that the approach to assessment and management was not consistent between locality teams. Two experts by experience who have a diagnosis of BD were invited to become involved with the development of the pathway. Meetings were set up to enable coproduction and elicit information from those with the diagnosis. The responses provided insight into the effectiveness of different approaches used nationally to inform the methods and resources that are most helpful and appropriate to comprehensively support those with the illness.

NICE guideline evidence was used to create two algorithms to streamline the care of those with BD in both primary and secondary care. These algorithms include pharmacological, psychological and social approaches. It also considers the junctions at which referrals should be made and the criteria on which decisions are based.

Result. One algorithm was designed for use in primary care and will be distributed to local GPs to clarify the initial steps for assessment and management of BD and the criteria for referral. A second decision tree will be made available to all doctors working in mental health services with detailed medication options, when they are appropriate and whether additional psychological intervention should be considered e.g. post-discharge groups. Other specialist options such as Early Intervention for Psychosis and Perinatal Mental Health Services were also included. An information pack was created to be offered to all those with a diagnosis or possible diagnosis of BD. This contains useful resources such as skills and exercises that patients may find of benefit, external resources and websites regarding additional support and further information on BD, its nature and management.

Conclusion. The approach and resources collated here will help to streamline the management of those with bipolar disorder whilst also ensuring a more consistent approach. The involvement of experts by experience and the incorporation of NICE guidelines ensures a well-rounded and comprehensive set of documents that will be helpful to both clinicians and patients.

Demystifying the pathway of assessment and treatment for bipolar disorder – utilising co-production and algorithms to personalise the approach

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Aims. To develop an evidence based, patient centred treatment pathway for people experiencing symptoms of bipolar disorder (BD), modifiable to include local resources.

Method. This project was developed in line with current approaches to service development such as coproduction, with patient and public involvement (PPI) and enhancing personalisation of treatment in medicine. As part of a local initiative, a multidisciplinary team was brought together to understand and analyse the current local pathway for those affected by BD. It was found that the approach to assessment and management was not consistent between locality teams. Two experts by experience who have a diagnosis of BD were invited to become involved with the development of the pathway. Meetings were set up to enable coproduction and elicit information from those with the diagnosis. The responses provided insight into the effectiveness of different approaches used nationally to inform the methods and resources that are most helpful and appropriate to comprehensively support those with the illness.

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Conclusion. The approach and resources collated here will help to streamline the management of those with bipolar disorder whilst also ensuring a more consistent approach. The involvement of experts by experience and the incorporation of NICE guidelines ensures a well-rounded and comprehensive set of documents that will be helpful to both clinicians and patients.

Where's the emergency? Improving emergency psychiatry experience for core trainees in Bath and North East Somerset (BaNES) and Gloucestershire Health and Care (GHC) localities

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Aims. The Royal College of Psychiatry advises that core trainees should be involved in 50 first-line emergency assessments during their core training. This includes assessment of suicidal risk following self-harm at least monthly. Trainees in Bath and Gloucester are not meeting these requirements. We set up an emergency experience rota, with the aim of increasing trainees' experience and confidence in assessment and management of emergency psychiatry.

Method. An emergency experience rota was implemented in Bath in September 2017. Trainees were surveyed before and after their 6 month rotations. In cycle 1, trainees spent two weeks with the Crisis team and an additional three days with the Liaison team per rotation. In cycle 2, we made some modifications to the rota so that it was more flexible. This system was then adopted in Gloucester where trainees were encountering similar difficulties. We hope to complete cycle 3 across the two localities by July 2021.

Result. From the initial two cycles conducted in Bath, post-change surveys showed an increase in trainees' confidence in assessments in acute settings and completing risk assessments in cases of self-harm and suicidal ideation. All of the trainees who took part would recommend the experience to other trainees (100% (7/7)). In Gloucestershire, only pre-change data have

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