Background – Psychiatry on-call shifts can feel daunting, especially if this is the clinician's first (and perhaps only) exposure working as a doctor within this specialty. Psychiatric hospitals are not equipped to deal with physically unwell patients which can be challenging especially as the only junior doctor on-call out of hours. Although there is a comprehensive induction programme, doctors in training raised concerns that there is insufficient, readily available practical information whilst on-call.
Methods. Surveys were sent out to doctors in training to ascertain their initial viewpoints about producing a poster and which information they feel should be included. Doctors included were foundation years, GP and core trainees on their psychiatry placement in the South West Yorkshire Partnership NHS Foundation Trust. Both qualitative (free text responses) and quantitative information (yes/no responses) were obtained via SurveyMonkey. An initial draft poster was produced and sent out to all doctors in training as well as the project lead and clinical lead. The poster was amended accordingly. The posters were printed and displayed in the on-call rooms and doctors' office.
Results. Four respondents responded to our initial pre-poster survey. They were highly receptive to the suggestion that this information would be in poster format to provide easily accessible information to help whilst on-call. Key topics identified for the poster included navigating logistical issues and information on-site, clerking new admissions and the relevant investigations required, important telephone numbers, personal safety and where and how to access relevant information and guidelines.

Feedback regarding the initial draft poster survey and the included information was also positive. Seven respondents replied and overall, they felt that the poster provided the relevant information. The project supervisor and clinical lead also provided constructive feedback and identified that locating risk assessments and discussing with a consultant when a patient is recalled to hospital on a CTO should also be included. The initial draft poster was amended following this feedback.
Conclusion. In conclusion, we found that there was an unmet need for easy to access logistical information regarding on-call work. The on-call poster provided the necessary information in a succinct and clear manner which the trainees benefited from.

Compliance With 72 Hour Follow-Up and 6 Week Medical Review in a Brixton Community Mental Health Team

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Aims. We sought to determine to what extent guidelines regarding 72 hour follow-up and 6 week medical review were being followed in a Community Mental Health Team in Brixton. Further, we aimed to find out what was happening in situations where these guidelines were not met, then implement interventions to ameliorate some of the identified barriers.
Methods. First, we conducted a retrospective review of all patients discharged from any hospital or home treatment team, over a time period from 01/07/2023 to 01/11/2023. Patients with discharge dates not in this timeframe, or those still admitted to hospital, were deemed ineligible and excluded. We extracted the dates of discharge, 72 hour follow-up, and medical review, and calculated percentages of patients who received follow-up in the required time who should have received it. Supplementary data on care-coordinator contact within a month, and primary support contact were gathered as well.

Our primary intervention was direct engagement with the involved community mental health team, delivering the findings of our retrospective review in an oral presentation on 01/11/2023. We also designed an informational poster to be disseminated among the team as well as a discharge template proforma for care coordinators to bring to patient discharges to help them acquire vital contact information details. Following the intervention, we gathered the second round of data in the same way as described earlier, from 01/11/2023 to 19/01/2024.
Results. A considerable improvement was noted in the rate of 6 week medical review, with 69% of patients successfully achieving this target in the post-intervention population (n = 18), as compared with 56% in the pre-intervention population (n = 18). However, no significant change was observed in rates of successful 72 hour follow-up between the populations (63% to 58%). This was attributed to deep-rooted barriers such as lack of robust communication services between the wards and community mental health teams, which potentially shows a need for development of underlying system integration. Qualitatively, positive feedback was given by members of the team who described dedicating more time than previously on checking if patients have been followed up on time.
Conclusion. Overall, we demonstrate moderate success for a low-intensity quality improvement intervention bringing about significant improvements in 6 week medical review compliance. Interestingly, our results indicate that the longer-term 6 week medical review may be more amenable to our awareness-based intervention than 72 hour follow-up, suggesting a different array of logistical barriers between the targets.

Digitalising Regional Induction for Junior Doctors in Mental Health and Learning Disabilities Department of Betsi Cadwaladr University Health Board

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Aims. Induction training is a crucial part of starting work in a new organization as it orientates new staff to their work role and environment, which ensures that they can work safely and competently. Given the wide geographical area of North Wales, there is logistic difficulty to continue with face-to-face induction sessions for new junior doctors. A digital format for regional induction for new doctors from all sites was introduced in 2021. This virtual induction has dealt with the accessibility problem effectively. Nevertheless, there seemed to be some ongoing issues regarding organising the session with speakers due to overlapping clinical duties. Therefore, a quality improvement project

