improvement by 2021). Response to treatment was inconsistently documented in the 2017 audit. In 2021 there remained some inconsistencies in documentation. Improvements in recording response to treatment would assist with clearly evidencing compliance with the NICE standards.
Conclusion. Overall, treatment and follow up for anxiety disorders was good or excellent (and remained so in 2021). Areas for improvement lay in the assessment of anxiety disorder. Recommendations to promote ongoing improvement include: 1) Circulation of re-audit results to the team 2) Brief recap of guidelines on assessment of social anxiety disorder to the team 3) Written/ email reminder to consider and document the other areas that received less than 80% compliance 4) Continue use of ROMS. Effective assessment and management of anxiety disorder is an important area of clinical practice for all clinicians in the team; we would recommend this is re assessed in 2023 to ensure standards continue to improve.

A Quality Improvement Project to Increase Junior Doctors' Satisfaction With Handover Process Using Microsoft Teams (MS Teams) as a Platform

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Aims. To improve junior doctors' satisfaction with handover process to >70% over a period of 10 weeks.
Methods. Baseline level of overall satisfaction with current handover practice was measured through a survey using Likert scale. Using the same scale, the team also looked at:

1. Degree of confidence in tasks being completed
2. Degree of confidence in handover being confidential
3. Degree of confidence in handover being sufficient for medico-legal purposes

Part of the survey also asked junior doctors using free text comments on how handover is currently carried out between shifts. The results from the survey were analysed and suggestions were considered for improvement.

A new method of handover using MS Teams was trialled. During subsequent PDSA cycles change ideas were adopted to improve engagement with the new process and allow for safe handovers.

On a weekly basis, post-intervention level of overall satisfaction with the new handover process was measured using the same Likert scale. Other measurements measured weekly included:

1. Percentage of handovers completed using the agreed template
2. Percentage of handed over jobs being acknowledged to signify receipt of handover

Results. Pre-intervention, verbal handover was the most frequent way of handing over (85.7%) followed by Whatsapp/text messaging (64.3%) and paper (42.9%).

Baseline level of overall satisfaction of handover process is 21.4%. At the end of PDSA Cycle 1, this increased significantly to 78% and by week 10 (end of PDSA Cycle 2) it rose to 92%.

Pre-intervention, 35.7% of junior doctors reported feeling confident in the handed over tasks being completed. 28.5% were confident that the handover process is confidential and 14.3% that it is sufficient for medico-legal purposes.

Post-intervention, 100% of the handovers are completed using a standardised template and 100% of the tasks were being acknowledged by the appropriate team members.
Conclusion. Prior to this intervention the process of junior doctor handover was not uniform and led to near-misses. This created confusion hence opportunities for errors to occur which can compromise patients' care. Following the introduction of MS Teams as the handover platform, overall satisfaction from junior doctors on the handover process has increased significantly. Moreover, it provides a clear record of handovers taking place which ensures accountability, safety and continuity of patients' care.

Improving Cardiac Monitoring for Patients on Depot Antipsychotic Medication in a Mental Health Service for Homeless People

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Aims. Patients under the Joint Homelessness Team (JHT) in Westminster have poor health outcomes as they face the double-hit of serious mental health illness (SMI) and homelessness. Many patients are on depot antipsychotic medication to manage their SMI. Depot antipsychotics are associated with increased risk of arrythmias and guidance advises annual electrocardiogram (ECG) monitoring for all (Maudsley: Prescribing Guidelines in Psychiatry, Taylor). However, a proportion of JHT patients are not well engaged with services and do not have an annual ECG recorded on SystmOne. In this QI study, we aimed to improve the percentage of JHT patients on depot antipsychotic medication who have a recorded ECG within the year on SystmOne, from current level to 80% over a 4-month period.
Methods. 44 patients at JHT were identified as being on depot antipsychotic medication (1 patient was later excluded due to ongoing inpatient admission). PDSA cycles were used over a 4-month period from October 2022 to January 2023.

Intervention 1: Using available ECGs from GP or secondary care records to update SystmOne records.

Intervention 2: Email to GP requesting they invite patients for annual ECG.

