National Resident Doctors' Conference 2025

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Empowering Minds, Transforming

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Park Regis Birmingham, 160 Broad St, Birmingham, B15 1DT

Poster Booklet

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Wellbeing of North Hampshire Trainees On The On-call Rota at Parklands Hospital

Wellbeing of North Hampshire Trainees On The On-call Rota at Parklands Hospital

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Parklands Hospital

Introduction

"Wellbeing" has become a common focus in nearly every area of modern life. It plays a significant role in how we perceive both our personal and professional lives.

The GMC's National Training Survey 2024 found that over 21% of trainees were at high risk of burnout, with 52% experiencing high emotional exhaustion. Additionally, 26% of trainees in secondary care roles reported training being impacted by poorly managed rota gaps, with 13% of psychiatry trainees affected.

Good medical practice emphasizes that doctors should prioritize their own health and wellbeing, recognizing when they may not be fit to work and taking appropriate action.

Background

We initially conducted a wellbeing survey across four divisions of Hampshire and IOW Trust, each with different rota schedules (North - Non-residential, Southwest - Twilight, East - Residential and Southampton – Non-residential). The survey included adapted questions from the Copenhagen Burnout Inventory to better assess the impact of on-call work on wellbeing. However, the initial findings showed consistently high burnout scores across all divisions, with no significant differences.

After reviewing these results, we concluded that a new questionnaire was needed to provide a more comprehensive understanding of trainees' wellbeing. We also decided to narrow our focus from all divisions of the Trust to North Hampshire only, using it as a pilot site for the new survey. This would allow us to gain more specific insights and make any necessary changes more easily before considering wider implementation.

Aims and Hypothesis

Our aim was to assess the overall wellbeing of trainee doctors on the on-call rota at Parklands Hospital. We hypothesized that the current challenges trainees face, such as burnout and exhaustion, may be linked to the existing rota schedule.

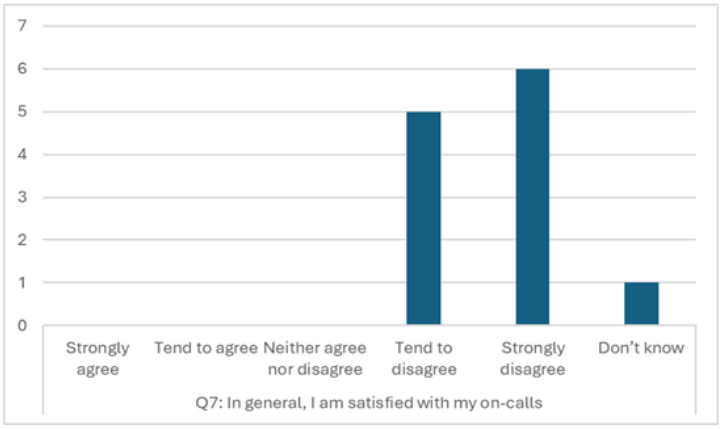
We aimed to collect this data to present to senior staff and rota coordinators to implement a change in the rota style.

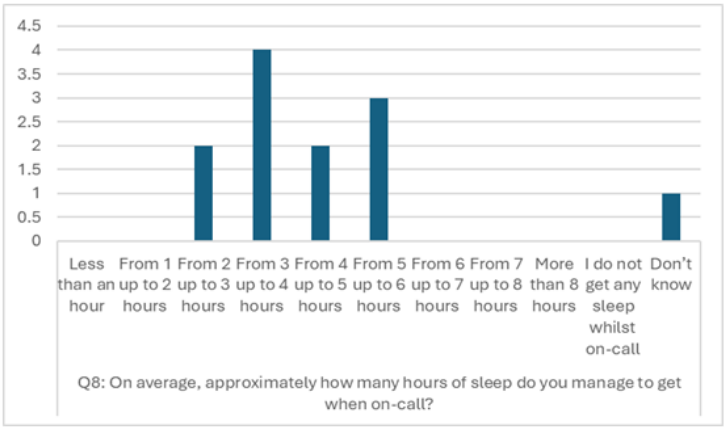
Method

A new 17-question survey was developed, incorporating elements from the Copenhagen Burnout Inventory and the Employee Wellbeing Scale (EWB). Since there are no standardized tools to assess the nutritional needs of trainees, we also designed multiple-choice and open-ended questions to evaluate sleep, nutrition, and overall wellness. A total of 12 (10 CTs, 1 GPST and 1 FY) trainees on the on-call rota at Parklands Hospital completed the survey.

Results

The respondents were mostly core trainees, with some GPST and FY2 doctors. 83% of trainees reported unhappiness during on-calls, and 92% reported anxiety. Trainees averaged only four hours of sleep, which was rarely restful. 75% reported above-average stress levels on the morning of their on-call shifts. 42% of trainees could take time off in lieu, and 66% had breaks to eat and drink. 50% found peer support meetings helpful, while 33% found clinical supervision useful. The most common suggestions for improving on-calls were changing the rota structure, with 42% voting for twilight shifts and 25% for residential on-calls.





Conclusions and Next Steps

Trainees reported high anxiety, stress, and disrupted sleep due to heavy workloads and inadequate handovers. The key recommendation was to modify the rota and introduce a system where senior nurses screen calls to improve handovers. We plan to present these findings to senior management and nursing teams and aim to repeat the survey after implementing changes. We also plan to expand the survey to other divisions to assess whether similar issues persist across the Trust. To further support trainee wellbeing, we will also add the contact information of the wellbeing champion to the SHO handbook, providing a direct point of support for trainees.

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Monitoring Compliance with Antipsychotic and Lithium Guidelines

Monitoring Compliance with Antipsychotic and Lithium Guidelines

Foxrush House –EIP and Treatment & Intervention team

Tees, Esk and Wear Valleys NHS Foundation trust.

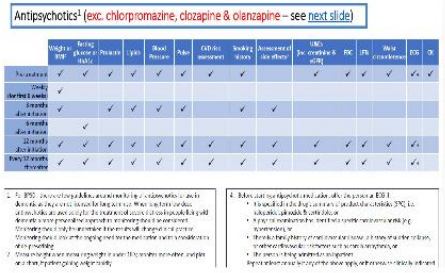
Dr.O Akintunde (CT2 Psychiatry),Dr.J. Alabi (ST1 GP, Dr. S. Chauhan(Consultant Psychiatrist)

Aims and Hypothesis

- To assess the compliance of EIP and treatment &intervention teams at Foxrush House with monitoring guidelines for patients initiated on Antipsychotic and Lithium treatment in the past year.
- Ideally ,100% compliance is expected

Background

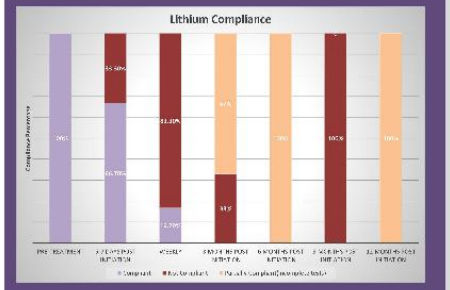
Psychotropic medication though efficacious in the treatment of mental health disorders may also pose some risk to patient health as every medication has its side effect. In order to mitigate this risk, trust guidelines dictate regular monitoring of some blood and physical health parameters are required to be carried out at specified intervals(image if guideline below).
Annual psychotropic reviews carried out by medics in the team identified gaps in adherence to these guidelines thus risking undetected side effects and potentially compromising patient safety

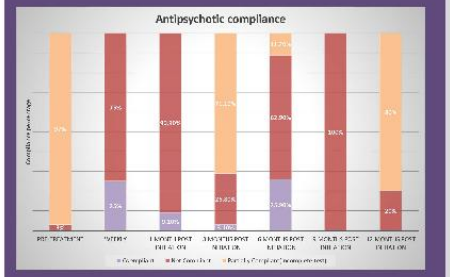


Methodology

- Data Source: Teams spreadsheet and trust's lithium register
- Data tabulated in a spreadsheet that indicated which test was done and not done for every time monitoring is required as per guideline.
- Sample size: 42 patients. (6 lithium, 36 antipsychotics)
- Data period: November 2023-November 2024
- Sample collection : December 14 2024 to December 31 2024.

Results





- Generally low level of compliance except in pre-treatment check for Lithium
- Of note is the 9 month review in both arms which recorded 100% non compliance)
- The parameters that were mostly not checked for in the antipsychotics arm were Smoking history, CVD assessment, Waist circumference, HbA1c, ECG.
- In the Lithium arm ACR, calcium, Complete TFT and consecutive stable levels of TFT were mostly not carried out.

Conclusion

Overall compliance was suboptimal. Most patients did not undergo the full recommended monitoring process.

To prevent adverse outcomes, adherence to psychotropic monitoring guidelines must be improved.

The findings of this audit though specific to this team may be a reflection of the situation in many other teams in the country. This is a wake-up call for us as mental health professionals as we treat and provide care to our patient to take care to mitigate the risk that our treatment may be predisposing them to.

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Exploring Religious Leaders' Understanding of Mental Health within the UK South Asian Population (SAMH-UK)

Exploring Religious Leaders' Understanding of Mental Health within the UK South Asian Population (SAMH-UK)

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NHS Hampshire and Isle of Wight Healthcare NHS Foundation Trust

National Resident Doctors' Conference Birmingham 2025

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Aims

This study aims to explore the knowledge and experiences of South Asian religious community leaders in the detection and sign posting of mental illness.

Background

British South Asian communities are the largest minority group in the UK, comprising 9.3% (5.5 million) of the overall population of England and Wales, as noted in the UK Census 2021. This is also the fastest growing ethnic community. (1)

British Asian communities face significant mental health challenges, and they accounted for the second largest number of referrals to Talking Therapies in 2022/23 but were 30% less likely to access mental health services, compared to their Caucasian counterparts. (2,3)

In a 2010 study, the perceptions of minority groups about mental health were analysed, and members of the South Asian community held strong beliefs that mental illness, especially psychosis, was related to punishment for previous sins or due to supernatural forces. (3) The South Asian communities preferred to seek help from religious leaders or elders. (3)

With religious leaders often being the first point of contact for community members in distress and previous studies suggesting that these leaders have varied levels of mental health literacy and engagement (4), there is an opportunity to enhance mental health support through culturally tailored community partnerships.

Methods

This is a qualitative study that employs an ethnographic approach to capture culturally contextualised perspectives. Data are being collected via face-to-face, and online semi-structured interviews, using focus groups and 1-1 interviews with religious leaders from diverse South Asian faith communities (Hindu temples, Mosques, and Churches). Data are to be analysed using a framework approach to thematic analysis, with verbatim statements being categorized into themes and subthemes, followed by data summary and interpretation.

Results and Conclusion

This is an ongoing study; therefore, results, conclusion, and the next steps will be presented at a later stage.

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Lessons learnt from a national audit on emergency department management of self-harm in under-18s

Lessons learnt from a national audit on emergency department management of self-harm in under-18s

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Abstract

Background
Conducting a national audit offers invaluable research, leadership and clinical governance experience. However, student-led audits face unique challenges. This audit assessed the management of self-harm in under-18s across UK emergency departments (EDs). We focused on the challenges faced during the audit process and the lessons learned to inform future student-led initiatives.

Methods
Overseen by a committee of doctors and medical students, this audit reviewed nearly 500 ED records across nine medical schools between 2021 and 2023. Data collection, based on NICE guidelines, involved retrospective review and was complicated by a mid-audit guideline change. The snowball teaching method was employed to recruit and train data collectors.

Results
29 students took part in the audit, with 9 as regional leads who organised local data collection, developing skills in data extraction, communication and governance. However, 25% of collected records were excluded due to data quality issues, including errors in record eligibility and logical errors in questionnaire completion. A decentralised peer-driven training model led to inconsistent knowledge transfer, highlighting the need for more structured training frameworks and automated data collection tools.

Key messages
This audit highlights the critical importance of robust training and data management systems in national student-led audits. Lessons learned underscore the value of structured protocols and ongoing assessments to ensure data quality and encourage sustainable student engagement in understanding clinical governance.

Introduction

Auditing is a crucial element of clinical governance, ensuring that patient care aligns with evidence-based standards. National audits provide opportunities to examine clinical practices, identify inconsistencies, and propose improvements. For medical students, involvement in these projects offers hands-on experience in research, teamwork, and quality improvement.

This poster outlines the lessons learnt from conducting a national student-led audit of ED management of self-harm in under-18s between 2021 and 2023. Challenges included a mid-cycle change in NICE guidelines and data collection issues common in large-scale national audits of emergency healthcare settings (1). With nine medical schools involved and nearly 500 records reviewed, this audit offers valuable insights for future student-led national audits.

Methods

Audit criteria
During the planning stages, NICE released updated guidelines (2,3) (fig. 4). As a result, the audit criteria had to be amended to reflect the updated guidelines. This presented a challenge, as the project had to assess records retrospectively, based on criteria that were not in effect at the time of care.

Recruitment
Data collectors were recruited via social media, university psychiatry societies, and word-of-mouth. We initially attracted interest from many of the UK's medical schools, but due to attrition – primarily regional leads finishing medical school and their wishes to prioritise academic work – the final cohort included nine medical schools. One medical student from each participating university served as the regional lead. These regional leads received training from the committee on the audit process, data collection, and maintaining unique ID systems; they then disseminated this learning to data collectors. However, issues with data quality suggest that this method may not have been as effective as anticipated (4) (fig. 1), mirroring challenges noted in other audits that rely on distributed data collection models (5).

Data collection
The audit used a questionnaire designed around NICE CG225 (3), which focused on auditable aspects such as documentation of safeguarding risks or stratification of risk. Data collectors retrospectively accessed ED the records of under-18s who presented with self-harm to their university's local hospitals between 7th September and 7th November 2022 inclusive.

Data cleaning
Despite training, approximately 25% of the collected records were excluded due to errors, such as a lack of documentation of self-harm or inclusion of patients outside the age or date range. Logical errors in the completion of the questionnaire were also common, and issues with adherence to the unique ID format complicated data cleaning. These challenges are not unique to this project; data quality issues are a recurring theme in national audits (6).

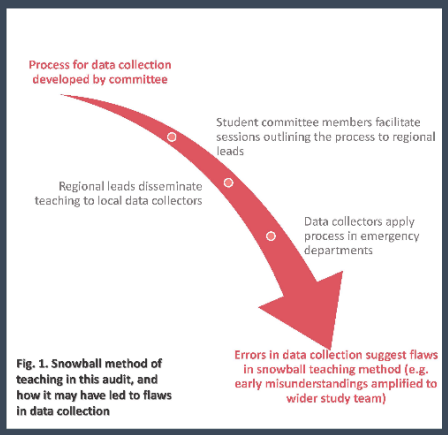

Fig. 1. Snowball method of teaching in this audit, and how it may have led to flaws in data collection

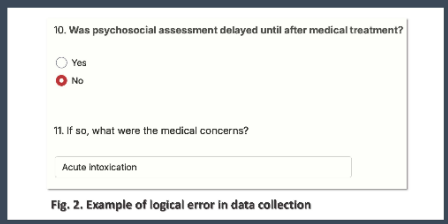

Fig. 2. Example of logical error in data collection

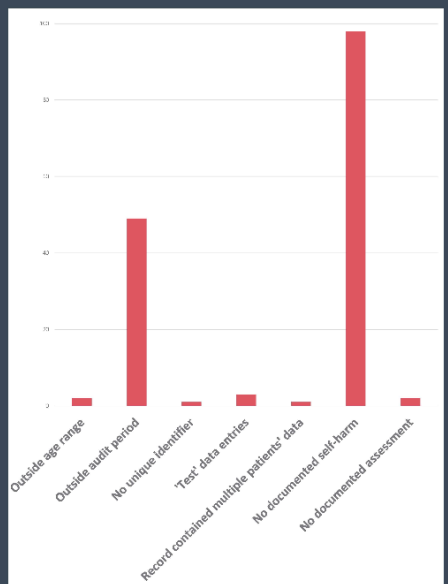

Fig. 3. Chart illustrating reasons that nearly 200 records were excluded from data analysis

Fig. 4. An update to NICE guidelines partway through the design process of this audit hampered progress and added complexity

Results

The audit involved 9 medical schools, with a total of nearly 500 ED records reviewed across England, Scotland and Wales. Despite comprehensive training, many data collectors misunderstood key criteria, leading to a significant number of excluded records. Many records did not meet the audit's inclusion criteria, and logical errors in completing the questionnaire were frequent, reflecting broader issues with data quality that have been noted in previous national audits (7).

The difficulties in following a consistent unique ID format created additional barriers during data cleaning. These issues highlighted gaps in both the training provided and the snowball teaching method, where information trickled down through layers of student trainers (fig. 1). Without a more rigorous assessment of the understanding of regional leads' these errors were inevitable. Furthermore, the mid-cycle change in the NICE guidelines added complexity (fig. 3), requiring us to assess clinical practice retrospectively based on criteria that had not been in place when many of the records were documented.

Conclusion and recommendations

The national audit on the emergency department management of self-harm in under-18s has yielded critical insights into both the challenges and successes of conducting student-led audits in high-pressure healthcare environments. The need for improved training frameworks, more structured data collection tools, and careful planning around guideline changes is paramount. By addressing these challenges, future audits can be more successful in driving meaningful improvements in clinical practice and patient care.

Enhancing training programmes, utilising structured data collection tools, and fostering a culture of continuous learning and feedback will be essential in elevating the quality of audits and, ultimately, patient care in this vulnerable population. The collaboration between medical students and professionals, as demonstrated in this audit, serves as a testament to the potential of student-led initiatives in driving meaningful change within healthcare.

Summary of recommendations for future audits
These recommendations, developed from the student committee's perspective, are intended to support continuous improvement in student-led audits.

Observed challenge	Recommended solution
Inconsistent knowledge transfer through snowball method of peer-led training (fig. 1)	Ensure that regional leads and data collectors receive comprehensive training, including formal assessments of understanding
Data excluded from analysis due to data collection errors (fig. 3)	Use digital forms that enforce consistency and minimise errors in data entry
Mid-audit NICE guideline audit update complicated project development (fig. 4)	Avoid auditing criteria that are likely to change during the audit period or ensure that the audit timeframe aligns with the most up-to-date guidelines
High-pressure ED settings with medical abbreviations that may be unfamiliar to medical students	Consider auditing in settings where documentation is more consistent and comprehensive, such as general practice or psychiatry
Attrition of data collectors as medical students opted to focus on academic work or graduated	Complete audit design before recruitment so that data collection may proceed promptly

Fig. 5. Table summarising observed challenges and recommendations for future student-led audits

Acknowledgements

We would like to extend our gratitude to all the medical students, foundation doctors, and faculty members who contributed to this audit. Special thanks to the emergency department staff at the participating institutions for their cooperation and support during data collection.

This audit was conducted by the Student Psychiatry Audit and Research Collaborative (SPARC) UK.

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Psychiatry e-learning for foundation doctors: Barriers, engagement and future directions

Psychiatry e-learning for foundation doctors: Barriers, engagement and future directions

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Introduction

'Foundation doctors are required to gain mental health competencies, regardless of whether they rotate into a psychiatry placement' (1). Despite the growing emphasis on integrating mental health competencies into the foundation programme (FP) curriculum (1), the rotational nature of training means many FP doctors still do not receive formal psychiatry placements during their rotations, with at least 55% of FP doctors not rotating into psychiatry (2).

Research has highlighted that, while mental health competencies are critical to holistic patient care, 'foundation doctors who do not undertake a psychiatry placement report feeling less competent in managing mental health conditions' (2). A set of e-learning modules, hosted on elearning for healthcare (elfh) was developed by the Royal College of Psychiatrists (RCPsych) to help support local education providers (LEPs) deliver training to address this frequently unmet need.

The e-learning package contains four module: addictive behaviours, anxiety disorders, self-harm assessment and management, and medically unexplained symptoms.

Aims

1. Understand the motivations of FP doctors who voluntarily engage with the psychiatry el-earning package.
2. Gather feedback on the content, quality, and delivery of the package.
3. Explore barriers to engagement with the e-learning package among non-completers.
4. Identify preferences for alternative educational methods, such as simulated learning, peer teaching, or in-person workshops.

Methods

A questionnaire was developed using Jisc Online Surveys and disseminated among foundation doctors in the Northern Foundation School, via local WhatsApp groups, mailing lists from LEPs and mental health trusts, and the 'Found Your Place in the North East and North Cumbria' careers app.

The questionnaire was designed to adapt to responses to assess perceptions of both completers and non-completers. Completers are those who have completed at least one of the modules. Descriptive statistics were performed to summarise trends and patterns in responses.

Results

Of 493 doctors in the Northern Foundation School, 27 completed the questionnaire (a response rate of 5.5%).

