe mental illness) admitted to acute psychiatric ward as risk can be reduced by relevant changes in lifestyle, optimizing treatment of relevant comorbidities, and by drug treatment, if appropriate. Nice guidelines for CVD risk assessment and management were followed for those with CVD risk of 10% or more.

Methods. This QI project focused on patients with a diagnosis of severe mental illness admitted to ward Ty Cyfannol, YYF hospital, ABUHB in South Wales from 1st April 2021 to 30th November 2021. QRISK®3-2018 risk calculator used to estimate risk of cardiovascular disease. Patients younger than 25 years old at the time of QI project were excluded as QRISK tool is only valid for patients aged 25–84 years. Patients who already had a diagnosis of Ischaemic heart disease or stroke/transient ischaemic attack were also excluded as per criteria of QRISK3. Total number of patients included in this project was 43 patients. Data were collected from patients' medical records including their weights, heights, routine physical examinations and laboratory investigations requested during their admission. In order to maintain anonymity, patients were assigned to their hospital number. This information was saved in a password protected Excel Spreadsheet.

Results. The mean age of patients was 43.3 ± 11.06 years ranging from 25-69 years. Most patients were males (65.1 %). Schizophrenia was the most prevalent diagnosis (32.5%) followed by emotionally unstable personality disorder (18.6%). 72% out of total 43 patients were smokers. The mean BMI was 23.6 ranging from 17 to 31. 41.9% had their BMI $\geq$ 25, 8 patients out of those with BMI equal to or higher than 25 scored 10 or more on QRISK3. 13 (30.2%) patients were estimated to have high CVD risk using QRISK3 assessment tool, of whom 76.7% (n=10) aged 55 years or more. 69.2% (n=9) were current smokers, 23% (n=3) were diabetic and 15.2% (n=2) had hypertension.

Conclusion. The findings of this project conform the consensus that people with SMI are at a higher risk of having CVD. Therefore, this should emphasize the importance to assess CVD risk in patients with SMI and to manage modifiable risk factors accordingly and to incorporate the assessment of cardiovascular risk in patients with severe mental illness in day-to-day practice in mental health inpatient units.