Intervention 3: JHT inviting patients for targeted ECGs.
Results. At baseline only 48.8% of patients had an ECG recorded on SystmOne within the last year. Intervention 1 increased our recorded ECGs to 72.1%. Intervention 2 increased completed ECGs to 74%. Finally, intervention 3 increased completed ECGs to 83.7% by Mid-January 2023. Overall, results show an improvement of 34.9% or relative increase of 1.71 times the amount of recorded ECG over 4 months.
Conclusion. As a result of incorporating dedicated liaison and clinical time, we have improved uptake of annual ECG monitoring of patients on depot antipsychotic medication. We found there was a lot of existing physical health data in the GP and secondary care records that was not readily accessible to JHT. In the future, with the development of shared clinical data systems, both

primary and secondary care teams may be able to save time and resources by avoiding duplication of data.

There remains room for improvement with 16.3% of patients still without an annual ECG. This is due to accessibility and engagement difficulties for people with SMI & history of homelessness.

We propose further intervention with a portable ECG machine to improve engagement with

these remaining patients. This project is being used as a business proposal to secure funding for a portable ECG device currently.

Quality Improvement Project to Improve Management of Disclosed Sexual Assault in the General Adult Inpatient Population

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Aims. This quality improvement project aimed to improve mental health professionals' understanding and confidence in management and support of patients in the general adult inpatient setting who have disclosed sexual assault. It also aimed to improve patients' experience of support following their disclosure of sexual assault.
Methods. Baseline knowledge and understanding was evaluated using an anonymous questionnaire sent to staff.

Stakeholders were identified from medical, nursing, police, FME and third sector agencies and patient advocacy – their expertise was utilised to develop standardised guidance.

The intervention included an education session delivered at site-wide teaching, and the creation of a procedure with associated resources for staff reference.

Teaching sessions and guidance were based on this expertise to fill knowledge gaps identified in the baseline knowledge questionnaire.

The questionnaire was subsequently redistributed and collected to analyse for an improvement in knowledge and confidence.
Results. Initial questionnaires presented qualitative and quantitative data suggesting lack of confidence and understanding of the processes involved in reporting and management of disclosed sexual assault.

Post-intervention dataset analysis shows an improvement in staff understanding, confidence and access to appropriate resources in management of sexual assault in the general adult inpatient population.
Conclusion. Prior to the project there was no protocol for the management of disclosed sexual assault in the local general adult inpatient population.

This left uncertainty amongst staff regarding the appropriate steps to take. This resulted in an increased risk of crucial time windows not being considered associated with a potential loss of evidence.

The Quality Improvement project improved staff confidence regarding management of disclosed sexual assaults thus optimising patient outcomes and experience when reporting assault.

Meeting the Needs of Asylum Seekers & Refugees: The Norfolk Experience

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Aims. As the number of forced migrants continues to raise every year due to conflicts, wars, climate change, and other factors, mental health services need to find innovative and new solutions to meet the needs of these vulnerable groups. We present here our experience of establishing the first mental health clinic for asylum seekers and refugees in Norwich, Norfolk (United Kingdom).
Methods. The clinic was established as part of the Advancing Mental Health Equalities QI Collaborative, which the Royal College of Psychiatrists launched to reduce barriers to accessing mental health services for disadvantaged populations. QI methodology was used to promote equality, increase access and improve outcomes over the next three years.

The monthly clinic has no funding and is run by a consultant psychiatrist (Yasir Hameed) and GP (Hannah Fox). Two research assistant psychologists offered the administration support. Another assistant psychologist and two core trainees joined the small team to offer reviews and follow-ups for the patients.

The monthly clinics are based away from the mental health settings (as some patients might be reluctant to attend these clinics) and are held in a friendly well-being hub run by the MIND organisation close to the city centre, which is easily accessible.

The clinic receives referrals from primary care, social services, charity organisations (such as the British Red Cross), Well-being service (Psychological Therapies), and inpatient and Community Mental Health Teams.

The clinic aimed to offer a person-centred, trauma-informed approach and improve the communication between services (through regular meetings with various services on a monthly basis), and enable access to appropriate treatment.

In addition, the team of the clinic run drop-in session in local hotels where asylum seekers are housed to talk about mental health and access mental health services.

Finally, the clinic offered training opportunities in transcultural psychiatry and working with interpreters.
Results. Between March 2022 to January 2023, 40 referrals were received, mainly from primary care.

Nearly 20% had a diagnosis of PTSD.

We followed nearly half of these patients in the clinic in subsequent visits and worked closely with the psychological therapy to refer patients for appropriate therapies.
Conclusion. The clinic improved the access of forced migrants to comprehensive, trauma-focused mental health assessments and improved communication and collaboration amongst services. It provided training opportunities. The drop-in sessions were a great opportunity to meet asylum seekers in their accommodation. Lessons learned and full data analysis will be shared in the poster.