Table 1. Participant demographics

Career stage		Psychiatry rotation		Completed any of the e-learning modules	
FY1	FY2	Yes	No	Yes	No
6 (22%)	21 (78%)	12 (44%)	15 (56%)	1 (4%)	29 (96%)

Only one participant had completed any of the e-learning modules (specifically, the module on medically unexplained symptoms) and offered the below feedback:

- **Overall:** Good
- **Clarity:** Good
- **Relevance:** Good
- **Interactivity:** Average
- **Engagement:** Average
- **Difficulty:** Easy
- **Preparedness for psychiatry-related cases after completing:** Somewhat prepared

The remaining feedback is therefore from participants who had not completed any of the modules. The below figures illustrate reasons given for not completing any of the modules (fig. 1), as well as alternative methods used to meet core FP competencies in mental health (fig. 2).

Figure 1. Barriers to completion

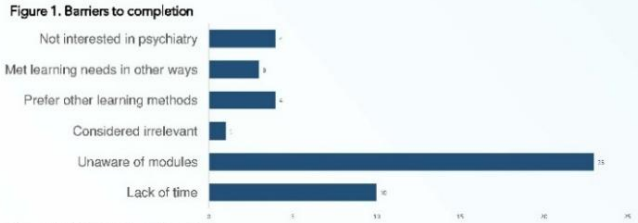
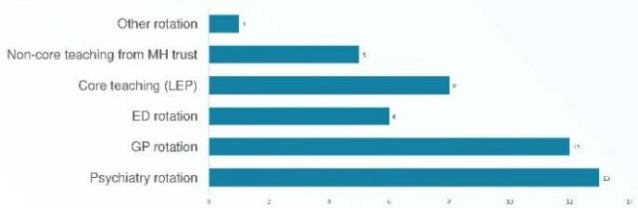


Figure 2. Alternative learning sources



Results (cont'd)

The below figure (fig. 3) outlines how easy participants found it to meet their core psychiatry FP competencies without completing the modules, and select comments are also provided:

- *"I feel my medical degree equipped me with the appropriate skills to meet my mental health competencies."*
- *"I had a very proactive educational supervisor during my psychiatry rotation that supported me in attending as many different seminars and learning opportunities as possible. I think if I did not have this I would have benefited massively from completing the e-learning courses listed here."*
- *"Did a lot of psych in GP, and from conversations with those that had a psych rotation and no GP rotation I would argue I was actively doing more 'psych medicine' in my GP consultations (MSE, risk assessment, titration of medication) than those on psych who were observing or being the 'medic' on the ward."*

Figure 3. Ease of meeting competencies without e-learning

Most participants (n=18, 67%) preferred alternatives to e-learning, and a large portion of the remainder (n=6, 25%) were unsure what learning method they preferred. The below figure (fig. 4) illustrates participants' preferred alternatives to e-learning.

Figure 4. Preferred alternatives to e-learning

When asked what psychiatry topics participants felt were most important to cover, responses clustered around 8 key topics:

1. Basics of psychiatry for managing inpatients
2. Acute mental health crisis management in A&E and hospital wards
3. Risk assessment and de-escalation techniques
4. Managing common psychiatric conditions (e.g. depression, anxiety, psychosis)
5. Recognising and managing delirium and dementia
6. Use and monitoring of antipsychotic medication
7. Paediatric psychiatry, including ADHD and ASD
8. Practical applications of the legal frameworks

Discussion

The low response rate (5.5%) and low module completion rate (4%) reflect well-documented challenges in recruiting FP doctors for educational research, where competing clinical demands, limited awareness of resources, and a preference for interactive learning methods often impact engagement (3,4). Passive e-learning formats may be less effective for this cohort, as time constraints make it difficult to prioritise self-directed online learning over structured, interactive, and clinically integrated teaching methods.

A blended learning approach, incorporating targeted awareness campaigns, structured teaching sessions, and case-based discussions, may be more effective in delivering key mental health competencies. The planned focus groups will provide further insights into barriers and motivations, informing strategies to enhance psychiatry education for foundation doctors.

Next steps

1. Focus groups in progress to complement quantitative data.
2. Development of four further modules in progress.
3. A series of recommendations based on these findings have been presented to the RCPsych Foundation National Working Group to improve awareness of the existing resources and to address the requested topics in innovative and engaging ways.

Acknowledgements

We are grateful to the Northern Foundation School, elfh, the UKFPO and the RCPsych Foundation National Working Group for their support in running this project, as well as the foundation doctors who took the time to participate.

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Who's Afraid of Getting Old? Ageism and Aging Anxiety in Egyptian Society

Who's Afraid of Getting Old? Ageism and Aging Anxiety in Egyptian Society

Alaa Abdelkader [1], Rana Elbayar[2], Aya Ashour[3], **Mariam Alwerdani[4]**, Abdallah Elgabry[3], Sara Hashish[3], Ayat Ashour[5]

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Summary

This study examines their prevalence in Egypt, highlighting key individual factors and the connection between them. Our survey of 359 adults found that lower income, being single, unemployment, and low religiosity were linked to higher aging anxiety.

Frequent interaction with older adults was associated with lower ageism and anxiety. These findings suggest that increasing awareness and social engagement could help reduce fear and stereotypes about aging.

Background

- With global aging on the rise, the number of people aged 60+ is projected to reach 2.1 billion by 2050.
- As societies age, ageism—stereotypes and discrimination based on age—has become a public health issue, negatively impacting older adults' quality of life.
- Aging anxiety, or the fear of age-related changes, has been shown to correlate with stronger ageist beliefs. However, greater exposure to older adults and education on aging are linked to more positive attitudes.

- Despite its significance, ageism remains underexplored.
- This study assesses public attitudes toward aging and examines the individual factors influencing ageism and aging anxiety, hypothesizing that negative perceptions of aging are associated with increased anxiety about growing older.

Methods

- We conducted a cross-sectional survey of 359 adult Egyptians using a predesigned questionnaire.
- It included sociodemographic factors, the Fabroni Scale on Ageism (FSA), the Ageing Anxiety Scale (AAS), a question about contact with older adults, and another on religiosity

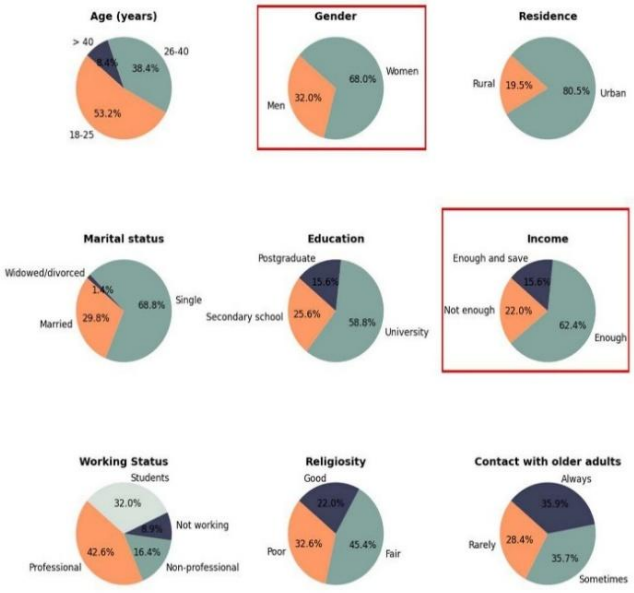
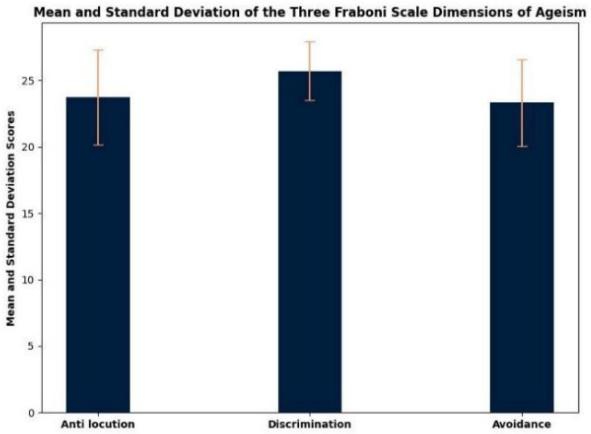


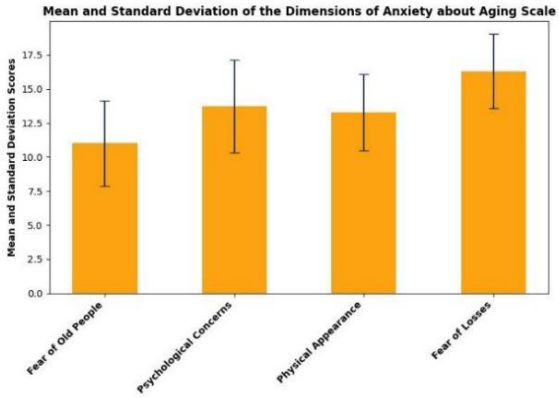
Figure 1. Characteristics of study participants (N=359)

Results

- **The mean total score of ageism was 72.79 (± 6.3 SD).**



- **The mean total score of ageing anxiety was 54.33 (± 8.83 SD).**



- Lower income is associated with higher ageism and ageing anxiety scores ($p = 0.006$ & 0.036 respectively) while frequent contact with older adults was associated with lower ageism and ageing anxiety scores ($p = 0.000$) for both.

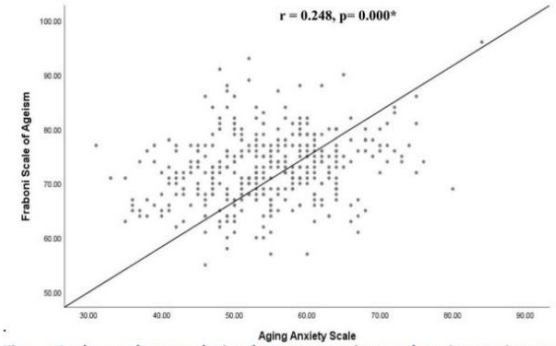


Figure 4. shows the correlation between ageism and ageing anxiety scale.

Conclusion and Next steps

- **This study underscores the importance of raising awareness, incorporating aging education for young people, and fostering intergenerational interactions to alleviate aging anxiety. Additionally, policies that enhance education and income levels may contribute to this effort as well.**

Presented by:
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Mind the Gap: Strengthening Handover Practices in Psychiatric Admissions

Mind the Gap: Strengthening Handover Practices in Psychiatric Admissions

NHS Lanarkshire

Dr Aalap Asurlekar, CT1
University Hospital Hairmyres, NHS Lanarkshire

Aims

This study assesses the frequency and adequacy of handovers for newly admitted patients in a community psychiatry hospital, focusing on formal communication to the duty doctor.

Background

Effective handovers are critical for patient safety and continuity of care[1]

Fragmented care
Delayed interventions
Safety risks[2]

Methods

- Udston Hospital, NHS Lanarkshire, 2 Older Adult Wards
- 50 random patients included between January 2024 and January 2025
- MORSE electronic record
- Primary Outcome Measure: Handover Rates
- Any documented verbal/written communication to the duty doctor
- Categorical data analysis

Conclusion

- Handover communication was inconsistent, with over half of admissions lacking a formal handover
- Hospital transfers and care home admissions had the lowest handover rates
- Legal status significantly influenced handover practices, with all CTO patients receiving a handover
- Informal patients were least likely to be handed over indicating gaps in structured communication for non-detained individuals

Results

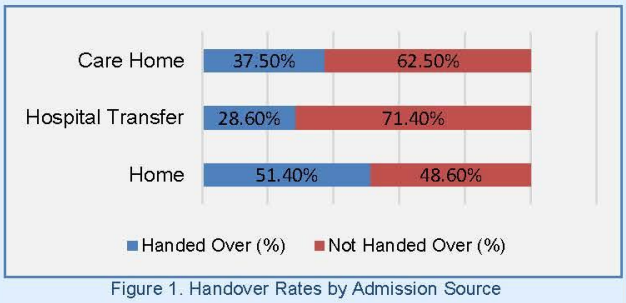

Figure 1. Handover Rates by Admission Source

Category	Handed Over	Not Handed Over
Overall Admissions	46%	54%
Admission Source		
Home	51.40%	48.60%
Hospital Transfer	28.60%	71.40%
Care Home	37.50%	62.50%
Legal Status		
Informal Patients	43.30%	56.70%
Compulsory Treatment Order (CTO)	100%	0%
Short-Term Detention Certificate (STDC)	50%	50%
Emergency Detention Certificate (EDC)	50%	50%

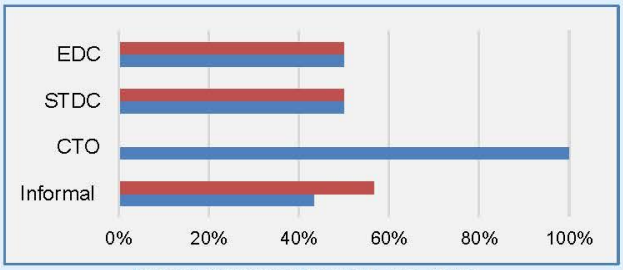

Figure 2. Handover Rates by Legal Status

Next Steps

- Implement a standardized handover protocol
- Introduce electronic handover templates
- Introduce staff training and awareness programs
- Monitor and audit handover compliance regularly

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Timing Matters: The Impact of Late-Afternoon Psychiatric Admissions on Patients & Staff

Timing Matters: The Impact of Late-Afternoon Psychiatric Admissions on Patients & Staff

NHS Lanarkshire

Dr Aalap Asurlekar, CT1
University Hospital Hairmyres, NHS Lanarkshire

Aims

To investigate the timing and patterns of psychiatric admissions, allowing resource allocation by identifying peak arrival times.

Background

Late admissions cause:
Treatment Delays[1]
Poor Patient Sleep[2]
Staff Burden

Understanding peak admission times can inform staffing and improve workflow

Methods

- Udston Hospital, NHS Lanarkshire, 2 Older Adult Wards
- 50 random patients included between January 2024 and January 2025
- MORSE electronic record
- Primary Outcome Measure: Admission times
- Secondary Outcome Measure: Admission source and Legal status
- Categorical data analysis

Results

- Only 14% of admissions occurred between 9 AM - 12:59 PM
- Peak admission period: 2 PM - 4 PM (46%)
- 74% of admissions occurred after 2 PM
- Half of the admissions were informal and from home

Results

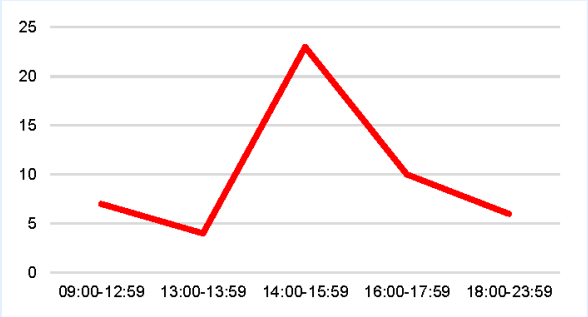

Figure 1. Admission Volume by Time Slot

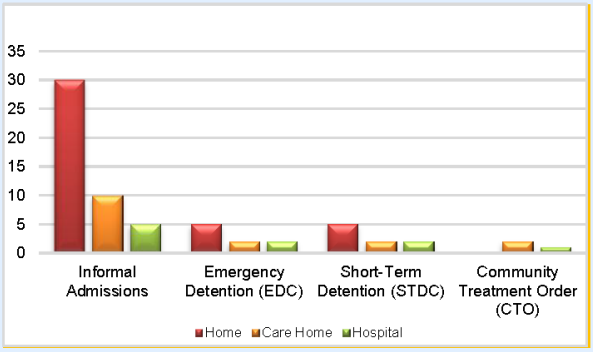

Figure 2. Admission Distribution by Legal Status

Conclusion

- Poor utilization of morning hours for informal patient admissions
- Informal admissions from home require targeted intervention
- Resource allocation should prioritize afternoon and evening coverage

Next Steps

1. Designate morning admission slots for non-urgent cases
2. Introduce a Dedicated Admissions Coordinator
3. Increase staffing levels during peak hours

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The Unscheduled Care Service in NHS Grampian: A Year in Review

The Unscheduled Care Service in NHS Grampian: A Year in Review

Dr Rachel Ball (CT3)

Dr Murray Smith (Consultant Psychiatrist)

Background

The Unscheduled Care Service (UCS) at Royal Cornhill Hospital (RCH), Aberdeen, operates 24 hours a day, 365 days a year. It provides both urgent (within 5 days of referral) and emergency (same-day) psychiatric assessments to patients in Aberdeen City and Aberdeenshire. The service is staffed by a team of experienced nurse practitioners as well as resident doctors, who typically work in the team as part of their on-call duty shifts. The team is also supported by administrative staff and on-call registrars and consultants, with a consultant psychiatrist acting as a permanent clinical lead for the service.

Aim

The aim of this review was to quantify:

1. The sources of referral
2. The reasons for referral
3. The mode of assessments
4. The outcomes of assessments

for patients referred to the UCS for the year of 2024.

Methods

Administrative staff working in UCS collected data about referrals to the service and entered this into secure EXCEL spreadsheets on a contemporaneous basis throughout 2024. These spreadsheets were then retrospectively reviewed at the start of 2025, to collate data regarding: sources of referral, reasons for referral, mode of assessments and outcomes of assessments.

Results

A total of 4714 referrals were made to the UCS during 2024.

Figure 1 - Top 3 Sources of Referral to the UCS in 2024

Self-Referral	Emergency Department	Police (including Custody Suite)
22.7% (n=1072)	19.1% (n=900)	16.9% (n=797)

FIGURE 2 - MODE OF ASSESSMENT

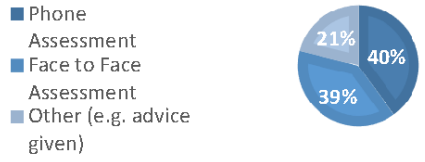


Figure 3 – Outcomes of Assessments by UCS in 2024

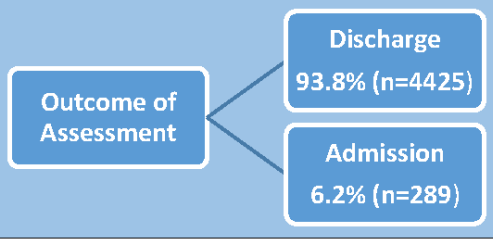


Figure 4 – Most Recorded Diagnoses of Patients Referred to UCS in 2024

Not Recorded	Personality Disorder
35.6% (n=1682)	24.6% (n=1161)

Discussion and Next Steps

Administrative staff do not record demographic data about referrals. This gap in the data makes it hard to determine which patient groups are utilising or finding it challenging to access the UCS. Gathering more granular data represents a potential area for development in the future. Additionally, there are significant gaps in the recording of information around the reasons for patients being referred to UCS. This may represent a need to improve the documentation process of referrals by clinical staff. Data collection for 2025 is ongoing, and it is expected a similar review of the UCS will occur around the start of 2026.

Cultivating Resilience In Times Of Distress: A comparative study of resilience amongst psychiatrists in training

CULTIVATING **RESILIENCE** IN TIMES OF DISTRESS:

A comparative study of **resilience** amongst psychiatrists in training

Dr Nawal Benachar, Psychiatry Resident, North London NHS Foundation Trust

Background:

- 'Resilience' has become a popular term in medical wellbeing research, but remains poorly understood.
- Mixed outcome of interventions that aim to increase resilience amongst doctors.
- Lack of doctor-informed perspectives and narratives.
- In time of instability, more robust understanding of not only what it means, but how best it can be achieved required.

Research questions:

1) *How do psychiatrists in training define 'resilience'?*

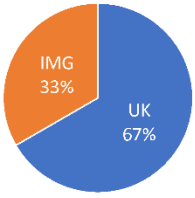
2) *What are the differences between attitudes and behaviours related to resilience between UK and International Medical Graduates (IMGs)?*

3) *How (if at all) can resilience be taught effectively to psychiatrists in training?*

Methods & Methodology:

- Mixed methods.
- Validated MeRS tool to measure resilience in IMGs vs UK graduates; select groups invited to interview.
- **Interpretive Phenomenological Analysis** to identify unique experiences of participants → identify **idiographic themes**, then overall patterns of meaning across data and overarching, generalizable themes.

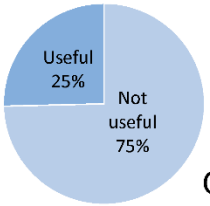
Results:



- 25 UK graduates and 12 IMGs responded.

*'ability to **cope… to reflect**'*
*'ability to **process experiences** through talking'*
*'sitting with **difficult emotions** without **disintegrating**'*

*'**Resilience isn't a helpful word or concept**… It comes with connotations that doctors need to carry on despite struggles, and puts **blame** on doctors rather than systemic issues or lack of support…'*



76% responded 'supportive colleagues' improves resilience at work.

On average, IMGs **have higher resilience**.

