psychosis in the community. In line with national and trust guidance, physical health checks are completed at baseline, 3 months, 6 months and annually, through a weekly physical health clinic run by the core trainee (CT). This is an essential opportunity to assess and monitor patients' physical health and aid decisions regarding psychotropic medications, which is particularly important given the increased morbidity and mortality in this group and their reduced engagement with health services. It was noted that attendance to the clinic was poor and there was no guidance about how to communicate the results to the General Practitioner (GP).

Method. Data on the number of clinic appointments booked and attended were collected over 3 defined 9 week intervals between 17/09/18 and 29/07/19. The interventions were implemented prior to the third round of data collection and included an educational session to the STEP team and a protocol for booking and running the clinic to be used by the CT. We devised a physical health questionnaire to be completed by patients on arrival, which includes a summary of the Maudsley guidelines for antipsychotic monitoring. Finally, we created a template letter to communicate the results to the GP.

Result. Following the interventions, the percentage of available clinic slots booked increased from an average of 27.8% to 100%. The proportion of slots attended reduced from an average of 80% to 50%. However, the absolute number of patients booked into clinic increased from an average of 10 patients over 9 weeks pre-intervention, of which an average of 8 patients attended, to 36 patients post-intervention, of which 18 attended.

Conclusion. We observed full utilisation of available clinic slots post-intervention and an increase in the absolute number of patients attending. Given the ongoing use of the protocols developed, we expect these changes to be sustainable. The number of patients attending could be further increased by training additional staff to run the clinic more often and more flexibly. The number of Did-Not-Attends could be reduced by care-coordinators sending reminder texts prior to the appointments.

Investigating sleep quality on an inpatient psychiatry ward

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Aims. Sleep is essential for optimal physiological functioning, but often interrupted in hospital settings. Disturbed sleep is associated with relapse of mood disorders and multiple comorbidities including impaired immunological function and increased cardiovascular risk. There are unique environmental challenges on psychiatry wards, such as overnight monitoring. Recent studies highlight the importance of evaluating and managing inpatient sleep disturbance. Aims include exploring the extent to which patients' sleep is impacted by inpatient admission, elucidating causes of sleep disturbance and determining ways to improve sleep during admission.

Method. Patients aged 18–65 years, who consented and were expected to be inpatients for a week, were approached after 72 hours of admission (n = 35). Quantitative and qualitative data, including on pre-hospital and hospital sleep quantity and quality, were gathered, as part of a cohort characterisation. Questionnaires using Pittsburgh Sleep Quality Index elements were used to gather data. Offering earplugs as a sleep-aid intervention was implemented, with sleep quantity and quality reassessed 72 hours post-intervention. In response to feedback, sound monitoring at regular intervals overnight was undertaken using a decibel-metre to determine noise baseline and variation.

Result. All patients approached agreed to participate. Pre-hospital average sleep quantity was 5.2 hours, with restedness score of 4.3, and 71% patients rating their sleep as 'bad'. After 72 hours post-admission, average sleep length was 6.5 hours and restedness 5.3. Of patients who accepted earplugs (59%), there were improvements to mean sleep quality and quantity (7.6 hours), with 86% patients rating earplugs helpful. All patients surveyed thought that earplugs should be offered routinely on admission. 70% of patients were prescribed benzodiazepines or z-drugs as required. Self-reported factors affecting sleep included noise, psychiatric symptoms and medication side effects, with 13 patients mentioning the former. Sound monitoring recorded an average decibel level with a range of 35–75 dB, with peaks reaching 95 dB.

Conclusion. Poor sleep in hospital is widespread. There is a need to understand and address modifiable environmental and ward factors implicated in sleep disturbance within inpatient settings. Pharmacological options for sedation are common, but it is important to focus on alternative options of low-cost, non-pharmacological interventions which promote sleep optimisation and enhance inpatient care.

Developing a local service to improve the provision of palliative care to people who use substances

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Aims. To develop a new service model that engages and improves the provision of palliative care to PWUS.

Background. Although people who use substances (PWUS) continue to die prematurely compared to the general population, they are now more likely to die from chronic diseases rather than from drug-related deaths. Challenges to providing palliative care to PWUS include delayed care-seeking behaviours, complex drug interactions and lack of healthcare provider experience.

Method. An informal factorial analysis elucidated population needs through: a review of local databases to estimate the prevalence of palliative need, a thematic review into the deaths of patients in specialist drug services and, a survey of health practitioners' knowledge and attitudes. These informed the service development phase which involves three key components: 1. A systems approach to increasing patient identification, incorporating key multi-disciplinary stakeholders across hospital- and community-based care 2. Targeted training of healthcare providers and 3. Medicines management for symptom palliation amidst concurrent substance use (including substitution treatments).

