

presentations with handouts, ahead of the January 2021 examinations. Content was based on national guidelines and published research. 5 sessions were delivered with the final session including guest consultant panellists to answer trainee questions. Quantitative and qualitative feedback was collected from the attendees.

Result. 172 doctors registered onto the course, with 44 NHS trusts represented. Doctors from a variety of grades attended, with 55% CT3s, 17% Specialty Doctors, 16% CT2s, 8% CT1s, 4% in other roles. 100% of attendees stated that they would recommend the course to any doctor sitting the CASC. 97% of attendees rated the course as either 'Excellent' or 'Good'. Qualitative feedback was positive and 3 themes were identified- communication, content and the online format.

Conclusion. The CASC course provided an opportunity to deliver national teaching to trainees based on national guidelines and peer-reviewed research, with a focus on addressing areas that trainees may feel less confident with. The course received significant positive feedback from attendees. The significant number of pre-CT3 trainees attending the course suggests that there may be an interest from this group for further support in developing the complex communication skills that ultimately are assessed by the CASC exam.

An innovative CASC training redesign – ‘experience of virtual mock CASC exam’

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doi: 10.1192/bjo.2021.428

Aims. Cardiff CASC Training (CCT) has provided structured and formal training for the CASC exam for Wales trainees since 2012, in conjunction with Wales Deanery. For the past 8 years CCT has delivered face-to-face mock CASC exams and received excellent feedback from candidates and examiners, in addition to an extremely positive outcome of improvement in CASC pass rate for candidates.

Due to the current COVID-19 pandemic restrictions delivery of the mock CASC examination had to be adapted with the aim of running it remotely via an online platform.

Method. The examinations were run online via Zoom due to its ease of use, including the ability to screen share candidate instructions and assign participants in to breakout rooms. One lead exam coordinator manually rotated candidates around the circuit of 16 stations.

Result. A total of 16 candidates sat the mock exam over two separate sittings. Written feedback was obtained from candidates and examiners. Limitations identified during the initial sitting included high logistical workload for the lead exam co-ordinator and Zoom not being supported by all hospital computer internet browsers, these issues were addressed prior to the second sitting. Feedback from candidates regarding the overall experience of the online exams ranged from 'extremely effective' to 'very effective', this is in line with feedback obtained following previous face-to-face mock exam events CCT has run.

Conclusion. Although online learning may feel very different to the face-to-face interactions we are all used to we are in an era where adaption is necessary. These online mock CASC examinations have been a success and are also in keeping with how the real CASC examination is currently being run by the Royal College of Psychiatrists. CCT are running a further online mock examination to support the next cohort of candidates through their CASC exam in this particularly challenging time.

Peer-led medication education in the time of COVID-19

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doi: 10.1192/bjo.2021.429

Aims. To set up an online peer-led medical education programme for core psychiatry trainees during the COVID-19 pandemic.

To determine trainees' views regarding the role of peer-led education in psychiatry.

Method. A peer-led education programme was set up for psychiatry trainees in their third year of core training, held over an online video-conferencing platform. The weekly sessions were organised and led by trainees. Each week a trainee either presented a journal article or a particular psychiatric topic, with a group discussion afterwards.

An online survey was sent to psychiatry trainees that had participated in the programme to determine their views. Close-ended questions were asked as well as open-ended questions for more qualitative responses.

Result. There were 9 peer-led sessions in total, with 11 trainees (out of 18 invited) attending at least one session, and an average of 5 trainees at each session.

Five core trainee psychiatrists responded to the survey following the sessions. All of the respondents found the sessions either "very" or "fairly" useful. 80% stated that there should be more peer teaching opportunities as part of normal psychiatry training. All respondents found engaging with online teaching either "easy" or "OK".

Open-ended questions showed that respondents found the sessions were useful for: 1) connecting with peers during a difficult time 2) free discussion due to being around peers 3) wide interest and variety of topics. Improvements that could have been made were: 1) more sessions 2) advance knowledge of journal articles being presented.

Conclusion. Peer-led sessions are a useful form of medical education for core psychiatry trainees. During the restrictions brought about by the COVID-19 pandemic they are a way to connect with colleagues during an isolating time. They are easy to organise and access; and can take pressure off medical institutions, whilst having the advantages of allowing trainees to feel they can discuss topics in a more open manner and can follow their own interests.

Immersive psychiatry simulation: a novel course for medical student training

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doi: 10.1192/bjo.2021.430

Aims. Over the last decade, there have been significant developments in the use of simulation for undergraduate medical education. Despite simulation's diverse applications across the medical school curriculum, it has thus far been underutilised within psychiatry teaching. Psychiatric simulation can support students to develop strategies to elicit psychopathology, de-escalate an aggressive patient or perform a risk assessment. Such experiences can be difficult to encounter during clinical placements and may

expose a student or patient to an unacceptable level of risk. We have therefore developed an immersive simulation course that aims to enhance undergraduate psychiatry training.