Conclusions & next steps:

- Inborn, fixed trait or developable skill? → likely **both**.
- Strong **reflective and emotional** component to resilience, **process** rather than noun.
- Trainees emphasize **external locus** i.e. colleagues and environment – suggests significance of ***social connection, communication,*** *and* ***collaborative work environment*****.**
- IMGs score higher for resilience – multifactorial social factors.
- If capacity to learn is limited, so is capacity to teach.
- Most trainees do not find interventional measures useful – *perhaps time to **switch focus** from making trainees **more 'damage-proof'**, to creating **less damaging environments**.*

Improving the Management of Hyperglycaemia on an Adult Inpatient Psychiatric Ward

Improving the Management of Hyperglycaemia on an Adult Inpatient Psychiatric Ward

Dr Eliza Bradley, CT1 Psychiatry

NHS Greater Manchester Mental Health NHS Foundation Trust

Figure 1 (1)

Introduction & Background

People with severe mental illness (SMI) are known to be at increased risk of diabetes. (2) Meta-analysis has shown this to be as high as a two-fold risk of diabetes in people with schizophrenia-like illnesses. (3) Conversely, those with diabetes are also more likely to experience severe mental illness. (2)

Eagleton Ward is an Acute Male Inpatient Psychiatric Ward in Salford. It has 18 beds, with ≥70% of service users having a diagnosis of a psychotic illness at any one time. Therefore, the appropriate identification and management of T2DM is relevant for our patient population, who are at increased risk secondary to lifestyle factors and antipsychotic medications.

In 2023, Goff et. al conducted a cross-sectional survey of NHS staff working in Psychiatric inpatient settings. The results showed that 93% of participants felt addressing physical health needs was an important part of the mental health team's role, but only 68% reported that they had adequate skills and knowledge to manage diabetes safely on the wards. (4) Discussion with Registered Mental Health Nurses (RMNs) on Eagleton Ward reflected these findings.

Aims

1. For 100% of Hyperglycaemic episodes to be managed in accordance to the MM12 Hyperglycaemia Guideline (5) at Eagleton Ward by 24th Jan 2025
2. Improve confidence of Registered Mental Health Nurses in managing episodes of Hyperglycaemia on Eagleton Ward

Methods

Audit

Service users on Eagleton Ward with a diagnosis of Diabetes Mellitus were identified (through admission clerking or their GP summary). A 2 week period (28/11/24-12/12/24) was audited by identifying episodes of hyperglycaemia on the physical health tab of PARIS for each of these patients. The progress notes were then reviewed for each hyperglycaemic episode to audit:

- If it was escalated to the medical team or on-call doctor
- If a National Early Warning Score (NEWS) was calculated
- If urinary or blood ketones were taken
- If capillary blood glucose readings (BMs) were repeated 2-4hrs later

It was also recorded if any other actions were taken eg. Administration of short-acting insulin

The audit was then repeated, using the same method, for a 2 week period following the training sessions (10/1/25-24/1/25).

Questionnaire

A questionnaire was created to assess RMNs confidence in managing hyperglycaemia, as well as their understanding of Diabetic emergencies

Blank space questions were included for suggestions of further areas for training.

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Plan	Do	Study	Act
To assess key areas to improve RMNs confidence in managing episodes of Hyperglycaemia	Created a questionnaire and distributed to all RMNs working on Eagleton Ward	Reviewed the responses from the questionnaire	Created a training presentation, focusing on aspects that RMNs provided low self-ratings
To improve RMNs confidence in managing episodes of hyperglycaemia	Provided drop-in teaching sessions for RMNs on Eagleton Ward & created a laminated handout	Repeated the questionnaire	Physical Health Care Team to complete 11@11 training for staff on all wards using presentation & handout
To improve compliance with Hyperglycaemia Guideline MM12	Put up copies of Hyperglycaemia pathway in Clinic Room	Re-audited Hyperglycae mic episodes	*To Do: continue to provide teaching & re-audit*

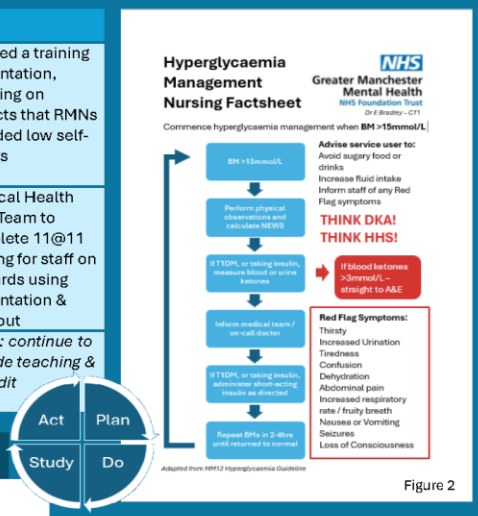


Figure 2

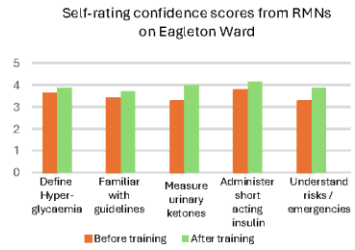
Results

Audit

The initial audit of 10 hyperglycaemic episodes (in a 2 week period) showed that only 30% of episodes were escalated to the medical team. 30% had a NEWS score calculated (however, in 2/3 cases this was because NEWS and BMs were taken at the same time) and only 10% had a repeat BM documented in 2-4hrs time. Blood/urine ketones were not performed for any of these episodes, despite 4/10 of the episodes relating to a patient taking insulin.

When attempting to re-audit the hyperglycaemic episodes on the ward, only one episode of hyperglycaemia was identified following completion of the training. However, this episode was well-managed and documented. NEWS score was completed following high BM and BMs we re-done 2 hours later. Ketones were not performed, but the service user had T2DM and was not on insulin.

Questionnaire



When would you escalate hyperglycaemia to the medical team?

Before training	After training
When BM >20	When 15 or above
When BM's >16	>15
If insulin not taking effect	>15 or signs of DKA/HHS
As per care plan	>15
When what I have to do is completed, but not improving	Once completed Obs
If no management plan or if	BM above 15 or below 3
BMs not responding to management plan	If BM above 15 or red flags

To assess whether the intervention had improved nursing confidence in the management of hyperglycaemic episodes, the questionnaire was repeated post-training. A mean score was calculated for each of the self-scoring domains and compared to the initial mean scores. There was an increase in the mean score for each domain following training. Most significant difference was seen for 'Confidence in measuring urinary ketones' and 'Understanding of risks and medical emergencies associated with hyperglycaemia'. The blank space questions were reviewed and it was found that the answers more closely fit the guidelines as demonstrated in the table above. 6/8 responses stated that there were no further areas in which they required training, compared to 0/8 prior to training.

Discussion & Recommendations

I believe that the training was successful in meeting the aim to improve the confidence of Registered Mental Health Nurses in managing episodes of Hyperglycaemia on Eagleton Ward. Training is now going to be rolled out to nursing staff on other wards at Meadowbrook Unit using the 11@11 teaching format. The laminated factsheet that I produced for nurses to keep with them will also be distributed.

I do not believe there is enough data to confirm or refute whether my aim for 100% of Hyperglycaemic episodes to be managed in accordance to the MM12 Hyperglycaemia Guideline (5) at Eagleton Ward by 24th Jan 2025 was met. In the two weeks following my training sessions, there was only 1 hyperglycaemic episode. This is due to one service user with diabetes being discharged and because another service user had better-controlled blood sugars. Although there was insufficient data, this supports the hypothesis that hyperglycaemia is poorly managed partly due to low exposure to the condition for nursing staff. For this reason, I would recommend that training is repeated at regular intervals e.g. monthly or during periods of staff turnover. I would also recommend regular re-auditing of hyperglycaemia management to identify when 'refresher' teaching may be beneficial.

Improving The Quality Of Local Inductions By Introducing "Rota Guides" For SHO Rotas Covering Multiple Hospital Sites

IMPROVING THE QUALITY OF LOCAL INDUCTIONS BY INTRODUCING "ROTA GUIDES" FOR SHO ROTAS COVERING MULTIPLE HOSPITAL SITES

Dr Samuel Button [1] (CT3), Dr Ann Gollo [1] (CT2), Dr Gizem Yazici [1] (CT2), Dr Basak Ersavas [1] (CT2),
Dr Akshita Dandawate [1] (CT2), Dr Unsa Athar[1] (ST2), Dr Talha Amanullah [1] (CT2), Dr Indira Vinjamuri DME[1] (Consultant Psychiatrist)
[1] Mersey Care NHS Foundation Trust

NHS Mersey Care NHS Foundation Trust

Background

Resident doctors in various training programmes regularly rotate between different roles and on call rotas. One particularly stressful element is the prospect of on call rotas covering multiple sites. Often for foundation doctors and GPSTs this is the first time they've had to do so. Resident doctors often face the daunting prospect of being responsible for providing medical cover to several unfamiliar hospitals often first stepping foot in them out of hours.

Inductions are packed and practical on-call information such as parking, how to access buildings, where you can find workspaces/rest areas, the specialties of various wards and which community teams might approach you for prescriptions can be difficult to cover in depth. Even when this is covered it can be easily forgotten as people prioritize adjusting to their in-hour roles.

Aim

Our aim was to collect knowledge from peers on each rota in the Mersey care trust and create written guides as an easily accessible resource that resident doctors could refer to running up to and during their shifts.

We wanted to see what effect this would have on doctors' ratings of confidence around important practical topics relating to their on-calls as well as their account of how it effected their stress around on calls.

Method

We used a quantitative survey-based approach with a pre-post assessment design to evaluate the confidence of trainees before their first on call. Two surveys—pre-induction and post-induction—were conducted to assess:

1. The perceived importance of key on-call information
2. Confidence levels before and after induction
3. The effectiveness of rota guides in reducing stress

A Likert scale and numerical rating scales were used to ensure consistent, measurable responses.

The study included trainees on the various on-call rotas in Merseycare NHSFT. Participation was voluntary and anonymous.

5-point Likert scale questions were used to measure perceptions and confidence on:

- Perceived Importance of On-Call Information (Pre-Survey)
- Confidence Levels Before and After Induction

This scale measured responses ranging from 5-very confident/ likely/ important to 1-very unconfident/ unlikely/ unimportant

A Numerical Scale (1 to 10) was used to measure the following with 10 being the highest

- Effectiveness of Rota Guides in Reducing Stress (Post-Survey)
- "On a scale of 1 to 10, how would you rate the rota guides' effect on reducing stress before your on-call shifts?"

The pre-survey was administered a month before core trainees were due to rotate. The post-survey was conducted roughly a month following the subsequent rotation measure improvements in confidence and the perceived usefulness of induction materials. Responses were collected via an online questionnaire.

Data collected was analysed using:

- Descriptive Statistics: Mean, median and standard deviation were calculated for each response category.
- Comparative Analysis: Confidence levels and perceptions before and after induction were compared.

Reflections and recommendations

Survey results showed confidence ratings on the key areas identified rose after the introduction of Rota guides. However, there was decrease in the confidence level for the Wards/Sites coveraged. The guides were introduced at the same time as some hospitals moved between rotas which may explain the decrease in confidence of sites covered.

Overall the evidence we collected suggests that the Rota guides improved the clarity of induction and helped reduce the stress related to on calls.

Going forward establishing how to keep the guides up to date is important so this improvement can be maintained.

During the project we identified several other benefits of the guides including

1) It provided a useful reference point for admission protocols helping to improve compliance with other trust targets and might be useful in other QI projects.
2) Registrars having to step down have expressed that the guides help make this less stressful and potentially improve patient safety.

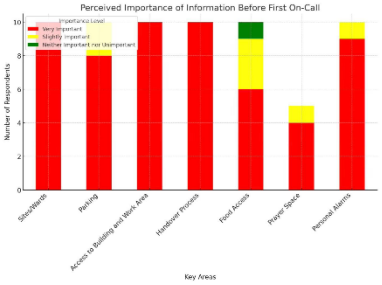
Acknowledgements

St Helen and Knowsley Rota and co-ordination of project: Dr Samuel Button North - Southport Rota: Dr Gizem Yazici - Dr Basak Ersavas
South Rota: Dr Ann Gollo
Warrington Rota: Dr Unsa Athar - Dr Talha Amanullah
Maghull Health Park Rota: Dr Akshita Dandawate
Medical Education Team - Mersey Care NHS Foundation Trust

RESULTS

1. Perceived Importance of Information Before First On-Call:

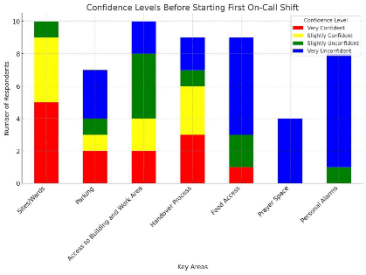
Majority of trainees rated all areas we identified for coverage as "Very Important."



Areas such as ward/site coverage, parking, access to buildings, and handover process were consistently rated as highly important. Areas like prayer spaces and personal alarms showed lower importance ratings but still considered important.

2. Confidence Levels Before First On-Call

Confidence on areas covered in the rota guides varied significantly.



Some trainees felt very confident in aspects such as parking and building access, others reported low confidence in areas such as handover procedures. The overall trend suggests that lack of prior knowledge contributed to lower confidence levels in key areas.

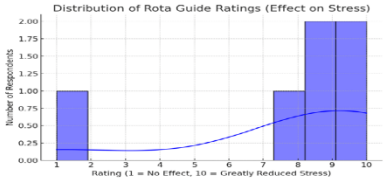
3. Likelihood of using the Rota guide

Majority of trainees said they would "very likely read the guide before starting a new job. 60% would also refer to it when uncertain about something

4. Rota Guides and Their Effect on Stress

Trainees were asked to rate the effect of rota guides on reducing stress before on-call shifts, on a scale of 1 to 10 (1 = no effect, 10 = greatly reduced stress).

- Average Rating: 7.83
- Median Rating: 9.0
- Minimum Rating: 1
- Maximum Rating: 10
- Standard Deviation: 3.43



Most of responses rated the guides greatly reducing the stress related to on calls. However one respondent indicated they had no impact.

5. Rating of the Quality of induction to the On call:

Respondents were asked to rate their induction to their on call duties out of 10, prior to the rota guides the average rating was 5.6 this rose to 7.3 after the introduction of the guides.

6. The table below highlights that better pre-call information and structured guides contribute to increased confidence and reduced stress among on-call staff.

Area	Pre-Survey (Confidence %)	Post-Survey (Confidence %)	Change
Ward/Site coverage	50% very confident	40% very confident	Slight decrease
Parking	20% very confident	40% very confident	Improvement
Building access	20% very confident	40% very confident	Improvement
Handover process	30% very confident	50% very confident	Improvement
Food access	10% very confident	40% very confident	Significant Improvement
Prayer space	Mostly unconfident	50% very confident	Major improvement
Personal alarms	10% very confident	20% very confident	Slight improvement

Contact information

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Want to make guides for your area?

During this project we developed a template that could be easily filled in by volunteers recruited if you'd be interested in developing guides of your own for your area please follow the QR code below and feel free to use the template we've developed to streamline things.

Baby Loss during training: A personal case study to improve awareness and clinician wellbeing

Baby Loss during training: A personal case study to improve awareness and clinician wellbeing

Dr Bethan Cameron MBChB, MRCPsych

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Aim

To use my personal experience to improve the wellbeing of Resident psychiatry doctors in the workplace who experience baby and pregnancy loss.

Background

1 in 4 pregnancies end in loss (3), pregnancy and baby loss will affect many Resident doctors. I am a Specialty Trainee 6 (ST6) in forensic psychiatry in Scotland. My son Ruairidh was born still in 2023. On returning to work I experienced challenges. In my experience, there was scope for improved awareness about pregnancy and baby loss amongst several organisations associated with the training scheme.

Ruairidh (4)

The challenges included;

- Human Resources (HR) being unaware I was off work following my loss and chasing up pregnancy paperwork
- A challenging Occupational Health appointment which suggested a limited awareness
- A meeting with the Trainee Development and Welfare Service (TDWS) which avoided the subject of baby loss
- Returning to work to an office with pregnancy items displayed
- Struggling to meet new forensic training curriculum requirements (90 sessions in a custodial setting (5)) due to pregnancy related circumstances. Custodial settings often have restrictions about attending during pregnancy. My personal circumstances of recurrent pregnancy and loss make this curriculum requirement challenging.

Methods

I highlighted the issues to my Local Programme Lead (LPL), and Training Programme Director (TPD). They approached the relevant organisations (HR, Occupational health, TDWS, and the Training Committee). I suggested resources for training about baby loss in the workplace offered by charities (5). I approached my Clinical Director (CD) about the workplace environment.

Results

I had a positive response from my LPL, TPD and CD. The need for a clearer method of flagging a loss within HR systems was highlighted to them and an email reply indicated this was being investigated. A further meeting with the TDWS was supportive, and the previous experience was fed back to the service. A "clear desk" policy was promoted, and some personal items from the workplace were removed immediately. The Training Committee took the curriculum issue to the Specialty Training Board and discussions are ongoing. It has been advised that discretion will be utilised regarding personal circumstances when considering the curriculum requirement of 90 sessions in a custodial setting.

Conclusions

Baby and pregnancy loss are devastating. Improved awareness, and simple practical measures can improve the experience of Resident doctors in the workplace. This will help support their wellbeing and ability to work.

Next steps

Continuing to talk openly about my experience of losing my son and returning to training will promote awareness. I will keep myself informed about how improvements are developing. I will continue to volunteer with the charity Held in our Hearts (6). As well as providing support for bereaved parents, they provide parent voices and training for healthcare workers and workplaces.

References

1) Stock image. Microsoft PowerPoint (2025) Candle and Flowers Clip Art.
2) Held in Our Hearts Logo. Utilised with kind permission from CEO Nicola Welsh. Held in Our Hearts (2025). Available at: https://heldinourhearts.org.uk (Accessed 11/03/2025)
3) The Pregnancy Loss Research Network. The University of Bedfordshire. (2025) Available at: https://www.beds.ac.uk/ihr/the-pregnancy-loss-research-network (Accessed 11/03/2025)
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5) Royal College of Psychiatrists (2024) Psychiatry Silver Guide. Available at: https://www.rcpsych.ac.uk/docs/default-source/training/training/silver-guide-version-august-2024.pdf?sfvrsn=6933c4cb_19 (Accessed 11/03/2025)
6) Held in Our Hearts (2025) Held in Our Hearts Education and Training. Available at: https://heldinourhearts.org.uk/education/#training (Accessed 11/03/2025)

Medical Student Balint Group – a tool to improve empathy, transform communication skills and empower tomorrow's socially aware patients' advocates

Medical Student Balint Group – a tool to improve empathy, transform communication skills and empower tomorrow's socially aware patients' advocates

Dr. Justyna Wroblewska[1] Dr. Burak Cardak[2], Dr. Michael Milmore[3]
[1] Core Psychiatry Trainee in Rotherham Doncaster and South Humber NHS Foundation Trust
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AIMS & BACKGROUND

- A Balint Group trial for eleven medical students during their psychiatry placement in Rotherham, UK, explored its impact on empathy, communication, doctor-patient interactions, and socio-political awareness.
- The goal was to enhance agency, consultation skills, advocacy, and well-being in future doctors.
- Developed in the 1950s, Balint Groups help doctors reflect on patient care's psychological aspects, improving empathy, communication, and resilience.
- They reduce burnout, strengthen professional identity, and promote patient-centered care.
- Increasingly integrated into medical education, they also serve as a tool for teaching social justice.

METHODS

Balint Groups were facilitated by two Psychiatry Core Trainees with weekly supervision by a consultant medical psychotherapist. Five sessions were integrated into the students' weekly timetable. The students were sent questionnaires before and after the pilot, asking for views on the role of psychological factors in the doctor-patient interaction as well as Balint Groups. There were seven closed questions in both questionnaires and an extra two open questions in the ending questionnaire.

1) Have you heard of Balint groups before?
2) What are your initial thoughts about participating in a student Balint group?
3) How often do you think psychological factors play any role in a patient's presentation?
4) When I meet a patient whose behaviour is self-destructive, I think that they are wasting healthcare professionals' time and resources.
5) How often do you think psychological factors play any role in a patient's recovery?
6) I feel uncomfortable when talking to patients who are upset or angry.
7) I think a patient's symptoms can have psychological meaning.
8) As a future doctor, it feels wrong to dislike a patient.
9) When a patient is upset or angry, I find it difficult to know what to say.
10) The doctor's reaction to the patient is important to consider as this can influence management / care.
11) Reflecting on a patient's emotional experiences is useful for my development as doctor.
12) I would consider attending a Balint Group as a medical student.
13) I would consider attending a Balint Group as a qualified doctor.
14) Please give your reasons for your answers to questions 13 and 14.
15) What do you feel you have gained participating in a Balint Group?
16) What were the main themes which were discussed?

RESULTS & DISCUSSION

- Three students attended all sessions, while others had inconsistent attendance, with six to ten students per session. Ten students completed the initial questionnaire, and nine completed the final one.
- Over time, students became more open and reflective. Discussions covered therapeutic relationships in the context of **abortion**, **homophobia**, **migration**, **racism**, **menopause**, and **socio-economic prejudice** in healthcare.
- Closed-question responses showed no significant change, likely due to inconsistent attendance, the trial's short duration, and question ambiguity. Students were already highly aware of psychological factors in patient care and doctors' attitudes.
- Facilitators improved their leadership, organization, and psychotherapy skills. Open-question responses highlighted increased empathy, better understanding of psychosocial factors, improved self-reflection, reduced burnout, and stronger peer solidarity.
- Table 1, table 2, and table 3 summarizes the thematic analysis of open-ended questions in the questionnaire.