Result. The palliative needs of PWUS are under-identified: the local substance service was not partaking in the palliative referral pathway. Only 7% of a local hospice's annual caseload was recognised as having substance use problems. The care pathway was described as fragmented. Although >80% of surveyed palliative care practitioners had experienced caring for PWUS, confidence

and knowledge around managing withdrawal, pain and opioid substitution therapies was poor.

Conclusion. A new pathway is designed to identify PWUS and in their last year of life at key treatment points e.g., accident and emergency, ward-based care. The pathway will then streamline referrals to relevant specialist services depending on complexity of palliative/dependency need. Teaching resources and prescribing guidelines have been developed in collaboration with secondary care pain specialists.

Quality improvement supervision comparison between training and non training posts

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Aims. To explore the level of supervision between training and non-training posts at LSCFT.
Background.

- Supervision is defined as 'provision of guidance and feedback on matters of personal, professional and educational development in the context of a trainees' experience of providing safe and appropriate patient care'.
- Along with the trainees, doctors working in non-training posts such as staff grade, specialty doctors, trust grade doctors (TJD) and MTI (Medical training initiative) doctors form an integral part of patient care in the NHS.

Method.

- A mixed method approach was adopted with both qualitative and quantitative data collected simultaneously in the form of an online questionnaire.
- An anonymous online questionnaire was sent to junior doctors currently in training and non-training posts at LSCFT in 2019 using Meridian software.

Result. 1- Quantitative Data: - Participants included were doctors in training post such as Foundation Doctors (5), Psychiatry Core Trainees (6), GP STs (2) and doctors in non-training post such as TJD (4), Specialty Doctors (2) and MTI doctors (4). Based on the Meridian score, 84% of doctors were satisfied with the supervision. It was found that 72% of doctors received weekly supervisions, 10% monthly (1 TJD, 1 Foundation trainee) and16% bi-monthly (1 MTI, 1 SAS, 2 CTs). The data suggested that there was no difference in the frequency of supervisions between training and non-training posts at LSCFT.

2- Qualitative Data: - The feedback was common as there was no major difference between training and non-training doctors.

- Positives – WPBAs, discussion on reflections, management of complex cases and medication, personal issues affecting work.
- Negatives – Limited discussion on QI, Audit, Research and Psychotherapy.

- More specific help, need more support at times.
Conclusion.

1. To prepare a checklist of contents to be discussed during supervision.
2. To prepare a timeline chart of supervision.
3. Preparing a 'menu' of QI projects that junior doctors can sign up to at the start of each post.
4. To formulate training packages available to support junior doctors with QI/Audits.

Developing a dashboard for use in a forensic and intensive care psychiatric unit: a quality improvement project

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Aims. Dashboards provide a visual summary of relevant data to track performance against key indicators over time. They are used in healthcare to monitor the quality of patient care and to identify potential quality improvement projects. There is little published evidence of them being used in mental health services, especially in forensic psychiatric care.

This project aims to design a dashboard for use in a forensic and intensive psychiatric care unit, by specifying measures and ideal features it would include.

To develop a model for a quality dashboard for use

To decide which measures would be reported on the dashboard

To find reliable methods of assessing said measures

To explore staff preferences as to how the dashboard would display data, and how they would like the information to be disseminated

To use blank data to design a mock dashboard interface for feedback

Method. A literature search was conducted on healthcare dashboards and quality improvement projects taking place on low-secure psychiatric wards similar to the Blair unit. Potential outcome measures and methods of assessing them were researched. Staff thoughts on the dashboard, and which measures they would like to see included, were explored in interviews and using a survey

Result. Blank data were fed into excel to create example graphs for a mock dashboard. The results section details: measures to be included, such as staff turnover rate, absences, and patient satisfaction levels; how they can be assessed; and specific features of the dashboard, such as the capability to track trends in selected quality indicators over a period of time. Further development of this project out with the 4 week development timeframe will require cooperation from IT services and unit management staff.

Conclusion. Many staff suggestions, whilst valuable measures, were more suitable for use in a clinical or nursing dashboard, rather than a quality dashboard. COVID-19 factored into reasons why staff requested certain measures, and also meant that less staff were available to be contacted about the project. This project has limitations based on the four-week timeframe, but could be further developed by staff on the unit if desired.

Hyperprolactinaemia: audit of practice and new guidance

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