Method. Our course was developed by medical education faculty and psychiatry staff. The course handbook includes storyboards, patient scripts and debrief guidelines. Clinical scenarios are mapped to university intended learning outcomes and include; conducting a risk assessment for a patient with emotionally unstable personality disorder and comorbid depression, managing a manic patient in the Emergency Department and assessing a patient with obsessive-compulsive disorder who has developed skin damage due to hand washing.

The one-day course is delivered to groups of 4-8 students from the Universities of Glasgow and Edinburgh during their placements in NHS Lanarkshire. The course takes place in a simulation suite and is facilitated by psychiatrists and medical education faculty. Students each take the lead role during a clinical scenario in which they will encounter a simulated patient. Live video from the simulation is broadcast to other candidates. Scenarios last 10-15 minutes with a 20-30 minute group debrief immediately afterwards. The debrief utilises the PEARLS framework (Promoting Excellence and Reflective Learning in Simulation) and provides the opportunity for peer and facilitator feedback, as well as discussions regarding mental state examination, diagnosis and management.

Result. Qualitative and quantitative feedback has been collected via an anonymous electronic post-course questionnaire. To date, the course has received universally positive feedback. 93% of candidates rated the overall quality of the course as a learning experience as 'excellent'. Students reported that the course helped them develop communication skills which they could apply to future clinical situations. In addition, candidates felt participation had increased their confidence in taking a psychiatric history and performing a risk assessment.

Conclusion. Immersive simulation is an underutilised tool in psychiatry education. Our course complements the existing educational programme of lectures and ward-based teaching and has been positively received. It provides the opportunity for students to develop interview techniques and communication skills in a safe, controlled environment.

Bedside teaching: an invaluable tool in undergraduate medical education

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doi: 10.1192/bjo.2021.431

Aims. Bedside teaching is one of the most important modalities in medical education. Sir William Osler stated, "Medicine is learned by the bedside and not in the classroom". Despite this, the use of bedside teaching in the undergraduate curriculum has been declining, potentially due to changes in course design, increasing clinical workloads and reducing inpatient numbers. In my role as a Clinical Teaching Fellow (CTF), I have aimed to maximise bedside teaching and promote it as the primary approach for student learning.

Method. As a CTF, I deliver teaching to students from the Universities of Glasgow and Edinburgh during their placements in NHS Lanarkshire. Weekly teaching is provided to groups of 2-4 students, with around 50% of sessions delivered 'at the bedside'.

Within psychiatry, there is a vast range of potential bedside teaching topics. Given the length of time required to conduct a

full psychiatric history and mental state examination (MSE), teaching sessions instead focus on one specific component of the patient interview, for example, assessing perceptual abnormalities or delusions, conducting a substance use history or exploring social circumstances and the functional impact of illness. This approach allows for more focussed feedback and teaching. Session structure is based upon Cox's model of bedside teaching, which I have modified slightly for the psychiatry setting.

Student feedback has been collected via an anonymous electronic end-of-block questionnaire.

Result. Qualitative feedback reveals that students in NHS Lanarkshire value bedside teaching, with one student describing it as "informative, comprehensive and relevant for upcoming exams and clinical practice".

There are a number of potential barriers to consider when delivering bedside teaching in psychiatry. These include issues identifying suitable patients who can provide informed consent to participate and the ethical concerns regarding exploring difficult subjects such as suicide risk assessment with patients for purely educational purposes.

These issues can be overcome; in inpatient units, there is usually a small cohort of patients who are able to consent and engage in student teaching, and difficult subjects can alternatively be addressed during role-play or simulation sessions.

Conclusion. Despite its challenges, bedside teaching can be an enjoyable and rewarding approach in undergraduate medical education, with feedback revealing it is positively received in NHS Lanarkshire. By utilising Cox's model and focussing on specific aspects of MSE and history-taking, bedside teaching is more accessible and an invaluable tool for psychiatric teaching. Clinicians and educators are encouraged to keep the patient at the centre of student learning.

Balint in the time of COVID-19: participant and facilitator experience of virtual Balint groups compared with in-person

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doi: 10.1192/bjo.2021.432

Aims. Our Trust increased Balint group provision, relocating virtually for psychiatry doctors to explore the emotional impact of clinical practice and doctor-patient relationships, during unfamiliar challenges of the pandemic. This unique context allowed comparison of multiple virtual and face-to-face (F2F) Balint-type group experiences for participants and facilitators.

Method. In March 2020, existing core trainee (CT) year 1 and 2, higher trainee (ST) and consultant Balint groups became virtual, with new CT3 and Speciality Doctor and Associate Specialist (SAS) virtual Balint groups established.

All 57 participants and 5 facilitators were sent an anonymous electronic survey to retrospectively rate virtual Balint (March-August 2020) and their preceding F2F Balint group (suggesting September 2019-February 2020) experience.

Result. The response rate was 89% for participants (51 respondents) and 100% for facilitators (5 respondents).

For group participants, 90% (virtual) and 78% (F2F) agreed or strongly agreed that Balint group provided an opportunity to explore challenging aspects of clinical work. 76% (virtual) and 71% (F2F) agreed or strongly agreed that it made them feel more supported. Almost 50% agreed or strongly agreed that virtual and F2F Balint group helped work feel less stressful. Both