Themes	Frequency
Development of reflective practice and analytical skills	3
Appreciation for psychological and emotional aspects of care	1
Empathy and new perspectives	1
Coping mechanism and safe space for emotional expression	2
Non-responses	2

Table 1: Answer of the question on the initial questionnaire: "What are your initial thoughts about participating in a student Balint group?"

Themes	Frequency
Development of reflective practice	5
Emotional support and managing burnout	3
Holistic approach to patient care	2
Challenges with group dynamics or participation	1
Non-responses	1

Table 2: Thematic analysis of responses to the question in the ending questionnaire regarding reasons for attending a Balint group either as a medical student or as a qualified doctor in the future

Themes	Frequency
Development of reflective practice and analytical skills	3
Appreciation for psychological and emotional aspects of care	1
Empathy and new perspectives	1
Coping mechanism and safe space for emotional expression	2
Non-responses	2

Table 3: Thematic analysis of the responses to the question in the ending questionnaire: "What do you feel you have gained participating in a Balint Group?"

CONCLUSION

This five-week Balint Group pilot improved **empathy, psychosocial awareness, reflection, burnout reduction, and peer bonds**. It also highlighted Balint Groups as a tool for **enhancing sociopolitical understanding, empowering doctors as advocates, and addressing biases in healthcare**.

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Re-audit of Antipsychotic Monitoring in Inpatient CAMHS

Re-audit of Antipsychotic Monitoring in Inpatient CAMHS

NHS Manchester University NHS Foundation Trust

NHS Greater Manchester Mental Health NHS Foundation Trust

Galaxy House, Royal Manchester Children's Hospital

Dr Clarine Chow, Dr Pavan Sohal, Dr Amy McCulloch, Dr Rachel Elvins

Introduction

- Between 2000 to 2019, the prescription of antipsychotics in CYP (children and young people) has doubled [1].
- There are currently three antipsychotics licensed by NICE (National Institution for Clinical Excellence) for CYP, including Aripiprazole, Clozapine and Risperidone [1]. Other antipsychotics such as Olanzapine and Quetiapine are used off license as well for other conditions [1,2,3,4,5].
- Antipsychotics are licensed for by the MHRA (Medicines and Healthcare Products Regulatory Agency) for conditions such as Bipolar Affective Disorder, psychosis, challenging behaviours in ASD (Autism Spectrum Disorder) and conduct disorders [1].
- Antipsychotics can have side effects on physical health. These include metabolic side effects such as weight gain [6], and hyperlipidaemia [6]. Arrhythmias [7], hyperprolactinaemia [8], extrapyramidal symptoms and disruption of thyroid hormone synthesis are also known side effects [9].
- As CYP taking antipsychotics are at risk of several side effects, it is necessary to monitor for such effects.

Aims and Objectives

Aim

To assess if inpatients on a CAMHS ward (Galaxy House) were receiving appropriate physical health monitoring in line with current guidelines, as well as to see if action plans from the previous audit were applied efficiently. This was the fourth cycle of a re-audit.

Objectives

1. To investigate the compliance of physical health monitoring in CYP in Galaxy House
2. To assess if appropriate discussions surrounding antipsychotics were fulfilled and documented. This includes benefits, risks, timescale for response of the relevant antipsychotic.
3. To ensure antipsychotic medications are reviewed on a weekly basis for each CYP

Changes implemented from previous cycle

1. Antipsychotic proforma used for each inpatient receiving antipsychotics was updated to include medication counselling and consent
2. For standardisation, Blood glucose monitoring was performed in the form of HbA1c instead of fasting glucose or plasma glucose.
3. Lipid monitoring was reduced to baseline, 3 months and then 1 year.

Methods

Data was collected from current inpatients at Galaxy House that were on antipsychotics in the week of 3 April 2024 to 10 April 2024. Records were reviewed retrospectively on two electronic patient records (EPR) named HIVE and PARIS that are used at Galaxy House.

Guidelines

The following guidelines were adapted to form the standards for this audit

- NICE Psychosis and schizophrenia in children and young people: How to use oral antipsychotic medication (CG155) [10]
  - Recommended that ECGs should be considered, which was added as NICE Standard 11 (see below)
- QNIC (Quality Network for Inpatient CAMHS) Royal College for Psychiatrists: Standards for Secure Services: Eleventh Edition [11]

Standards

NICE Standard 1 – Body weight (baseline, weekly for first 6 weeks, 3 months, 6 months, 1 year thereafter)
NICE Standard 2 – Height (baseline, 6 months)
NICE Standard 3 – Pulse and BP (baseline, 12 weeks, 6 months and 6-monthly thereafter)
NICE Standard 4 – Blood lipids (baseline, 12 weeks, 1 year and annually thereafter)
NICE Standard 5 – HbA1c (baseline, 12 weeks, 6-monthly thereafter)
NICE Standard 6 – Blood prolactin (baseline, 12 weeks, 6 months and 6-monthly thereafter)
NICE/QNIC Standard 7 – Serum Urea and Electrolytes (U&E) (baseline, annually thereafter)
NICE/QNIC Standard 8 – Serum Full Blood Count (FBC) (baseline, annually thereafter)
NICE/QNIC Standard 9 – Serum Liver Function Tests (LFT) (baseline, annually thereafter)
NICE/QNIC Standard 10 – Thyroid Function Tests (TFT) (baseline, annually thereafter)
NICE/QNIC Standard 11 – ECG (baseline, annually)
QNIC Standard 12 – Documented discussion of medication risks
QNIC Standard 13 – Documented discussion of medication benefits
QNIC Standard 14 – Documented discussion of timescale for response
QNIC Standard 15 – Documented young person or carer's consent
QNIC Standard 16 – Weekly antipsychotic medication review

Results

Out of 12 inpatients, four CYP were taking antipsychotics for eating disorder, Pervasive Arousal Withdrawal Syndrome (PAWS), and OCD with ASD. See Table 1 below.

YP	Indication	Antipsychotic	Duration on antipsychotics
YP1	OCD with ASD	Olanzapine	8 months
YP2	PAWS and agitation (for sedative effects)	Olanzapine	8 weeks
YP3	Eating disorder	Quetiapine	14 weeks
YP4	Eating disorder	Olanzapine	10 weeks

Table 1 Summary of CYP on antipsychotics

See Table 2 for monitoring compliance of this re-audit in comparison to the previous audit performed in 2023.

Compliance >95% | Compliance 75% - 94% | Compliance ≤ 74%

NICE/QNIC Standards	Time	Re-audit 2023	Re-audit 2024	Change
NICE Standard 1 Body weight	Baseline	100% (3/4)	100% (4/4)	↑
	6 weeks	100% (3/4)	100% (4/4)	↑
	12 weeks	100% (4/4)	100% (4/4)	↔
	6 months	100% (3/3)	100% (4/4)	↔
NICE Standard 2 Height	Baseline	100% (3/4)	100% (3/4)	↔
	6 months	100% (3/3)	100% (1/1)	↔
NICE Standard 3 Pulse and BP	Baseline	100% (4/4)	100% (3/4) *	↔
	12 weeks	75% (3/4)	100% (0/1) *	↑
	6 months	33.3% (1/3)	100% (0/1) *	↑
NICE Standard 4 Blood lipids	Baseline	60% (3/5)	50% (2/4)	↓
	12 weeks	25% (1/4)	100% (1/1)	↑
NICE Standard 5 HbA1c	Baseline	40% (2/5)	75% (3/4)	↑
	4 weeks (Olanzapine/ Clozapine)	25% (1/4)	66% (2/3)	↑
	12 weeks	66.6% (2/3)	100% (2/2)	↑
	6 months	40% (2/5)	100% (1/1)	↑
NICE Standard 6 Prolactin	Baseline	80% (4/5)	75% (3/4)	↓
	12 weeks	100% (4/4)	100% (1/1)	↔
	6 months	66.6% (2/3)	100% (1/1)	↑
NICE/QNIC Standard 7 Serum U&E	Baseline	N/A (new standard)	100% (4/4)	N/A
NICE/QNIC Standard 8 Serum FBC	Baseline	N/A (new standard)	100% (4/4)	N/A
NICE/QNIC Standard 9 Serum LFT	Baseline	N/A (new standard)	100% (4/4)	N/A
NICE/QNIC Standard 10 Serum TFTs	Baseline	N/A (new standard)	100% (4/4)	N/A
NICE Standard 11 ECG	Baseline	N/A (new standard)	75% (3/4)	N/A
QNIC Standard 12 Documented discussion of medication risks	Baseline	100% (4/4)	100% (4/4)	↔
QNIC Standard 13 Documented discussion of medication benefits	Baseline	100% (4/4)	100% (4/4)	↔
QNIC Standard 14 Documented discussion of timescale for response	Baseline	0% (0/4)	25% (1/4)	↑
QNIC Standard 15 Young person's consent recorded (or carer)	Baseline	75% (3/4)	100% (4/4)	↑
QNIC Standard 16 Weekly antipsychotic medication review	Weekly	100% (4/4)	100% (4/4)	↔

*CYP with OCD declined to have BP taken due to sensation of BP cuff. There were recorded attempts to measure BP and hence was coded as compliant

Table 2 Summary of results from the audit.
Please scan QR code below for table with audit results from 4 cycles

Conclusions and Challenges Identified

- Galaxy House has been maintaining safe standards of practice, except for in blood lipids and prolactin where there were poorer compliance in 2024. Ongoing scope for improvement in monitoring ECG, HbA1c, and documenting discussions about timescales for response to antipsychotics.
- Identified a challenge where CYP declined having their BP monitored due to the cuff sensation.
- NICE Guidelines for antipsychotics in CYP were aimed for psychosis and schizophrenia (CG155) [10]. Although none of our CYP were on antipsychotics for those indications, this guideline was referenced as it is the most appropriate guidance available. This meant that our CYP were on smaller doses and for shorter durations, thus at a lower risk of the side effects that require monitoring.

Action Plan

1. Develop a template to document discussions about commencing antipsychotics
2. Add a table outlining current guidance around therapeutic monitoring to the shared drive
3. Actively remind doctors to document clinical rationales for any non-compliance with standards
4. Continue to establish strategies to encourage blood taking and BP monitoring

Please scan QR code for reference list and table with audit results from 4 cycles

Re-Audit Of The Completion Rate Of BPD Admission Checklist For The Hospital Admitted Service Users With BPD

RE-AUDIT OF THE COMPLETION RATE OF BPD ADMISSION CHECKLIST FOR THE HOSPITAL ADMITTED SERVICE USERS WITH BPD

Audit Supervisor: Dr Simon Graham [1] (Consultant Psychiatrist) – Author of the BPD Policy
Audit Leads: Dr Jehan Elturky [1] (ST7 in General Adult Psychiatry and Medical Psychotherapy), Dr Basak Ersavas [1] (CT2), Dr Gizem Yazici [1] (CT2)
Audit Participants: Dr Adetokunbo Dacosta [1] (CT3), Dr Charles Odionye [1] (CT3)
[1] Mersey Care NHS Foundation Trust

NHS Mersey Care NHS Foundation Trust

BACKGROUND

Mersey Care NHS Foundation Trust (MCFT) introduced an admission checklist to guide the decision-making process for admitting patients with Borderline Personality Disorder (BPD), aiming to reduce potential iatrogenic harm. An audit conducted in 2023 revealed that the checklist was not being used. A set of trainings were conducted for Crisis and Home Treatment Services (CRHT) and clinicians involved in Mental Health Act assessments about managing BPD patients at times of crisis and the use of the admission checklist. In addition, the BPD policy was updated to include a new section on assessing capacity in these patients. There are also expert-led consultations and containment meetings being offered for teams that are managing complex PD patients.

AIM

1. Re-audit the use of the BPD Admission Checklist after training.
2. Provide data on the context of admissions.

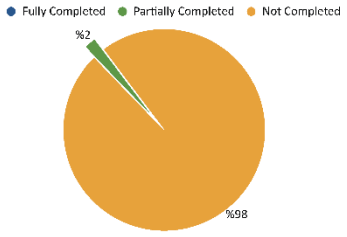
METHOD

Data was collected over a three-month period from admissions of patients with the diagnosis of Borderline Personality Disorder (BPD) to nine acute care wards at Mersey Care NHS Foundation Trust . A total of 52 admissions were identified for 47 patients, with 21 parameters assessed.

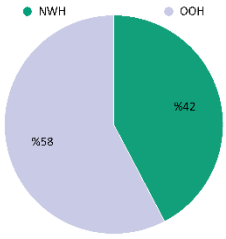
RESULTS

8 out of 9 wards in Mersey Care division of the Mersey Care NHS Foundation Trusts had admissions of patients with Emotionally Unstable Personality Disorder (EUPD) diagnosis during the audit time frame. Three patients had two admissions and one patient had three admissions during the re-audit period. Female proportion was 67.31% (35), male proportion was 32.69% (17). The majority are White British ethnicity (86.54%) while the rest are Black British (3.85%), White – Other (3.85%), Mixed – White & Asian (3.85%), Other Ethnic groups (1.92%). Age ranged 18-64 years old with a mean age of 34. Average duration of the admissions was 35.4 days overall and 13.2 days for patients that are open to PD hub.

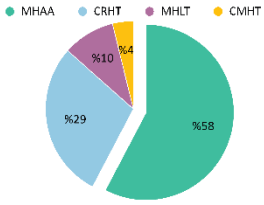
At the point of admission, 4 (7.69%) of the patients were not open to a secondary mental health team in Mersey Care NHS Foundation Trust prior to their referral for Mental Health Act assessments. 30 (57.69%) of the patients were under care of Community Mental Health Teams, 5 (9.62%) were open to the PD hub, 20 (38.46%) were open to CRHT, 15 (28.85%) were open to MHLT, and 5 (9.61%) were open to other services including EIT, Perinatal, Health Public Protection, Integrated Care Team and Step Forward.



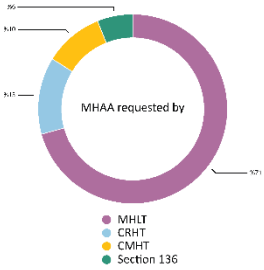
None of 52 recorded admissions had a fully completed BPD checklist. Only one admission had partially completed BPD checklist.

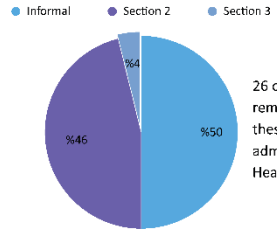


22 of the admission decisions took place during the Normal Working Hours (NWH) while the rest were made out of hours (OOH). There was no significant difference of MHA status between NWH and OOH admissions.

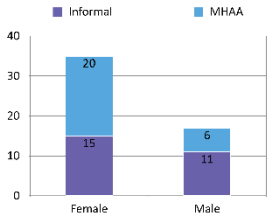


Admission decision was based on MHAA in 30 cases, on CRHT in 15, on MHLT in 5 cases, and on CMHT in 2 cases.





26 of all admissions were informal, while the remaining were under the Mental Health Act. Among these, 24 admissions was under the Section 2 and 2 admissions were under the Section 3 of the Mental Health Act.



Informal admission rate was 42.86% among female patients and 64.71% among male patients.

CONCLUSIONS

Despite training, there was no improvement in the completion of the BPD admission checklist. This could be due to the checklist being perceived as unhelpful bureaucracy. This could also be due to the checklist requiring positive risk decisions rather than admitting, which may cause anxiety for clinicians and practitioners, especially given the higher suicide rate of patients under the CRHT compared to inpatients.[3]

While the primary audit goal was not achieved, it did not measure other training outcomes such as level of inter-team liaison and management of patients in the community versus the hospital.

RECOMMENDATIONS

1. Share the results with CRHT and other teams to explore their views on possible explanations and to take suggestions for the next steps.

2. Discuss results with senior managers with the view of potentially removing the "BPD Admission Checklist", as teams might not be finding the checklist useful.

REFERENCES

1. Borderline Personality Disorder MCFT Policy, 2020 (Incorporating Clinical Guidelines)
LOC_024_BPD_Policy_Incorporating_Guidelines_May_21.pdf (merseycare.nhs.uk)
2. Dr Simon Graham & Dr Ivan Sebalo, "Designing Community Services for People With Borderline Personality Disorder to Reduce Hospitalizations"
3. RCPsych - Self-harm and suicide in adults - Final Report of the Patient Safety Group CR229

ACKNOWLEDGEMENTS

Audit Team and PD Hub - Mersey Care NHS Foundation Trust

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Quality Improvement of FP10 prescription writing in Home Based Treatment Team

Quality Improvement of FP10 prescription writing in Home Based Treatment Team
Dr Holly Melvin F2 Manchester University Foundation Trust, UK
Dr Kate Craddock F2 Manchester University Foundation Trust, UK
Dr Sally Wheeler Consultant Psychiatrist, Greater Manchester Mental Health Trust, UK

Introduction:

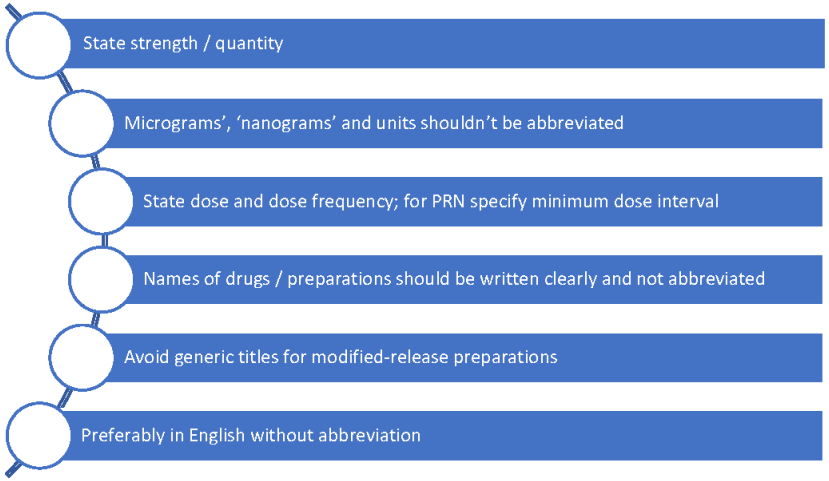
The purpose of this QIP was to improve FP10s written by home based treatment team (HBTT) in line with NICE 'Prescription writing requirements (1). The team had noticed differences in the writing of prescriptions. Inaccurately written FP10s lead to patient / team confusion, dispensation delays, and errors in self-administration / dosing.

Background:

NICE has written guidance on prescription writing for FP10s (1). Medication errors can be a significant cause of patient morbidity and mortality in a psychiatric setting and can have the potential for serious harm (2). Anecdotally, members of the HBTT had noticed differences and issues with FP10 prescriptions written in the service, including discrepancies in doses and patient confusion.

Aims:

- to initially compare 50 HBTT FP10s against NICE recommendations
- to input interventions to improve prescribers' awareness and concordance with NICE recommendations
- to improve FP10s to reflect NICE recommendations



Limitations

- data collector was not always present to collect data, depending on some prescribers' schedules, some may be more over-represented in the data collected than others
- unclear if the different proportions of FP10s collected for data collection reflects the true proportions of FP10s written by different prescribers
- prescriptions can be written and taken straight away so not always time for data collection. Anecdotally often PRN medications, may mean that PRN under-represented in sample.

Method:

50 FP10s were collected from the HBTT FP10 folder between 17/10/24-06/11/24. The inclusion criteria were any HBTT FP10 prescriptions, inpatient prescriptions were excluded. FP10s from all HBTT prescribers were captured. A spreadsheet containing criteria from NICE was used to collect data. (Figure 1)

Interventions to improve prescribing, including for residents covering HBTT during on-calls were inputted in tandem with second data collection.

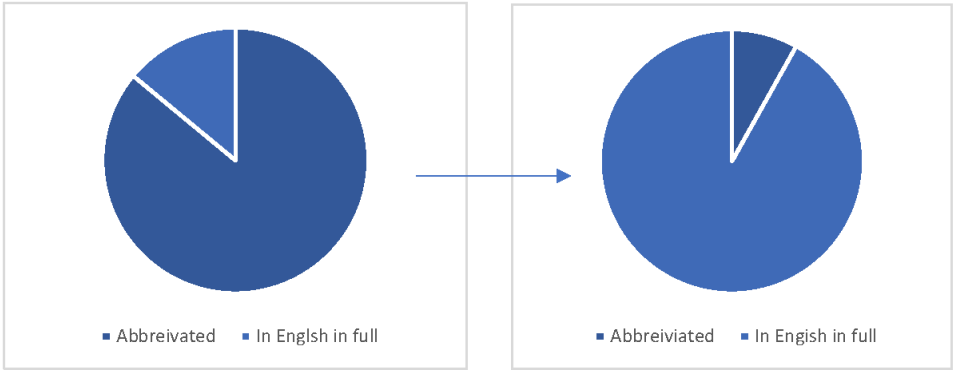
Interventions included presenting at doctors' teaching, during HBTT MDT and through a summary of NICE FP10 guidance for the resident on-call handbook and induction, HBTT FP10 folder and the hospital Microsoft teams page.