has been initiated to improve the delivery of the sessions with minimal disruption to clinical duties. This paper is aimed to share the preliminary experience of the process of digitalisation of the induction programme.
Methods. The pilot regional induction with the above changes was carried out on August 4, 2023 via Microsoft Team Meetings and was accessible to new starters from all three sites in North Wales. The sessions consisted of talks from consultants, the lead clinical pharmacist, the ST in psychiatry and clinical services/Rota coordinator. The induction was divided into morning and afternoon sessions. The participants consisted CTs in psychiatry, GPSTs, and FY trainees. The session was recorded and a pre-recorded session on history taking was introduced. Any queries about pre-recorded session were answered by the chair of session.
Results. It was found that an estimated time saved per induction was 285 minutes with an overall saving for 3 inductions per year of 14.25 hours. The estimated cost saved (based on the lowest pay scale in NHS, £) was £151.13 with an overall saving for 3 inductions per year of £453.39. There were two Assessments of Teaching (AoT) and two Direct Observations of Non-Clinical Skills (DONCS) signed.
Conclusion. Digitalising the regional induction helps to save both time and cost for the health board. It also reduces the risk of speakers in availability. Furthermore, the recording can be sent out early to all the JDs before they join MHLD, which can facilitate a quicker orientation into the new role. It is also a good opportunity for core and specialty trainees to achieve competencies for leadership and teaching.

4 Service Evaluation

Evaluating the Effectiveness of Skills Training in Affective and Interpersonal Regulation (STAIR) Therapy for Complex Post Traumatic Stress Disorder Delivered by Core Psychiatry Trainees

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Aims. This project aims to evaluate the effectiveness of Skills Training in Affective and Interpersonal Regulation (STAIR) psychotherapy delivered by Core Psychiatry Trainees (CPTs) within the Sheffield Specialist Psychotherapy Service; a regional tertiary psychotherapy service for people with complex trauma and personality difficulties.

STAIR is a manualised evidence-based skills-based psychotherapy for people with Complex Post Traumatic Stress Disorder (cPTSD) awaiting trauma processing that is deliverable by a range of qualified and non-qualified staff. It was introduced to address two key difficulties the service faces: a long waiting list for trauma processing potentially contributes to patient deterioration, and a difficulty in identifying suitable cases for CPT short psychotherapy case requirements given the majority of potential patients awaited longer term psychotherapy.
Methods. A modified STAIR protocol was developed to meet the requirements of CPTs.

A 1-year prospective evaluation was used to compare pre and post patient reported outcome measures. These include the Nine item Patient Health Questionnaire (PHQ9) for depression symptoms, Impacts of Events Scale Revised (IES-R) for trauma symptoms, Recovering Quality of Life – 10 question (ReQoL-10) for quality of life, and the Short form Inventory of Interpersonal Problems (IIP-32) for relational symptoms. Descriptive statistics were used and data analysed using repeated measure t-tests.
Results. 17 patients completed STAIR delivered by CPTs. There was statistically significant mean improvement in Quality of Life ($p = 0.001$), trauma symptoms ($p = 0.009$) and depression symptoms ($p = 0.019$). Mean ReQoL-10 and IES-R improvements additionally met criteria for reliable change. There was non-significant ($p = 0.0146$) improvement in relational symptoms measured by IIP-32.
Conclusion. This evaluation demonstrates promising patient outcomes from STAIR delivered by CPTs for people with Complex PTSD awaiting trauma processing. This may help both negate any potential deteriorations whilst awaiting therapy, as well as prepare patients. Further evaluations could focus on acceptability and outcomes for CPTs.

Whilst the nature of this small evaluation limits further interpretation and generalisability, this pathway offers a promising means of meeting CPT psychotherapy competencies whilst also improving outcomes for patients.

Developing the New Kent Complex Psychosis Service (KCPS): Reducing the Limitations Imposed by Treatment-Resistant Psychosis

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Aims. A third to a half of patients with psychosis fail to recover to premorbid levels of functioning. Within these are a group of patients with treatment-resistant psychotic disorders, whose presentations are complex, with significant comorbidities, prolonged hospital admissions, and poor social and occupational functioning. Reports suggest an underutilization of clozapine, which is the licensed treatment for resistant schizophrenia for reasons ranging from prescribers' expertise or reluctance to intolerable side effects and comorbid psychiatric or medical conditions. In Kent, Surrey, and Sussex, clozapine prescription is only 4.93%, which is the third lowest among NHS England Regions.

Complex psychosis in Kent and Medway NHS Partnership and Social Care Trust (KMPT) was handled through a referral through the Out-of-Area Treatment panels to the South London and Maudsley (SLAM) Psychosis unit. This had lengthy wait time for admission and required approval for out-of-area costs which can be significant for longer admissions, placed a considerable travel burden on the family/carers, and made it difficult for reintegration into the local community.
Methods. The KCPS was set up as a consultation service to ensure that patients receive the right care to facilitate recovery and that our healthcare professionals and teams are supported in meeting