Summary of findings:

In all FP10s reviewed, strength / quantity, dose, frequency, and full drugs were always written. Quantities less than 1g were always written in milligrams.
Initially, of the 16 PRN prescriptions, none included a minimal dose interval. Additionally, directions in English without abbreviation were only written in 7/50.

The further 34 FP10s reviewed demonstrated improved prescribing standards. Of 7 PRN prescriptions 6 included a minimum time interval. 31/34 prescriptions were written in English in full.

Some areas e.g., abbreviating 'micrograms' / 'nanograms' / 'units' did not apply to any FP10s reviewed. Discussion with the pharmacist confirmed generic titles for modified release preparations were suitable for those prescribed.



Looking to the future:

This QI demonstrated prescribers aren't always aware of NICE FP10 guidelines and simple interventions can lead to safer prescribing. We would recommend teams using FP10s identify if PRN medications contain minimum time intervals and prescriptions are written fully in English.
Due to the rotational nature of residents, it is possible that prescribing standards may decline after a certain period of time, recollecting data after the next rotation will help to establish if interventions targeting residents are effective in the long term.

References:

1. NICE Medicines Guidance Prescription Writing [online] Available at: https://bnf.nice.org.uk/medicines-guidance/prescription-writing/#requirements
2. Stubbs, J., Haw, C. and Taylor, D. (2006). Prescription errors in psychiatry – a multi-centre study. *Journal of Psychopharmacology*, 20(4), pp.553–561.

Navigating grief during psychiatry training- a personal account

Navigating grief during psychiatry training- a personal account

Dr Nikhita Handa, CT3 Psychiatry, North West

Grief as a daughter and a doctor- my ongoing reflections

During my CT2 year I sadly lost my mum after a short period of illness when I had also had the privilege of being a carer for her. Since experiencing this I have become more aware of how many of our patients suffer traumatic losses of loved ones and how this impacts their mental health.

Grief is always a challenging presentation as we cannot 'fix' the 'cause' and we also have to normalise degrees of sadness and anger around loss and not pathologise it.

Experiencing it myself has hugely helped with that, it has allowed me to feel comfortable sitting with patients in their grief and not looking for solutions or platitudes. Just as I am learning I have to feel comfortable sitting with my own loss and not being able to fix it.

Many aspects of grief can also mirror symptoms of depression and anxiety and living through these aspects has also helped me to see the difference between early grief and illness. Although I have avidly read definitions of grief reactions, **'abnormal grief', 'delayed grief, 'chronic grief', 'prolonged grief disorder', 'anticipatory grief' and many others**, until I lived through grief that deeply affected me and still does, I did not really understand the depths of emotional pain you can feel when grieving and how this is normal when adjusting to a deep loss. Being able to communicate this to well meaning others has also been of great help, as a society and particularly as doctors we are very much keen to make people 'better' and are uncomfortable often with the idea that to some extent sadness with suffering is to be expected.

This is also a challenge I had when speaking to patients who have suffered great losses. After returning to work the first few patients I saw had all suffered from relapses to mental illness following death of a loved one. My desire to help them was very strong but also now coupled with a want to acknowledge their losses and sit with them in their grief, rather than 'fix' it.

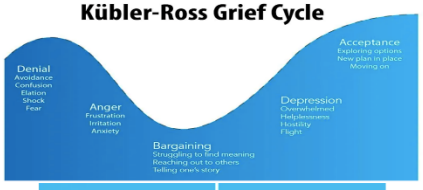
Personally I have found grieving can be very isolating and lonely, largely because I am missing a huge part of my life and identity. For my own wellbeing, starting to cultivate hobbies that I enjoyed with my mum has been a great source of gratitude and helped in my loneliness, although on some days it is too much of a painful reminder of what I am missing.

Another element that helped hugely was using my supervision time to reflect on how patients grief and being around illness was at times triggering my own emotions and talking about this openly helped me. I think one of the great strengths in psychiatry is being able to give people time to be listened to and using supervision for a safe space to express my emotions brought me a lot of comfort.

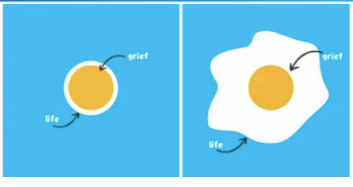
Reflecting on stages of grief models

The Cambridge English dictionary defines grief as 'very great sadness, especially at the death of someone' [1]. As psychiatrists especially we know there are many emotions and reactions associated with grief and documented stages of grieving processes, perhaps best described by Dr Elisabeth Kubler Ross in 'on Death and Dying' as **'denial, anger, bargaining, depression and acceptance'** and later expanded by Bowlby and Parkes to reflect grief more as having '4 phases' but not being a linear process [2]. I knew about the names of these phases but hadn't stopped before to think about what they mean. Although there has been criticism of these models as being unvalidated and reductionist as well as not taking into account other cultural models of the grieving process, for me they at least provided some tools to be able to describe how I was feeling. Much like how a feelings wheel can be useful in psychotherapy I found the names of these stages at least provided a starting block to be able to verbalise my experiences and normalise them as part of a process. I could then start to think about which day to day reminders trigger certain emotions so I can now prepare myself for how I may feel. This is especially helpful working in healthcare as there can be so many triggers to take you back to your own grief and bring back painful feelings.

Kübler-Ross Grief Cycle



[3] Dr Kubler Ross stages of grief model from 'On Death and Dying'



[4] Dr Lois Tonkin 'growing around grief' model also known sometimes as the 'fried egg model' of grief!

I personally have found the Dr Lois Tonkin **'growing around grief'** model very helpful in understanding my grief. As grief is tied to a person I love so dearly the idea of grief shrinking or being something you can move away from is unpalatable. So growing with and around your grief felt more comfortable and linked in with another idea I have taken comfort in which is that grief is a manifestation of love.

Resources that helped my wellbeing and may help others

For me, talking to others who had experienced loss in a similar phase of life helped me the most. I found in person groups helpful (but hard to find!) and then for quieter, more private or darker moments helplines and online resources are my main support.

I personally found supportive networks for grief and bereavement challenging to come across as a younger person with long working hours, I was fortunate that there is the Greater Manchester Bereavement Service that maps out local support but not all regions have this. Different regions have different options and many have suffered cutbacks or have closed. I happened to be working on a unit at the time that had patients from all over the UK so I tried to put together some resources that were nationally available, which in turn helped me too.

1) Lets Talk About Loss (LTAL)- A volunteer run organisation with hubs around many different locations of the UK with a focus on supporting grievers aged 18-35. They try to run monthly group meet ups.

2) Cruse helpline – perhaps one of the more widely advertised bereavement helplines, for one off calls for a safe space to speak 1:1 with trained bereavement volunteers

3) Bereavement Advice Centre - Offers a free helpline for people who are bereaved and for professionals. It also has information on its website about practical matters and coping with grief. **0800 634 9494** bereavementadvice.org

The Royal College of Psychiatrists website also has a page entitled 'Bereavement' with links to useful resources and support.

Some websites for bereavement support charities

•**Sue Ryder –** Their website provides advice and resources on grief and end of life care as well as an online community forum and options for video counselling.
https://www.sueryder.org/

•**Ataloss -** Support services, information, helplines and helpful reads for anyone who has been bereaved, whatever their age, loss or background. Includes a searchable list of local, national and specialist services across the UK. A free, professional counselling web chat is also available.
ataloss.org

•**Beyond Words -** Books, e-books and downloadable resources for people who find it easier to understand pictures than words, including people with learning difficulties. Topics like 'Getting on with cancer', 'When Mum died' and 'When Dad died'.
booksbeyondwords.co.uk

•**Dying Matters -** Find information to help you support those who've been bereaved. Includes a helpful leaflet called *Being there*. Helpline: 020 7520 8200
www.hospiceuk.org

•**Together for short lives -** Provides information and support for children with terminal illnesses and their families.
togetherforshortlives.org.uk

•**Untangle -** Provides personalised information, advice, services and support to navigate life after a death. Has a companion app to help you with everything from connecting with others who have lost, getting therapy, investing inheritance through to administering an estate.
untanglegrief.com

•**WAY (Widowed & Young) -** WAY is the only national charity in the UK for men and women aged 50 or under when their partner died. It's a peer-to-peer support group run by a network of volunteers who have been bereaved at a young age. It runs activities and support groups for people coping with grief. Helpline: 0300 201 0051
widowedandyoung.org.uk

•**Compassionate Friends-** A charitable organisation of bereaved parents, siblings and grandparents dedicated to the support and care of other bereaved parents, siblings, and grandparents who have suffered the death of a child or children.
Helpline: 0345 123 2304
tcf.org.uk

Some books I recommend about grieving

•The Grieving brain by Dr Mary-Frances O'Connor
•You Are Not Alone by Cariad Lloyd
•It's OK that you are not OK by Megan Devine

References
[1] https://dictionary.cambridge.org/dictionary/english/grief
[2] Tyrrell P, Harberger S, Schoo C, et al. Kubler-Ross Stages of Dying and Subsequent Models of Grief. [Updated 2023 Feb 26]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan. Available from: https://www.ncbi.nlm.nih.gov/books/NBK507885/
[3] https://www.healthcentral.com/condition/depression/stages-of-grief
[4] https://www.sueryder.org/grief-support/about-bereavement-and-grief/growing-around-grief/

Improving GP-CMHH Communication

Improving GP-CMHH Communication

G Behr, D Murray, C Chan, H Mohamed, E Aquilina, D Brogan, K Ieong, E Butcher
North Westminster Queen's Park & Paddington Community Mental Health Hub (CMHH)
(Queen's Park and Paddington = QPP)

CNWL IMPROVEMENT ACADEMY

NHS Central and North West London NHS Foundation Trust

Background

Regarding Mental Health in Primary Care: (Royal College of General Practitioners = RCGP)

- *The RCGP recommends that it is important that there is clear understanding of roles, responsibilities, provision, and standards of care within each treatment setting.*
- *The RCGP recommends communication is strengthened with other organisations to improve data sharing.*
- *The RCGP recommends prioritising communication partnerships, particularly electronic, across different organisations and services to enable effective primary care mental health to be delivered.*(1)

QPP CMHH receives referrals from 8 GP surgeries in the North Westminster area. Around 80% of referrals come from Grand Union Surgery (Westhill PCN) and Shirland Road Surgery (Inclusive PCN). QPP CMHH in turn liaises with the surgeries for actioning plans and regularly discharges patients back to primary mental health services. Due to structural and funding changes, roles and responsibilities have not always been reciprocally clear, leading to delayed patient care, duplication of work, and inefficient use of resources. Thanks to the geographical proximity, and consistency of senior staff, informal relations between local GPs and QPP CMHH have historically been cordial and collaborative; this initiative was aimed at formalising and structuring the process to streamline bilateral communication.

(Primary Care Network = PCN)

Aims

- To streamline primary and secondary mental health care, to support GP colleagues with management and to improve the quality of referrals received by CMHH.
- An additional aim was to boost GP satisfaction with CMHH interactions.
- This project was undertaken over a 1 year period.

Methods

- Selection of 2 GP surgeries for pilot project- Grand Union and Shirland Road, selected on the basis of quantity of referral.
- A 7 item questionnaire, consisting of 5 rating scale questions (very satisfied to dissatisfied) and 2 free text questions was disseminated among GPs in both surgeries. Virtual and paper copies used.
- Intervention involved a spreadsheet for GPs to populate with patient details and questions for CMHH doctors and pharmacist. 2 weekly meetings with slots allocated to each surgery to present cases and receive advice directly.
- The same questionnaire was disseminated to Grand Union GP surgery, virtually and physically for assessment of change after 1 year of 2 weekly meetings.

Results

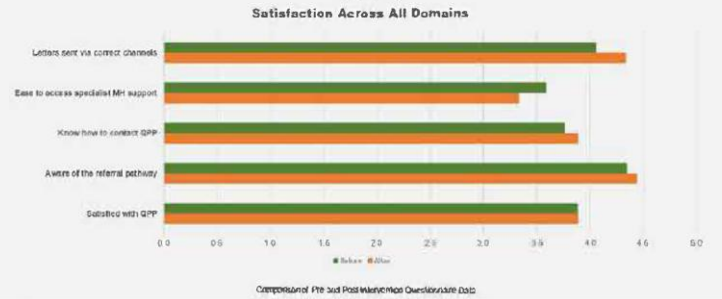
Pre-intervention questionnaires were filled in by 9 Grand Union GPs, 4 Shirland Road GPs, and 1 Elgin Clinic GP. All post-intervention data (9 questionnaires) were collected from Grand Union GPs.

There was overall improvement in the CMHH-GP relationship across all measures except ease of access to specialist mental health support.

There was greatest improvement in communications being sent through the correct channels. This was corroborated by qualitative results, where several GPs commented that QPP is easily and quickly reachable. Additionally, GPs appreciated the broad scope and detail-oriented approach taken during meetings.

When asked how things could further be improved, GP colleagues suggested a bypass telephone number to expedite access to QPP professionals, better support for duty GPs dealing with mental health crises, and integrating the discussion referral process into *SystmOne* which both GP surgeries and QPP use.

Project Driver Diagram



Comparison of Pre and Post-Intervention Questionnaire Data

Word Cloud displaying answers to 'What Works? Free Text Question in Post-Intervention Questionnaire

Word Cloud displaying answers to 'What Could be Better? Free Text Question in Post-Intervention Questionnaire

Conclusions and next steps

- 2 weekly CMHH-GP meetings are an effective way of improving the primary care and mental health service relationship as more GPs are aware of pathways and feel confident reaching out.
- As a result of this project, QPP staff members have become more aware of the constraints within which GP colleagues work. In turn, GPs have become more aware of what are realistic secondary care referrals, discharge rationales, and holistic management plans for complex patients.
- Limitations to the project included difficulty engaging with Shirland Road Surgery. An attempt to re-engage Shirland Road Surgery was made in October 2024 through email correspondence. Disengagement was put down to staff turn over, despite ongoing interest from senior staff.
- A limitation to the long term sustainability of the project is that it depends heavily on the input and commitment of permanent, often senior, staff members on either end, who need to ensure onboarding of rotating, temporary or locum staff.
- Moving forward, QPP CMHH will attempt to expand this pilot to include all 8 GP surgeries by formally inviting GPs and explaining the potential benefits of such a service. This will require the creation of further timeslots, as well as careful scheduling.

References

1. Royal College of General Practitioners, *Mental Health in Primary Care* Policy Statement, 2017

Re-Audit against DVLA guidance for new psychiatric pa9ent referrals at the Early Interven9on for Psychosis team (EIT) at St.John's Unit, Widnes

Re-Audit against DVLA guidance for new psychiatric patient referrals at the Early Intervention for Psychosis team (EIT) at St.John's Unit, Widnes

Isabel White (FY1), Deborah Kawaja (CT3), Nismen Lathif (Consultant psychiatrist EIT)

Introduction/Background:
Severe mental illness including psychotic disorder can have a significant impact on functioning and can increase risk to self and others whilst driving. As outlined in the GMC's professional standards, it is good practice to assess whether a patient is fit to drive or whether their safety is affected by a medical condition or treatment. It is clearly outlined by the GMC that medical professionals have a duty to inform patients how their driving may be impacted and remind them of the need to inform the DVLA. There is clear guidance outlined by the DVLA in the Assessing fitness to drive guidance for patients with a psychotic disorder, including in an acute episode. This also includes guidance on if the patient's condition is also associated with substance misuse.

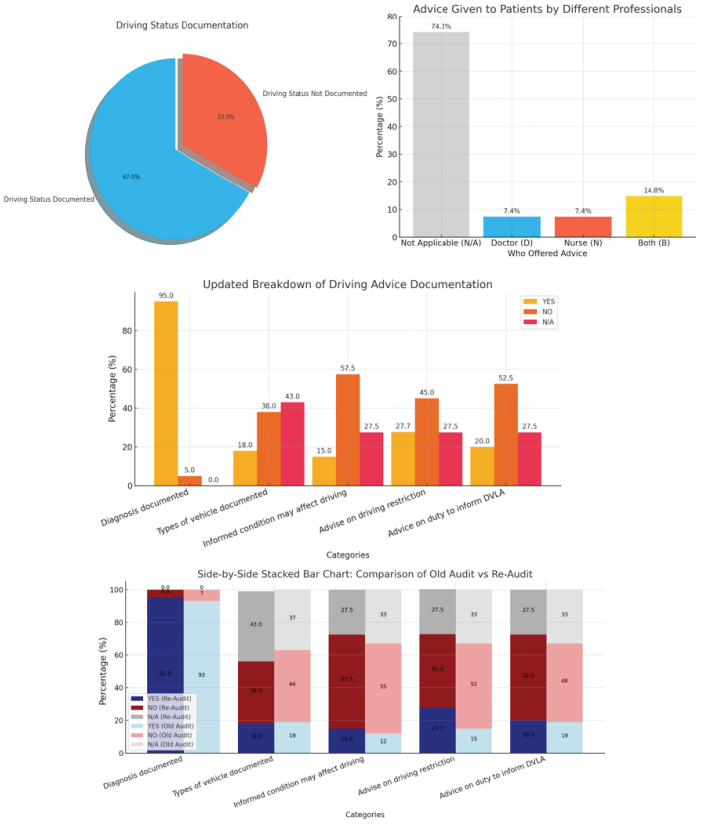
A previous audit identified gaps in compliance; this re-audit assesses improvements and ongoing challenges.

Aims:
- A re-audit to assess adherence following the initial audit and close the audit loop.
- To assess whether newly referred patients with psychosis are advised on DVLA reporting requirements.
- To evaluate documentation practices of DVLA guidance in patient records.
- To compare findings with the previous audit and recommend quality improvement strategies.

Objectives:
The audit will assess whether there was documented evidence of:
- Patients' driving status
- Type of vehicle driven
- Patient's diagnosis
- Being informed the condition may affect their driving
- Advice regarding driving restrictions (if applicable)
- Advice on duty to inform the DVLA (if applicable)

The audit will also assess:
- Who documented the driving status of the patient and advice given

Results



Methodology:
Study Design: Retrospective case-note review.
Sample: Patients newly referred to the Early Intervention for Psychosis (EIP) service, Widnes, over a 6-month period- August 2024 to February 2025
Sample size: 27
Inclusion Criteria: Patients with first-episode psychosis or other psychotic disorders over the age of 17 years

Discussion:
- Improvements since previous audit: no significant improvement noted since last audit. No documented evidence of leaflet offered to patients which was a recommendation in previous audit.
- Areas still needing improvement: lack of standardised documentation template.
- Possible reasons for non-compliance: time constraints, lack of awareness by rotating trainee clinicians, no structured checklist/timeline.

Recommendations and action plan:
- Introduce an electronic documentation template.
- Provide targeted clinician training on DVLA guidance.
- Create and print colourful, easy to read leaflets for consulting rooms.
- Re-audit in 6–12 months to assess progress.

References:
DVLA Assessing Fitness to Drive – A Guide for Medical Professionals (Latest Edition).
GMC Guidance on Confidentiality and Public Safety (2021).

Improving communication with patients in a secure hospital

Improving communication with patients in a secure hospital

Georgie Tucker (Patient engagement lead & Project lead), Maya Soni (Speech and language therapist), Rudo Mari (Associate specialist & QI mentor), Jonathon Adams (Consultant Forensic Psychiatrist & QI sponsor)
Elysium Healthcare, Wellesley Hospital, TA21 9AD

Aim

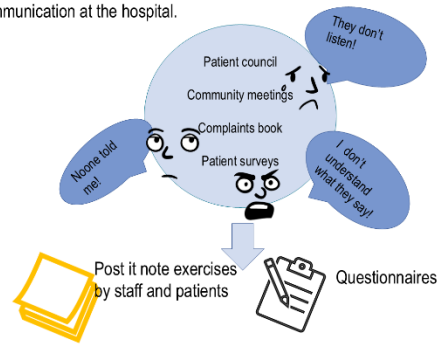
To improve the overall level of communication between staff and patients in a secure hospital through the implementation of a Quality Improvement (QI) Project

Introduction

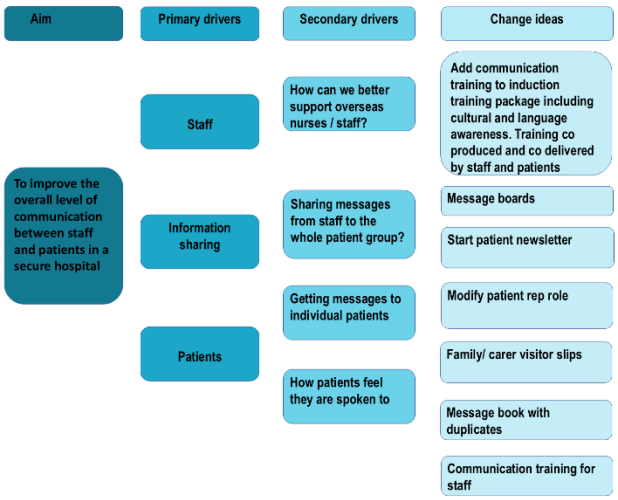
Wellesley Hospital (Elysium Healthcare) is a 100-bed medium and low secure hospital in Wellington, Somerset. All beds are commissioned by the South-West Provider Collaborative.

There were increasing complaints from patients about how staff were not communicating effectively with them. This included getting messages to individuals and to the whole patient group. They also reported facing difficulties when engaging with staff with foreign accents.

Frustrations within the patient group often lead to serious incidents. Therefore, it was necessary for the staff to work together with the patients to develop ways of improving communication at the hospital.



Driver diagram



Measures

Process measures

- Number of messages passed on from the message book

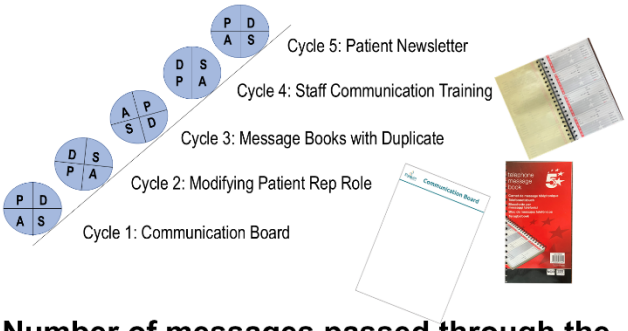
Outcome measures

- Patient feedback through communication survey

Balancing measures

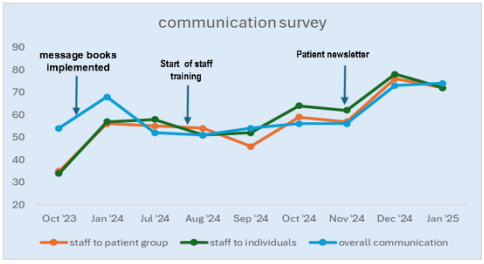
- Number of hate crime incidents recorded on the incident reporting system IRIS
- Number of formal complaints submitted

PDSA cycles

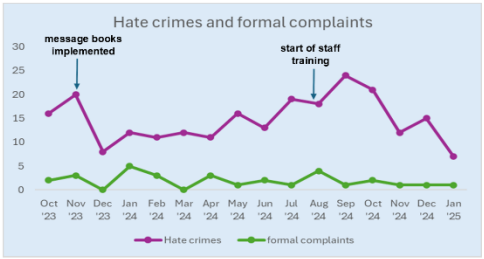


Number of messages passed through the message books

Communication survey results



Hate crimes and formal complaints per month



Conclusion

The project demonstrated how patient involvement is crucial in successful implementation of QI projects.

The communication training made the greatest impact; there was more buy in by both staff and patients, and there was an increased uptake of the other change ideas afterwards. The communication rating has steadily increased since the training.

The change ideas have been incorporated into daily practice and the measures continue to be monitored.

Reducing waiting times from initial appointment to diagnosis in the Lambeth CAMHS ADHD pathway: A Quality Improvement Project

Reducing waiting times from initial appointment to diagnosis in the Lambeth CAMHS ADHD pathway: A Quality Improvement Project

S.Mehta[1],P. Sen[1], Z. Naim[1],E.Tatir[2]

[1]King's College London, United Kingdom [2]South London and Maudsley NHS Foundation Trust, United Kingdom

BACKGROUND

Attention Deficit Hyperactivity Disorder (ADHD) is a neurodevelopmental condition affecting daily functioning, academic performance, and well-being. Early diagnosis is crucial for timely intervention, yet long waiting times in the UK remain a challenge, impacting patient care[1]. This Quality Improvement Project (QIP) aimed to reduce the time from initial appointment to diagnosis by identifying bottlenecks and implementing targeted interventions.

AIMS & PDSA CYCLES

Cycle 1 aimed to reduce the time from initial appointment to diagnosis to a maximum of 60 days by October 2024 through collection of Conners questionnaires before the initial appointment. Cycle 2 aimed to further reduce times to 30 days by March 2025 by additionally collecting School Report Forms before the initial appointment.

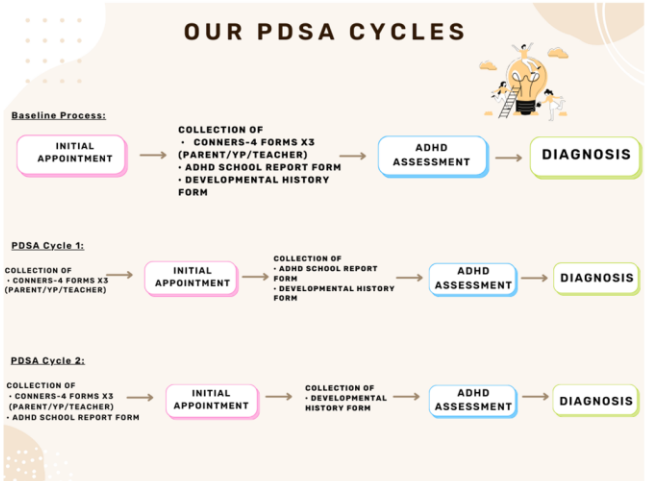


Figure 1: A schematic representation our PDSA cycles

METHODS

Patients aged ≤18 awaiting ADHD assessment under the 'Lambeth CAMHS Purple Waiting List' were identified using the EPJS clinical database. The primary outcome measured median time from initial appointment to diagnosis (days) and the secondary outcome assessed user experience of the process through qualitative data collection using questionnaires from parents, teachers and clinicians eliciting stakeholder engagement.

RESULTS

The median wait time decreased from 71 days (interquartile range (IQR) = 60) at baseline to 38 days (IQR = 37.5) in Cycle 1 (46.5% reduction). In Cycle 2, the median dropped to 14 days (IQR = 10), a 63.2% decrease from Cycle 1. Overall, from the baseline process to the completion of PDSA cycle 2, we achieved a 80.3% reduction in waiting time. Clinician and parent feedback generally improved over the cycles, with greater satisfaction reported.

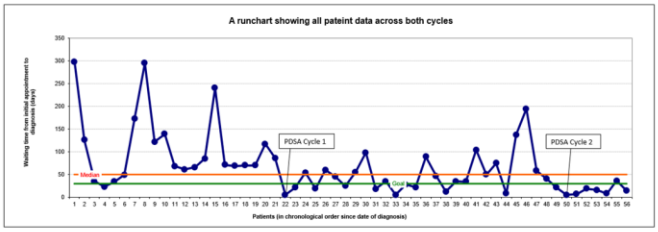


Figure 2: A runchart showing all patient data across both cycles

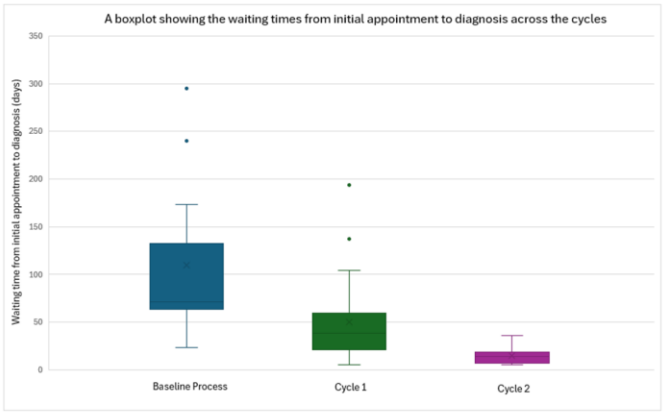


Figure 3: A boxplot showing the waiting times from initial appointment to diagnosis across the cycles

CONCLUSIONS & NEXT STEPS

This QIP successfully reduced time from initial appointment to diagnosis, but further refinements are needed to sustain improvements and address remaining delays including more ADHD training for those undertaking the consultations. A future 3rd PDSA cycle could involve additionally collecting the neurodevelopmental history forms prior to the initial assessment. This would ensure all 5 forms are collected before the first appointment, giving the clinician a more holistic view of the patient.

References: (1) ADHD Diagnosis and NHS Waiting Times - Think ADHD [Internet]. Think ADHD. 2023. Available from: https://thinkadhd.co.uk/for-patients/adhd-diagnosis-and-nhs-waiting-times/#:~:text=Implications%20of%20Long%20Waiting%20Times&text=Delayed%20diagnosis%20can%20result%20in,on%20an%20individual's%20mental%20health.

Audit of Section 117 Aftercare Meetings in Crocus Ward: A Retrospective Analysis of 2023 Admissions Under Section 3 – Basis for a Pilot Project

NHS South West London and St George's Mental Health NHS Trust

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

Audit of Section 117 Aftercare Meetings in Crocus Ward: A Retrospective Analysis of 2023 Admissions Under Section 3 – Basis for a Pilot Project

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BACKGROUND

Section 117 of the Mental Health Act mandates provision of aftercare services for patients discharged following detention under Section 3. This audit examined the implementation, consistency, and effectiveness of Section 117 aftercare meetings in Crocus Ward (Older Adult Inpatient Unit) during 2023.

METHODOLOGY

A retrospective analysis was conducted reviewing records of all patients admitted to Crocus Ward under Section 3 during 2023 (n=34).

Data was collected via a structured questionnaire examining meeting occurrence, attendance, timing, documentation, and discharge outcomes.

RESULTS

- **Only 14 of 34 patients (41.2%)** had documented Section 117 aftercare meetings, indicating significant gaps in compliance with statutory requirements.
- Meeting attendance varied significantly – with family/nearest relatives having the highest attendance rate (78.6%), followed by ward consultants/responsible clinicians and specialty registrars (both 71.4%), occupational therapists and social workers (both 64.3%), while patients themselves attended only 35.7% of meetings, and CMHT representatives were present at just 21.4% of meetings despite their critical role in post-discharge care (Figure 1).
- Meeting timing varied considerably, with the average time between meeting and discharge being 7.5 days (range: 0-94 days), suggesting potential inefficiencies in discharge planning.
- Post-discharge follow-up was largely completed (92.9% of cases), predominantly by Community Mental Health Teams, with only one documented readmission (7.1%).

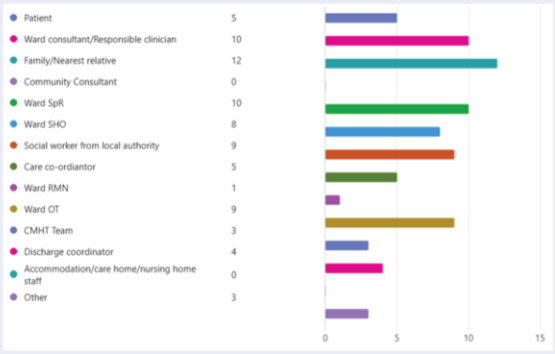
CONCLUSION

This audit identifies significant inconsistencies in the implementation, documentation, and structure of Section 117 aftercare meetings in Crocus Ward. The variable approach to these statutorily required meetings potentially impacts discharge efficiency, continuity of care, and patient outcomes. The low rate of documented meetings (41.2%) represents a particular concern regarding compliance with legal obligations and effective care planning.

OBJECTIVE

To evaluate the implementation, compliance, and effectiveness of Section 117 aftercare meetings for patients admitted under Section 3 of the Mental Health Act to Crocus Ward during 2023, identifying key areas for standardisation to improve discharge planning and aftercare provision.

Figure 1: Meeting attendance



RECOMMENDATIONS

Based on these findings, the authors have started a 6-month Pilot Project to standardise Section 117 aftercare meetings through:

- Development and implementation of a standardised meeting template and documentation framework to ensure consistency and completeness.
- Creation of clear protocols regarding meeting timing (optimally 2-3 weeks pre-discharge), required attendees, and roles/responsibilities.
- Provision of targeted staff training on Section 117 requirements and the standardized meeting format.
- Establishment of a monitoring framework to assess the impact of standardization on key metrics including meeting occurrence rates, attendance, timing relative to discharge, plan comprehensiveness, and post-discharge outcomes.
- This standardised approach aims to improve compliance with statutory obligations while enhancing the effectiveness and efficiency of discharge planning for patients detained under Section 3 of the Mental Health Act.

REFERENCES

Mental Heath Act 1983 Code of Practice - https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983

Inpatient discharge summaries audit: adherence to the Norfolk and Suffolk Trust guidelines and Mental Health Discharge Summary standards

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Norfolk and Suffolk mental health Trust

NHS Norfolk and Suffolk NHS Foundation Trust

INTRODUCTION

Discharge summaries have a critical role in patient care. They provide GPs with the relevant information required to ensure the continuation of quality patient care. Discharge summaries not only inform GPs about the patient's journey while in inpatient care. They also advise about immediate action in the community, medications that may need continuation or stopping, and future follow-up arrangements.

AIM

This audit aimed to evaluate the completeness and quality of inpatient discharge summaries relative to the discharge summary template provided by Lorenzo and the mental health discharge summaries standard. We wanted to investigate whether discharge summaries are submitted within the required timeframe and include all sections as per the template.

METHODS

This was a retrospective audit. We reviewed discharge letters completed from 01/08/2024 until 01/09/2024 within Lorenzo database. Sampling inclusion criteria were any patient discharged between 01/08/2024 and 01/09/2024. Exclusion criteria were patients discharged outside the chosen timeframe. We audited only wards located at the Norfolk and Suffolk Trust. We selected 30 patients. The selection was made by selecting patients from different NSFT wards.

CONCLUSIONS

Discharge letters are completed by resident doctors, and they can range from foundation year 1 to specialty registrar in psychiatry. This can impact the completion of discharge letters. Other factors include unclear documentation within inpatient notes, inconclusive MDT meetings, patient transfers between trusts, and time pressures. However, introducing quality-improving standards such as training on discharge letter writing for newly rotated resident doctors, administrative staff allocated for proofreading discharge letters, and regular audits within the team may boost compliance rates.

RESULTS

Audit Standard	Target %	Exception	Compliancy
Changes to medications recorded	100%	None	60%
ICD10 code	100%	None	67%
Discharge summary sent within 7 days	100%	None	47%
Medication discharge summary sent within 24 hours	100%	None	57%
Laboratory results (bloods/ECG)	100%	None	50%
Management plan including medications	100%	None	60%
Psychiatric hx	100%	None	73%
Date of admission and MHA status	100%	None	59%
Risk assessment	100%	None	60%
Alcohol and smoking status	100%	None	60%
Forensic hx	100%	None	40%
Physical health status	100%	None	60%
Discharge from Inpatient Care (C70a) Trust Policy			

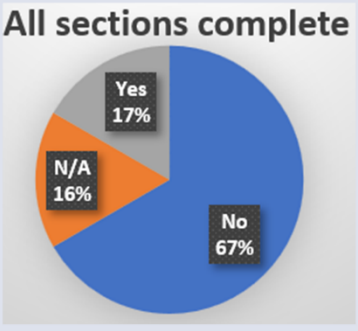

Figure 1. Only 17% of discharge summaries had all required sections complete and sent within the designated timeline. Not applicable was marked for discharge summaries which were not sent at all.

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Advice and Guidance: Shaping the future of delivering mental health care in the community, using asynchronous communication

Advice and Guidance

Shaping the future of delivering mental health care in the community, using asynchronous communication.

NHS
Avon and Wiltshire
Mental Health Partnership
NHS Trust

Authors: V. Nzouonta Ngwompo (1), P. Maddock (2), R. Harris (3)
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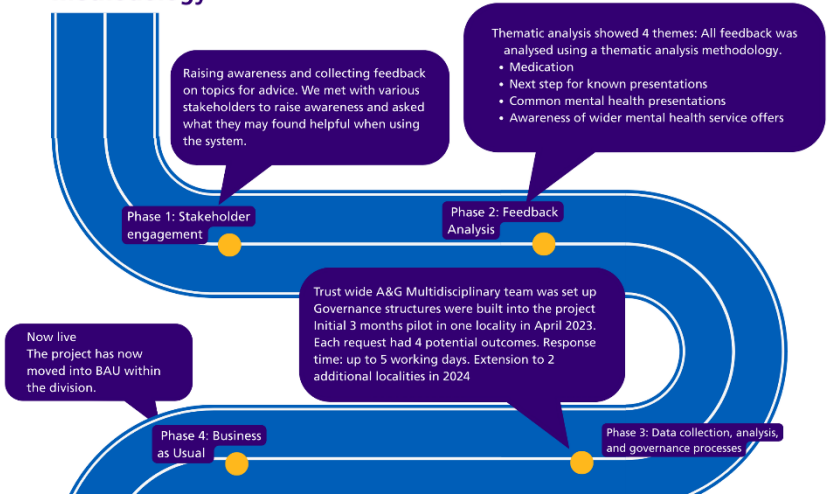
Background

We all face significant challenges in responding to the needs of our patients at a time when there are huge pressures on NHS resources overall.
Advice and Guidance (A&G) is a non face-to-face clinical activity that allows prompt, timely access to specialist medical advice, for non-urgent requests which are not a referral to mental health services, but could lead to a referral recommendation, using a digital platform.
Over 70-80% of referrals into Access Mental Health Services would not result in referral to secondary mental health services. The scale of work generated by this process is often disproportionate to the request being made and the outcome received, hence creating a heavy bureaucratic burden for Avon and Wiltshire Partnership Mental Health Trust (AWP) staff and frustration for GP's and patients alike. There is no established approved synchronous communication system between Psychiatrists and GPs, hence enhancing the risk of poor outcome in mental health care in the community.
Many services have developed their own internal system of providing A&G, creating governance issues and service offer inconsistencies.
The Bath, Swindon, and Wiltshire (BSW) Integrated Care System (ICS) division is committed to lessen health inequalities within the division and has been working collaboratively with local health care providers to meet that goal. For mental health trusts like AWP, this means designing new ways of working with primary care services in order to improve access and health outcomes . Therefore, implementing digital strategy has been seen as a key enabler for this system transformation. This is in line with the NHS Long term Transformation Plan , which aims to prevent up to one third of outpatient appointments within secondary care services over the next five years. The asynchronous communication, using an electronic-opinion system was chosen as the delivery tool.

Aims

- To strengthen share decision making between psychiatrists and general practitioners (GPs) while avoiding needless outpatient activities
- To promote a seamless partnership between GPs and psychiatrists that will improve efficiency and effectiveness for early interventions and better patient health outcomes
- To improve patient journey whilst responding to operational pressures

Methodology



Results

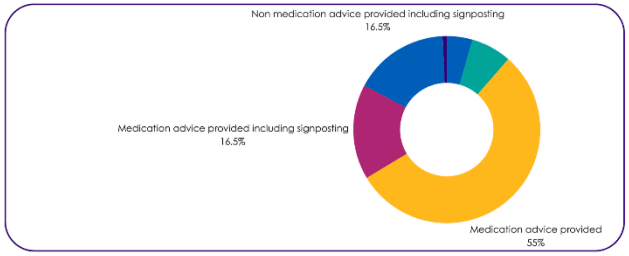
Just under **72%** all A&G requests across BSW had an outcome of medication advice (either with or without sign posting) this is likely resulting in these patients getting fast responses in the initiation of appropriate intervention

80% GP's "Very Likley or likely" to recommend the service to a colleague

Staff Feedback!
"Majority feels it works well and we have noticed fewer medication requests coming through as referrals route"

Average response time was **1.7** days

Only **6%** of responses were above 5 working days.



Conclusion

This clinical model has enhanced communication between GPs and psychiatrists. It has helped improved patients' journeys whilst transcending geographical barriers. It promotes continuous professional development for GPs and raise awareness on early detection and management of common mental illness. However, there is risk of increase workload burden in General Practices. Further studies are needed to demonstrate the robustness of this model in psychiatry

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Good Old Sertraline: Doubling Up as a Smoking Cessation Agent?

Good old Sertraline: Doubling Up as a Smoking Cessation Agent?

Authors
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Introduction

An 81-year-old woman who presented to the old age psychiatric clinic with a 3-year history of progressive cognitive decline.
She has a background history of hypertension, diabetes mellitus, and a 40-year history of smoking 40 cigarettes daily.
Additionally, she reported low mood and reduced energy for which she was prescribed Sertraline 50milligram.
Within one week of initiating Sertraline, she ceased smoking entirely-a development that utterly shocked her family.

Objective

This case report explores the potential of Sertraline, a selective serotonin reuptake inhibitor (SSRI), to support smoking cessation, particularly in individuals with coexisting mood disorders.

Methodology

A literature review was conducted to investigate antidepressants' efficacy in smoking cessation. The pharmacological basis of antidepressants suggests they alleviate nicotine withdrawal-induced low mood, target neural pathways implicated in nicotine addiction (e.g. inhibiting monoamine oxidase) or receptors (e.g. blockade of nicotinic-cholinergic receptors), and potentially substitute nicotine's antidepressant effects (Sutherland et al., 2013). While bupropion (Anisa Hajizadeh et al., 2023) and nortriptyline have shown efficacy in smoking cessation (Hughes et al., 2014). SSRIs like Sertraline have demonstrated mixed results (Covey et al., 2002).

Conclusion

Sertraline's unexpected effect on smoking cessation in this patient adds to the body of evidence supporting the neurobiological interplay between depression and nicotine addiction (Shoiab & Buhidma, 2018). As tobacco use remains the leading preventable cause of morbidity and mortality, Sertraline's dual role in treating depression and supporting cessation warrants further exploration to improve treatment options (Taylor et al., 2017).

Awareness of Voting rights among psychiatric inpatients - Patients should affect policies

Awareness Of Voting Rights Among Psychiatry Inpatients - Patients Should Affect Policies.

Authors Dr Rakesh Puli, Dr Dawood Razzak, Dr Olaide Oladosu, Dr Nicolas Upton, Dr Katie Fergus

BACKGROUND

All mental health inpatients have the legal right to vote, regardless of whether they are voluntarily admitted or detained under the Mental Health Act 1983 (with the exception of those under forensic sections). However, many patients may face practical barriers to exercising this democratic right. When mental health services fail to facilitate voting access, they unintentionally contribute to the stigma already faced by people with mental health conditions. Ensuring awareness, accessibility, and agency in the voting process is crucial for upholding their democratic rights.

Figure 1: 6 in 10 inpatients were aware of the requirement for photo identification in order to register to vote

AIMS

Our study aimed to:

- Evaluate patients' awareness of their voting rights for the 2024 general elections.
- Determine what proportion of inpatients are registered to vote
- Explore any misinformation patients have been given in the past with regards to their voting rights.
- Assess patients' interest in advocating for mental health policy changes based on their lived experiences of mental health services

METHODOLOGY

This study surveyed **67** functional psychiatric inpatients (both informal and detained under section) from adult psychiatry inpatient wards at Hafan y Coed (HYC) Hospital, Llanfair Unit, the Mental Health Services for Older People (MHSOP) ward at the University Hospital Llandough (UHL), and community inpatient rehabilitation wards.

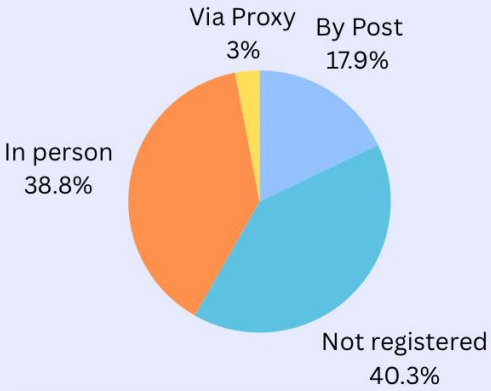
Data were collected from 25th June 2024 to 4th July 2024 via structured questionnaires completed by consenting patients. Participation was voluntary.

RESULTS

From our survey, these were the most telling statistics we found:

- **76%** of respondents were aware of the upcoming general election
- Yet only **64%** knew they had the right to vote
- **55%** intended to vote in the election (figure 2)
- With **14%** reported being incorrectly told they were ineligible to vote
- **60%** knew about the photo ID requirement for voting (figure 1)
- **53%** possessed a valid photo ID
- Only **50%** expressed interest in advocating for future mental health policy changes at a local level

Figure 2. Breakdown of methods by which patients intended to vote



CONCLUSION

More education is needed to ensure psychiatric inpatients fully understand their voting rights. **Voter registration remains a major barrier**, with additional support required, particularly for obtaining valid photo identification. **Voting access should be streamlined** to allow inpatients to vote via the most suitable method, whether in person, by post, or by proxy. **Patients demonstrate a clear interest in policy advocacy**, and this should be encouraged through structured opportunities for engagement.

NEXT STEPS

1. ***Develop educational materials*** specifically for inpatients about their voting rights
2. ***Create a streamlined process*** to help inpatients obtain necessary photo ID
3. ***Establish clear protocols*** for arranging appropriate voting methods (in-person, postal, or proxy voting) based on individual patient needs
4. ***Train staff*** to better support patients' democratic participation
5. ***Partner with electoral services*** to improve accessibility for mental health inpatients

Quality Improvement Project (QIP): Improving the well-being of resident doctors in forensic services in West London

IMPROVING THE WELL-BEING OF RESIDENT DOCTORS IN FORENSIC SERVICES IN WEST LONDON

DR. AMANDA BRICKSTOCK CT3 | DR. RACHEL ROZEWICZ CT2
WEST LONDON NHS TRUST

WHY THIS PROJECT?

Poor well-being of doctors is recognised to have an impact on mental health, quality of patient care and retention. In St. Bernard's Forensic Unit (West London), there were reports of trainees finding systemic factors stressful and this having an impact on their training.

AIMS

To identify factors contributing to poor well-being of resident doctors in St. Bernard's Forensic Unit, and aim to improve these areas where possible.

figure 1: driver diagram

METHODOLOGY

A plan, do, study, act framework was used to complete 3 cycles.

Cycle 1:
A google survey was made to identify current challenges faced by trainees, which was sent to all resident doctors (n=14).
Results were analysed and the following interventions were implemented:
a. Laptops provided to all doctors
b. Ward doctors in three bridges were informed about rooms they can use to work in
c. A Christmas well-being social was arranged

Cycle 2:
Focus group discussions were held and feedback was collated.
Results were analysed and the following interventions were implemented:
a. Findings were presented to the forensic Medical Advisory Committee (MAC).
b. Findings were discussed with the RCPYsch Well-being Committee, Dr Claire Dillon (Chief Medical Officer) and Darzi fellow working on well-being within the trust.
c. End of placement wellbeing social was organised.

Cycle 3:
The google survey was adapted and re-circulated.
Results were analysed.
a. The project was handed over to the new CT representative to focus on cover.

RESULTS

Cycle 1 (n=10)

Theme 1: '*workload, burnout and supervision*'
*20% reported feeling burnout
*30% reported having to stay beyond working hours
*40% reported issues getting annual leave
*30% reported issues getting study leave
*70% struggled to arrange cover for leave
·*30% either 'agreed' or 'strongly agreed that they felt 'guilty' for taking leave

Theme 2: '*environment*'
*40% '*strongly disagreed*' or 'disagreed' with having 'appropriate space to work'.
*60% '*strongly disagreed*' or '*disagreed*' that there were 'enough computers/laptops available to do work.
*20% 'agreed' that they had 'been subjected to bullying or harassment at work'.

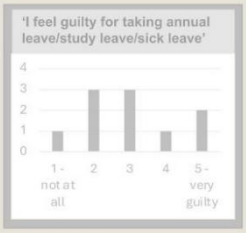


figure 2: cycle 1 results related to guilt for taking leave

Cycle 2 (n=5)

Cover system required for arranging annual leave:
'*It's very difficult to organise annual leave cover*'... '*It feels like an additional layer of stress and barrier to resident doctor's wellbeing.*'
'I have not used all of my study leave or annual leave yet because I feel guilty and unable to,'
'Leave can (and is) routinely declined for not following the arbitrary rules set by senior staff.'

Environment/atmosphere:
'I have noted an atmosphere towards more junior medical staff by senior doctors which is often condescending and dismissive. In particular some members of staff were unwilling to consider ways that things could be improved in terms of the way the rota works, and leave is approved.'

Cycle 3 (n=8)

Theme 1: workload, burnout and supervision
*29% reported feeling burnout
*43% reported having to stay beyond working hours
*29% reported issues getting annual leave
*29% reported issues getting study leave
*29%% either '*agreed*' or '*strongly agreed*' that they felt 'guilty' for taking leave

Theme 2: environment
*14% '*strongly disagreed*' or '*disagreed*' with having *appropriate space to work'.
·100% '*agreed*' or '*strongly agreed*' that there were *enough computers/laptops available to do work.
*29% '*agreed*' that they had 'been subjected to bullying or harassment at work'.

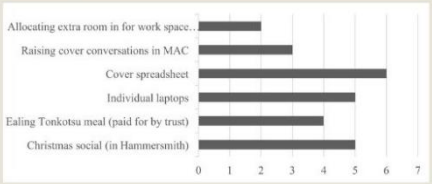


figure 3: trainees response to what well-being interventions helped

Phelan Mcdermid Syndrome: A Case Study And Literature Review In Children And Adolescent Mental Health Services

NHS South London and Maudsley NHS Foundation Trust

NHS East London NHS Foundation Trust

PHELAN MCDERMID SYNDROME: A CASE STUDY AND LITERATURE REVIEW IN CHILDREN AND ADOLESCENT MENTAL HEALTH SERVICES

DR LILIANA SANCHEZ ZELAYA (SAS, CIPPRD, SOUTH LONDON AND MAUDSLEY NHS TRUST),
DR UCHE OKONKWO (CT3 PSYCHIATRY, EAST LONDON FOUNDATION TRUST).
DR NORMA ESTRADA (ST4 FORENSIC PSYCHIATRY, EAST LONDON FOUNDATION TRUST)

AIMS

To illustrate diagnostic challenges, intervention strategies, and the importance of multidisciplinary care in improving outcomes for affected individuals.
To highlight the psychiatric and neurodevelopmental complexities of PMS in a Child and Adolescent Mental Health Service (CAMHS) setting.

BACKGROUND

Phelan-McDermid Syndrome (PMS) is a rare genetic disorder caused by a deletion or mutation of the SHANK3 gene on chromosome 22q13.3.(1,2) The SHANK3 gene is crucial for glutamatergic synapse function and plays a key role in neuronal communication (3). While the prevalence of PMS remains unclear, there have been at least 1200 cases reported worldwide and it is increasingly recognised as a significant contributor to autism spectrum disorder (ASD) and intellectual disability, accounting for up to 2% of cases (3,4). PMS presents with a complex neurodevelopmental profile that includes intellectual disability, speech and language impairment, hypotonia, and autistic-like behaviours (5). Due to its wide-ranging presentation, PMS poses significant diagnostic challenges, often resulting in misdiagnosis and inappropriate treatment (2,5,6).

METHODS

A literature review was held via Pubmed and Google Scholar, including the following MESH terms:

Primary Terms: Phelan-McDermid Syndrome AND Child Psychiatry, Neurodevelopmental Disorders.
Secondary Terms: Literature Review, Autism Spectrum Disorder,
Behavioral Symptoms, Psychiatric Treatment.

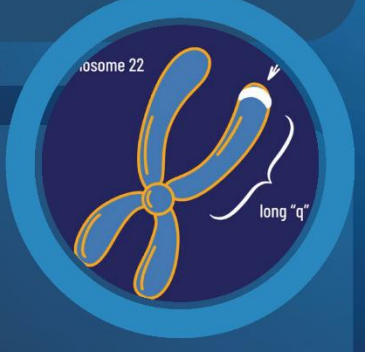
This review was followed by an anonymised case study involving a past history, clinical presentation, behavioural symptoms, differential diagnosis, and responses to interventions.

DISCUSSION/CONCLUSION

This case emphasises the need to consider underlying genetic conditions such as PMS in complex psychiatric presentations. Early identification can improve outcomes by enabling personalised treatment approaches, reducing ineffective interventions, and guiding non-pharmacological strategies. Increasing PMS awareness in mental health services can help clinicians provide better support for individuals with rare genetic disorders with neurodevelopmental and neuropsychiatric presentations.

NEXT STEPS

Raising awareness of PMS in mental health services is vital. Early genetic testing should be considered in complex cases, and personalized, multidisciplinary care approaches are essential to improving outcomes. Further research is needed to enhance understanding and treatment strategies for PMS.



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Use the QR code for the full reference list.

SCAN ME

1:1 interactions with nursing and medical staff: an audit

1:1 interactions with nursing and medical staff: an audit

Sebastian Siegrist and Dr Lilian Symons

Background

After the recent transition from paper to digital notes in NHS Grampian, it became increasingly difficult to track the number of both nursing and medical reviews in a psychiatric inpatient setting. We suspected that this was resulting in an unintentional decline in formal interactions with healthcare professionals.

Aims

1. To establish the current frequency of nursing and medical reviews for inpatients in Huntly Ward, Royal Cornhill Hospital
2. To review how the above information is documented using our digital note-taking system
3. To investigate whether patient characteristics influence review frequency

Results

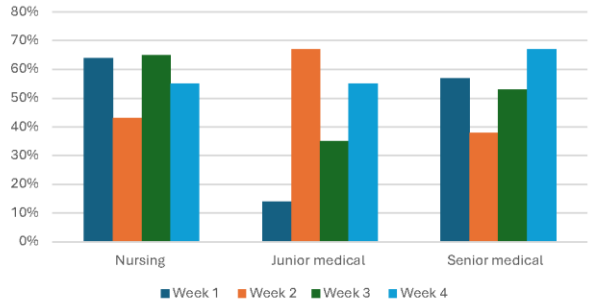

Figure 1 - percentage of patients receiving ≥1 review per week, by staff group

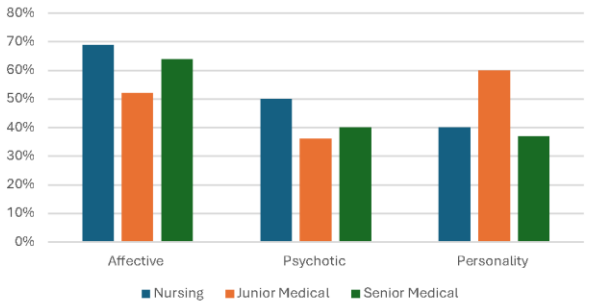

Figure 2 - average weekly percentage of patients receiving review, by pathology

Conclusions

On average, per week over the four-week period:

1. 57% of patients received ≥1 nursing review
2. 43% of patients received ≥1 junior medical review
3. 54% of patients received ≥1 senior medical review

Patients with personality disorders were least likely to receive a weekly senior or nursing review, with only 39% of these patients receiving at least 1 per week.

Conversely, these patients were most likely to receive a junior review, secondary to the high number of medical reviews required by this patient population.

Methods

We collected a total of 4 weeks of data retrospectively from the electronic patient records of 35 patients residing in Huntly Ward, Royal Cornhill Hospital between the 20th of January and the 16th of February 2025.

Data was collected relating to the number of junior medical, senior medical, and nursing reviews per patient per week, as well as the quality of documentation, and data relating to age, sex, and pathology.

Next steps

Our findings have been conveyed to senior staff at Huntly Ward, Royal Cornhill Hospital for review.

We will seek to work with staff in Huntly Ward to improve documentation and identify barriers relating to regular review.

We aim to close the cycle of audit in April 2024.

Harmonising Theory and Practice: Can Literature Supporting The Use of Music for Improved Maternal Mental Health and Mother-Infant Bonding Be Effectively Applied in an Inpatient Mother and Baby Unit?

Harmonising Theory and Practice: Can Literature Supporting The Use of Music for Improved Maternal Mental Health and Mother-Infant Bonding Be Effectively Applied in an Inpatient Mother and Baby Unit?

Dr Alice Watts

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NHS Kent and Medway NHS and Social Care Partnership Trust

1. Aims and Hypothesis

This project hypothesises that mother and baby music sessions within the inpatient perinatal mental health service can effectively reduce maternal anxiety, improve mood, and enhance the mother and baby bond.

The project aims to:

1. Conduct a comprehensive review of existing literature examining the relationship between participation in music groups and:
   a. Maternal anxiety,
   b. Maternal mood and
   c. The mother-baby bond
2. Reflect on the practical application of evidence from the literature in a pilot music group at a mother and baby unit (MBU), focussing on successes and challenges of translating the research findings into clinical practice.

2. Background

Mother and baby units are specialist inpatient mental health units for women with severe mental health problems during pregnancy or after the birth of their child. They were designed with the specific purpose of keeping mothers and their infants united to support the mother and baby bond during the mother's psychiatric treatment however specific therapeutic activities offered at each unit varies (1). This project seeks to explore whether mother and baby music groups could serve as a therapeutic intervention to meet these aims.

3. Methods

Stage 1: Literature Review

A search on the Pubmed® database was conducted to explore the evidence base supplemented by forward and backward citation tracking of relevant systematic reviews and meta-analyses identified. Boolean logic was applied as follows.

Keywords:

'Maternal' OR 'post-natal' OR 'post-partum' OR 'perinatal' AND 'mental health' OR 'anxiety' OR 'mood' OR 'bond' OR 'mother-baby bond' OR 'bonding' AND 'music' OR 'singing'

Study selection:

Initially, 1291 articles were found. This was reduced to 8 articles after closer inspection of the abstract for relevance to the hypothesis. Limitations of each study were noted.

Stage 2: The Music Group

The literature, supportive for singing to the infant, informed the design of the music group.

Setting and structure:

Six 1-hour sessions across 6 weeks involving nursery rhymes to encourage mothers to sing to their infants and an improvisation session where mothers were invited to express how they were feeling with key words or to play percussion instruments available. Songs were sung and played (on piano) by the author.

Participants:

15 mothers (2-8 per session) with a range of mental health conditions were in attendance .

Evaluation:

Whilst maternal health and bonding were not formally studied in this group, observations and reflections on its implementation were recorded, including strengths, challenges and anecdotal feedback from mothers (who did consent to their feedback being shared).

4. Results

8 studies were reviewed and the following themes identified:

Maternal anxiety

Improvement in maternal anxiety was variable across studies. 2 studies showed improvement with a statistical significance. A study was completed in an MBU and another in an unwell population in the community. This was supported with qualitative feedback from well mums who had a one-off session immediately after birth with a music therapist. However, when studied in the well and outpatient cohorts, there was no change in anxiety levels over the 10-week program.

Maternal mood

Similarly, evidence to support music improving mood was variable, as were the studies' methodologies themselves. All studies were positive for increasing affect although few had statistical significance. Upon closer analysis, the studies that did hold statistical significance were those involving mothers who were more unwell – either in a mother and baby unit, with a mental health diagnosis or showing signs of low mood.

Mother-baby bond

Across the board, the mother and baby bond was improved with music, although most articles examining this use a qualitative measure rather than a score of attachment. Those studies that used increase in the mother infant closeness and maternal-infant bonding scores showed an improvement in bonding with significance compared to the control groups.

The individual studies are reviewed in more details below, including limitations. Studies with statistical significance are highlighted in blue.

Study	Demographics and Setting	Study Type	Sample Size	Maternal Anxiety	Maternal Mood	Mother-Baby Bond	Limitations
Persico et al. 2017 (2)	Italy Well mothers in community	Concurrent cohort	168	Not studied	Not studied	Significant improvement in maternal infant bonding score (MIBS)	Mothers were well so more likely to engage better than those on an MBU.
Fancourt & Perkins 2018 (3)	UK Well mothers in community	Concurrent cohort	134	No change	Slight increase in affect (not significant)	Significant increase in mother infant closeness scale (IOS)	Mothers were well.
Perkins et al 2018 (4)	UK Mothers with postnatal depression in the community	Randomised control trial	54	Not studied	Not studied	Self-reported improved bond (qualitative)	Qualitative findings only so unable to know of significance.
Eriksen et al 2018 (5)	Australia Mothers with perinatal mental health diagnoses in the community	Randomised control trial	31	Significant anxiety reduction	Significant improvement in depressive symptoms	Observer-rated improved bonding	Not UK-based.
Reilly et al 2019 (6)	Australia Unwell mothers in an MBU	Single group	27	Significant anxiety reduction	Significant reduction in sadness post-session	Stronger mother baby bond (qualitative finding)	Self-reflection bias likely.
Corey et al 2019 (7)	USA Well mothers on the antenatal ward	Single intervention	320	Anxiety reduced (qualitative feedback)	Not studied	Stronger mother baby bond (qualitative finding)	Single session so limited evaluation of long-term impacts.
Wulff et al 2021 (8)	Germany Well mothers in the community	Randomised control trial	120	Not studied	No mood change	Initial significant improvement in attachment, not sustained at 12 weeks.	Mothers were well.
Kücükkaya et al 2024 (9)	Turkey Well mothers in the community with features of low mood	Randomised control trial	82	Significant anxiety reduction	Significant reduction in depressive symptoms	Not studied	Another short-term study (36 hours).

The literature was generally in favour of using singing in the improvement of maternal anxiety and mood and improving the mother and baby bond. However, when executing similar sessions in a mother and baby unit, when mothers were more unwell than those in the community, there were some additional challenges that are important to note.

Strengths	Challenges
• Mothers reported enjoying the sessions, with some expressing a desire to continue music groups post-discharge and staff reported maternal mood positively after the sessions • Improvisation exercises were particularly valued, with participants frequently describing feelings of relaxation and happiness. • Songs were mainly of British origin and sung in English, which made one mum less engaged, but another mum pleased because it helped to teach her daughter English. • Positive anecdotal feedback (verbal consent was given to share):	• Some mums with PTSD were triggered by song choices which were not obvious to the group facilitator at the start of the session • There were a few instances where unwell mothers, despite being told, filmed parts of the session including others' children which hindered engagement. • All patients were invited however some mothers were more unwell than others which did, on few occasions, make mothers too uncomfortable to engage. • There were pregnant mothers on the unit, for whom evidence of benefit is less robust. • One mother, separated from her baby, found the session emotionally challenging.

"I want to continue doing a music group with my baby when I am discharged"
"It's a relaxing experience"
"It distracts you from everything going on in your head."

5. Conclusions and Next Steps

The literature highlights the positive impact of singing to the infant, in a mother and baby music group, both for maternal mental health and bonding with the baby. Evidence is limited for mothers with severe perinatal mental illness, particularly those requiring admission to a mother and baby unit. This pilot project project yielded promising results, with the intervention being positively received by participants, who reported enjoyment and noted potential benefits for maternal mental health and mother-infant bonding but also highlighted practical challenges not mentioned in previous literature. Future directions include therefore:

- Conducting more robust studies with mothers experiencing severe perinatal mental illness, including those with psychosis and those on mother and baby units.
- Exploring the long-term impact of music groups and their potential as part of routine inpatient care to support mother and baby bonding whilst undergoing treatment for their perinatal mental health problem.

References

Scan the QR code for reference list

Duration Of Untreated Psychosis And Differences By Ethnicity In Merton & Sutton EIS

Making Life Better Together

NHS South West London and St George's Mental Health NHS Trust

DURATION OF UNTREATED PSYCHOSIS AND DIFFERENCES BY ETHNICITY IN MERTON & SUTTON EARLY INTERVENTION SERVICE (EIS)

1. Dr James Wilkinson (Core Trainee, SWLSTG) 2. Dr Daniel Hall (Higher Trainee, SWLSTG) 3. Dr Alberto Gutierrez Vozmediano (Consultant Psychiatrist for Merton EIS)

Background

The recommendation from the World Health Organisation is that the duration of untreated psychosis (DUP) length should be less than 12 weeks [1]. Studies indicate that a longer DUP is associated with poorer outcomes for patients [2][3][4]. Factors including poor insight, urban living, childhood adversity, early age of onset and delays in processing referrals have been associated with prolonged DUP [5][6][7]. There is strong evidence of health inequalities in mental health care and that black patients have worse clinical outcomes and more restrictive care[8][9]. NHS trusts have a legal and ethical duty to consider how health inequalities affect the quality of service and health of populations they serve. Research about association between DUP and ethnicity has yielded inconclusive results [10][11].

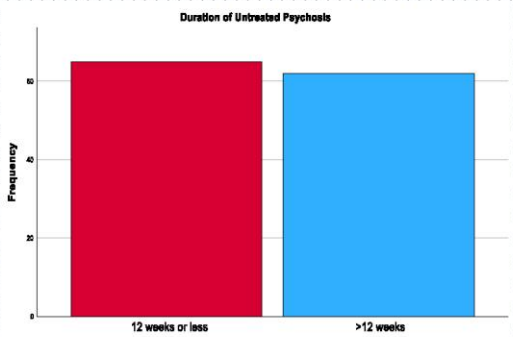

FIGURE 1

Aims

The aims of this audit were to assess:

1) whether 50% of the audit sample had a DUP <12 weeks
2) whether there was an association between DUP and ethnicity
3) whether there were any health inequalities within the audit sample.

Method

A cross-sectional sample of the caseloads of Merton and Sutton Early Intervention in psychosis Service (EIS) on 5 October 2023 elicited 127 cases for audit. Fisher's exact test and Bayes Factor were used to analyse the association of ethnicity with a variety of sociodemographic, clinical, healthcare and treatments related factors. We performed post-hoc tests using standardised residuals to examine the direction of change of any significant results

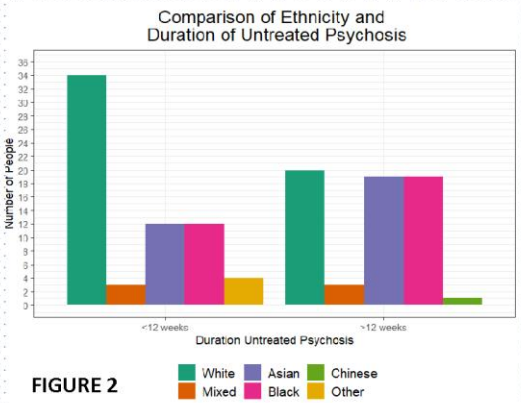

FIGURE 2

Results

A total of 51.2% (no. 65) of patients had a DUP of under 12 weeks **(figure 1).** However, almost the same amount of patients had a DUP of excessive length.

We found a statistically significant association between ethnicity and DUP X^2=11.2 (5, *N*=127), p=0.039, but this was not supported by the Bayes Factor (BF=0.24) **(figure 2).** We found no other association between ethnicity and other factors apart from co-morbid substance misuse X^2=15.15 (5, N=127), p=0.01, (BF=20.65).

There was a significant association between the type of service a patient had first contact with and the duration of untreated psychosis X2=13.2 (3, N=127), p=0.0044. The Bayes factor also strongly supported the alternative hypothesis (BF=10.29) **(figure 3).** When admitted through A&E significantly fewer patients than expected had a duration of untreated psychosis >12 weeks (z=-2.57).

There was a significant association between treatment with oral sedatives and the duration of untreated psychosis X2=6.50 (1, N=127), p=0.01. The Bayes Factor also supported the alternative hypothesis (BF=5.08). More patients treated with oral sedatives than expected had a duration of untreated psychosis <12 weeks (z=2.56) **(figure 4).** Similar associations were found with the use of IM sedatives.

Conclusions

Our EIS services meet the threshold of having >50% of patients have DUP <12 weeks. A conclusion about DUP being associated with ethnicity couldn't be made for the population in our audit, it is likely that we were not sufficiently powered to detect a difference.

Next Steps

We would recommend repeating this audit on a larger scale, including qualitative data, and examining how delays in accessing EIS care may further reduce prolonged DUP.

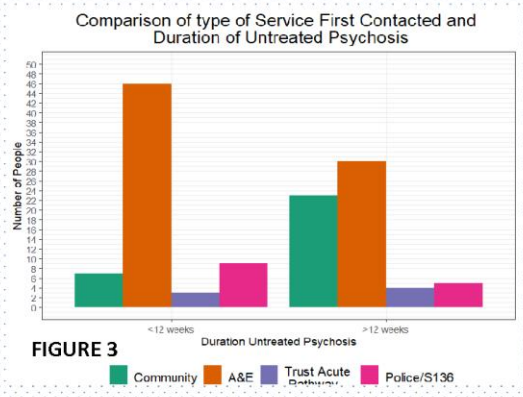

FIGURE 3

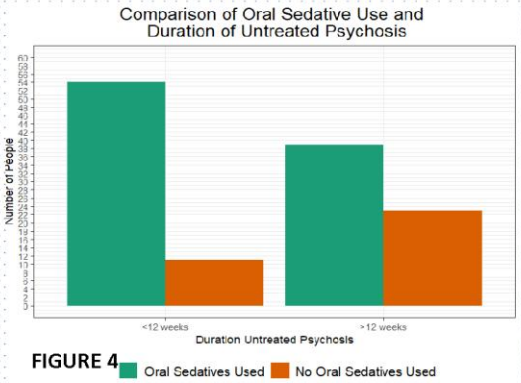

FIGURE 4

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Respectful Open Collaborative Compassionate Consistent

Improving Awareness of Wellbeing Resources Among Psychiatric Trainees and Supervisors in the West Midlands Deanery- A Quality Improvement Project

Improving Awareness of Wellbeing Resources Among Psychiatric Trainees and Supervisors in the West Midlands Deanery- A Quality Improvement Project

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Introduction

The Royal College of Psychiatrists position statement has described the importance of supporting the mental health and wellbeing of psychiatrists. It recognises the impact of wellbeing on quality of patient care, maintaining good mental health among staff and, crucially for trainees, on recruitment and retention to the profession(1). Trainee and resident doctors are recognised as a population at increased risk of poor mental health and suicide(2). During the Covid-19 pandemic further pressures on trainees made wellbeing particularly pertinent, trainees were working outside of their usual remit and faced changes to training pathways and exams(3). Remote induction, teaching and supervision due to Covid-19 restrictions impacted the information about wellbeing resources to which trainees were exposed. Many of these methods of remote working persist despite the end of the pandemic and reduce the 'word of mouth' sharing of resources and the availability of informal peer support . Trainees in the West Midlands Deanery have access to an excellent range of wellbeing support via local and national services, however, anecdotally there has been a lack of awareness among both trainees and supervisors about these resources.

Aims and Objectives

Using a quality improvement project format we aimed to gauge the awareness among trainees and supervisors in the West Midlands Deanery of the wellbeing and mental health resources available to them. We sought to identify which existing resources respondents were aware of and how these had been successfully promoted. In addition we aimed to identify any gaps in knowledge where further promotion of services was needed. Using this information we aim to improve signposting to resources, and create a central, easily accessible, source of wellbeing information.

Method

Core trainees in the West Midlands Deanery were invited to complete an anonymous online survey during November 2020. As a result of the initial findings a number of wellbeing resources were developed including posters for doctors' messes, leaflet inserts for induction packs and an online wellbeing page on the deanery postgraduate virtual learning environment. A further round of data collection took place in November 2022 following dissemination of the wellbeing resources to assess their impact. The latest round of data collection in November 2024 expanded the project to include higher trainees, educational and clinical supervisors.

Fig. 1 A poster of wellbeing resources for use in the doctors' mess.

Findings

The 2024 survey respondents consisted of 36 core trainees, 42 higher trainees and 24 clinical and educational supervisors from across 7 trusts. 25% (9) of core trainees and 5% (2) of higher trainees felt well informed about wellbeing resources. Among core trainees 50% (18) who attended deanery induction and 67% (24) who attended local trust induction did not think wellbeing had been discussed. Among higher trainees 83% (35) who attended deanery induction and 67% (28) local trust induction did not think wellbeing had been discussed. 29% (7) of supervisors felt very well informed, and 29% (7) well informed about wellbeing resources aimed at trainees, 54% (13) had received specific training on the topic. Trainees and supervisors identified 'BMA Wellbeing', 'Doctors in Distress', 'Practitioner Health Programme' and the local Professional Support and Wellbeing team as the resources they were most aware of. Trainees reported that their preferred format to access wellbeing resources was a website or mobile application.

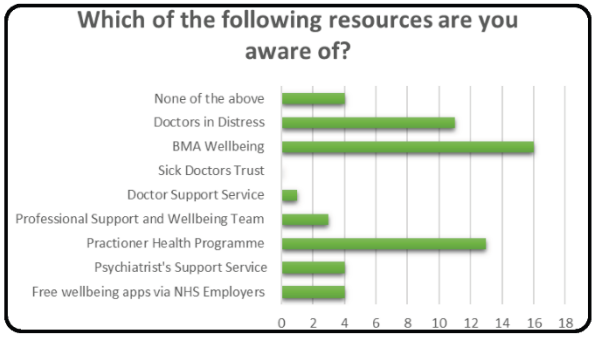

Fig.2 Core trainee awareness of wellbeing resources, 2024 survey.

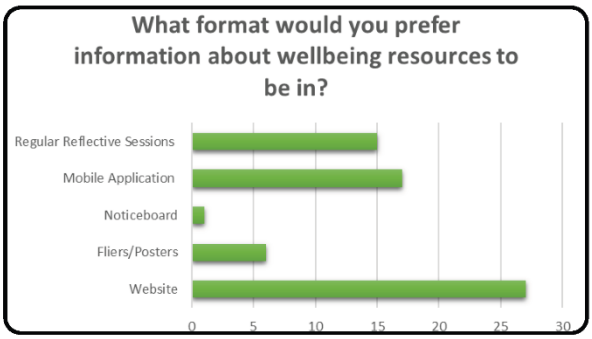

Fig.3 Higher trainee views on preferred format for wellbeing information.

Conclusions and Next Steps

Our results indicate that further work needs to be done at trust and deanery level to make wellbeing a priority during induction and improve awareness of resources. Supervisors feel relatively well informed about wellbeing resources and have received specific training on the topic, they may be able to signpost trainees, but only if trainees feel able to approach them to discuss their wellbeing. Resources developed in 2022, including induction pack leaflets and posters, should be updated and renewed efforts made to promote these in each trust. Trainees have identified that they would prefer to access information about wellbeing through a website or mobile application and we are currently developing these options.

Contact Information

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Scan to download our wellbeing poster for use in your hospital.

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Optimizing Psychotropic Prescribing Practices in Young People's Mental Health Inpatient Services: Insights from Austen House

2024/5 Psychotropic Medication in Children and Young People's (CYP) Mental Health In-patient Services – A Quality Improvement Programme- Austen House (LSU) Participation

Acknowledgment

The national team conducted an in-depth analysis of the census data, and I have summarized the findings and developed key recommendations for implementing improvements at Austen House

A. Introduction

The Psychotropic Medication in Children and Young People's Mental Health In-patient Services Quality Improvement Programme was launched by NHS England in October 2019 as part of a wider Quality Improvement Taskforce to enhance inpatient care for young individuals with mental health conditions. Since its inception, the programme has been dedicated to improving prescribing practices for psychotropic medications within these settings.

B. Methodology

- Child & Young Person Questionnaire: Gathers insights on medication experiences, understanding, and support needs.
- Parent/Carer Questionnaire: Captures family perspectives on their child's medication and overall experience.
- Medication Census Tool: Records clinicians' prescribing practices for psychotropic medications.

C. Discussion

- High Use of PRN Benzodiazepines and Antihistamines
- Frequent Use of Antipsychotics and Antidepressants
- Family Involvement and Shared Decision-Making
- Ensuring Evidence-Based Prescribing and Alternative Interventions

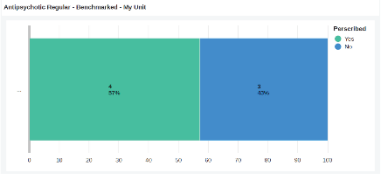
D. Results

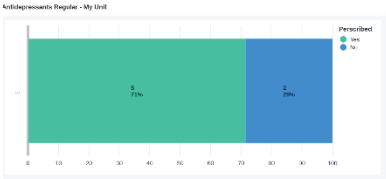
Data on psychotropic medication prescriptions were collected for 624 children and young people admitted to mental health units. Additionally, 156 children and young people and 91 parent carers completed questionnaires.

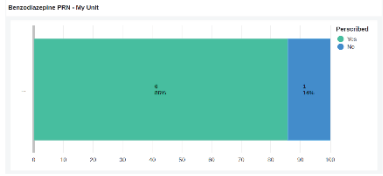
Austen House (LSU), data were recorded for 7 young people, with 4 young people completing questionnaires and 1 parent questionnaire submitted.

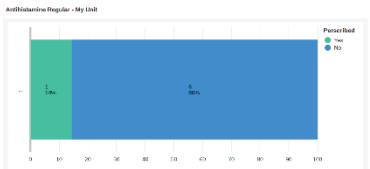
Medications prescription results:

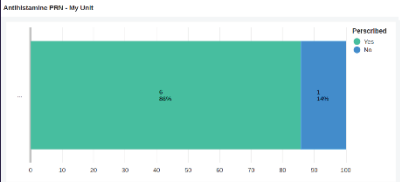
	Austen House/7	Same unit type/59	All units/624
Anti-psychotic Regular	4	50	401
Anti-psychotic PRN	0	10	63
Anti-depressant	5	36	324
Benzodiazepines Regular	0	10	59
Benzodiazepines PRN	6	51	277
Antihistamines regular	1	3	76
Antihistamines PRN	6	43	330
Hypnotics regular	2	27	178
Hypnotics PRN	0	4	92

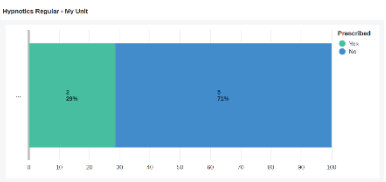












E. Recommendations

Key Strategies for Reducing PRN Benzodiazepine & Antihistamine Use

- Limit PRN use to short-term, severe agitation cases; avoid for routine anxiety management.
- Implement a PRN tracking system; reassess if used more than twice per week.
- Avoid continuous PRN prescriptions—use time-limited, reassess-able doses.
- Educate staff and young people on dependence risks, taper frequent users, and promote self-regulation techniques.
- Ensure good sleep hygiene before prescribing PRN antihistamines for sleep issues.

Enhancing Family Involvement & Medication Awareness

◆ Active Participation in Care
•Involve families in Personalized Care Plans (PCPs) to ensure their input is valued.
•Assign a Family Liaison (e.g., primary nurse) to maintain clear communication.

◆ Education & Support
•Provide clear, jargon-free medication guides for better understanding.
•Facilitate peer-led support groups for shared experiences and learning.

◆ Joint Crisis & Management Planning
•Include families in crisis planning to develop de-escalation strategies.
•Encourage collaborative decision-making for emergency response plans.

F. Conclusion

This programme reviewed psychotropic prescribing in children and young people's mental health inpatient services, led by specialist pharmacists to ensure evidence-based practice and prioritize non-medication therapies. It emphasized structured medication reviews, reducing PRN use, and encouraging active discussions on treatment choices, particularly during crises. The findings highlight the importance of greater family involvement in care planning to improve patient outcomes. By implementing these quality improvement strategies, Austen House can enhance safer, more person-centred mental health care.

Dr Hebaallah Zaghlol (Psychiatry CT2)
Dr Sarah Beer (Trust Doctor at Austen House)
Dr Tina Irani (Consultant Child and Adolescent Forensic Psychiatrist)
Hampshire And Isle Of Wight NHS Foundation Trust

Enhancing East of England (EoE) Foundation Hub Days: From Good to Great

Enhancing East of England (EoE) Foundation Hub Days: From Good to Great

Dr Afef Mahmoud, Dr Nikita Berman, Dr Meric Erden, Dr Sepehr Hafizi,
Dr Mohammad Malkera, Dr Robert Dudas, Dr Thirza Pieters, Dr Rebecca Jacob
Cambridgeshire and Peterborough Foundation Trust (CPFT)

Introduction:

As part of the East of England (EoE) Deanery's Taught Programme, foundation trainees attend three half-day 'hub' sessions, focusing on both clinical and non-clinical topics. These hubs as organised by CPFT since 2018, have recently expanded to include pharmacists and physician associates. The design and delivery of the hubs are led by Medical Education Clinical Fellows and are offered in both face-to-face and virtual formats.

Aims:

- To provide an engaging introduction to psychiatry for foundation doctors,
- Adapt sessions based on trainee feedback
- Explore their long-term impact on psychiatry recruitment.

Methods:

We reviewed the evolution of session content and format since the programme's inception, alongside participant feedback, to guide improvements over the years.

Results and Feedback:

Since 2018, the content of the hub has expanded beyond an introductory overview of psychiatry and medical education. Topics now include risk assessment, psychiatric emergencies, the Mental Health Act, substance use, child and adolescent psychiatry, research and mentorship, and psychotropic medications and prescribing. Initially lecture-based, sessions have evolved to incorporate open discussions, simulation exercises, and role-playing with professional actors.

What Worked Well:

✓ **Engaging Learning** – Role play, simulations, and case discussions enhanced participation.
✓ **Small Group Interaction** – Breakout rooms and structured scenarios
✓ **Comprehensive Topics**
✓ **Real-World Application** – Practical strategies for psychiatric presentation in medical, GP, and emergency settings.
✓ **Career & Research Exposure** – Insights into training pathways, portfolios, and subspecialties as well as mental health research.
✓ **Balanced Approach** – A mix of theory, discussion, and hands-on exercises.

Suggestions for Improvement:

- **More Case Variety**
- **Pre-Session Materials** – Providing an agenda or case scenarios in advance for better preparation.
- **Extended Career Talks** – More detailed discussions on psychiatry training pathways and career options.

"Very well-structured, role play, nicely broken down into different aspects e.g., history taking, meds history, risk assessment for focused learning."

"Enjoyed the interactive nature of the event. It helped to have teaching alongside role play scenarios to put the learning points into practice."

"Better understanding of assessing risk in patients on wards—very useful for training."

"Gained an appreciation of the nuance that can exist in capacity decisions."

"A useful structure for history-taking and MSE, but also knowing that we don't need to rigidly stick to it."

Topics of the Previous Hub Days:

2018-2019
- Overview of training in Psychiatry and career pathways
- Risk Assessment and Managing Psychiatric Emergencies
- Prescription in Psychiatry
- Mental Health Act / Mental Capacity Act

2020-2021
- An introduction to psychiatric illnesses and prescribing
- Medical Law /Mental Capacity act & Mental health Act
- Psychiatric Emergencies
- Acute Tranquilization
- "Do Your Research!" –Insight into the New FY3 Psychiatry Research Post in Cambridge
- Training in Psychiatry, Exams and Career Pathways

2021-2022
- Child and Adolescent mental health service- A talk from a higher trainee
- Risk assessment- in the form of an open discussion and role play

2022-2023
- General introduction to psychiatry
- Psychiatric emergencies
- Risk assessment,
- Alcohol and drug misuse
- Child and Adolescent Mental Health Service
- Careers in Psychiatry

2023-2024
- Psychotropic medications and prescribing,
- Introduction to psychiatric history taking and MSE,
- Risk assessment,
- Psychiatric emergencies
- Mental Health Act
- Mentorship and careers in Psychiatry

Conclusion:

The psychiatry hub has become increasingly engaging and clinically relevant, significantly enhancing trainees' understanding of the specialty. Future hubs, including those in April 2025, will continue to expand the multiprofessional approach. While the long-term impact on recruitment into psychiatry remains uncertain, future evaluations should track career preferences to assess the broader impact of the hub days. Ongoing feedback will remain integral to continuous improvement.

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