Conference Booklet

Programme

Session #1	
9:15-09:25	**Welcome and introductions -** Dr Amar Shah
09:20	**Opening address** Satwinder Kaur, service user representative, RCPsych QI committee and QI coach
9:25-9:50	**Keynote presentation: Improvement during Covid and lessons for the next stage** Penny Pereira, Q Initiative Director, The Health Foundation
9:50-10:00	Question & Answer Session, facilitated by Dr Amar Shah
10:00-10:10	**Improving mealtimes for patients and staff within an eating disorder unit; understanding of the problem and interventions during the pandemic** Lucy Gardner and David Hunt
10:10-10:20	**Improving functioning of ward rounds on an inpatient rehabilitation ward** Dr Bojana Aleksic and Dr Rebecca Hatton
10:20-10:30	**Moving from peripheral project to integrated governance: Developing System Sustainability in Excellence Reporting** Dr Jennie Ledger and Dr Jessica Scott
10:30-10:45	Question & Answer Session, facilitated by Dr Amar Shah
10:45-11:15	Morning Break
Session #2	
11:15-11:20	**Welcome back and introductions** Dr Deepa Krishnan, RCPsych QI committee Trainee representative
11:20-11:30	**Improving the number of Family and Friends test responses in a community psychiatric rehabilitation team** Dr Jianan Bao
11:30-11:40	**Oakley court Watching: Saving Time, Money and Reducing Waste** Charlotte Bonser and Satwinder Kaur
11:40-11:50	**Local Academic Programme Online: A Quality Improvement Project** Dr Indira Vinjamuri and Dr Christopher Bu
11:50-12:10	Question & Answer Session
12:10-12:20	**Closing plenary: Reflections, what does this mean for the future of QI in mental health** Satwinder Kaur and Dr Deepa Krishnan

Speaker Abstracts and Biographies

Session#1 Chair

Dr Amar Shah

Consultant forensic psychiatrist & Chief Quality Officer at East London NHS Foundation Trust, and National improvement lead for mental health and chair of QI faculty (RCPsych); Faculty with the IHI; Hon Visiting Professor, City University (London) & University of Leicester.

Dr Amar Shah is Consultant forensic psychiatrist & Chief Quality Officer at East London NHS Foundation Trust (ELFT). He leads at executive and Board level at ELFT on quality, performance, strategy, planning and business intelligence. Amar has led the approach to quality at ELFT for the past 10 years, and has embedded a large-scale quality improvement infrastructure and quality management system, with demonstrable results across key areas of organisational performance. He is the national improvement lead for mental health at the Royal College of Psychiatrists, leading a number of large-scale improvement collaboratives on the topics of suicide prevention, restrictive practice and sexual safety. Amar is also chair of the quality improvement faculty at the Royal College of Psychiatrists. Amar is an improvement advisor and faculty member for the Institute for Healthcare Improvement, teaching and guiding improvers and healthcare systems across the world. He is honorary visiting professor at City University (London) and the University of Leicester. Amar has completed an executive MBA in healthcare management, a masters in mental health law and a postgraduate certificate in medical education. Amar is a regular national and international keynote speaker at healthcare improvement conferences and has published over 40 peer-review articles in the field of quality management.

Session#2 Chair

Dr Deepa Bagepalli Krishnan

Dr Deepa Bagepalli Krishnan is an academic ST6 trainee in East Midlands Deanery and a PhD student in University of Nottingham. Deepa's interests include quality improvement, leadership and medical education. Dr Bagepalli Krishnan is passionate about improving QI training and coaching doctors in leading QI projects. Deepa completed a two-year Leadership fellowship in Health Education England East Midlands and a Masters in Leadership for Health Professions from the University of Swansea. Deepa was part of the first cohort of RCPsych Leadership and Management fellowship scheme (2019/20). Dr Bagepalli Krishnan developed an interest in QI and leadership early in core psychiatry training and led several Trust level QI projects and set up QI training for doctors in the Nottinghamshire Healthcare NHS Foundation

Trust in collaboration with Trainees improving Patient safety through QI (TIPSQI). As a part of this scheme, they have trained more than 150 doctors. Dr Bagepalli Krishnan has completed the NHS improvement and ACT academy, Quality and Service improvement and redesign practitioner (QSIR) training programme. As a Psychiatric Trainees Committee (PTC) Trent division representative, Deepa is involved in the RCPsych QI Committee. Deepa is a Trustee and Honorary Treasurer of the Association of University Teachers of Psychiatry (AUTP). In this role, she has supported the AUTP team in organizing several National events/conferences and projects with an aim to promote high quality in undergraduate psychiatric education.

Keynote presentation: Improvement during Covid and lessons for the next stage.

Penny Pereira, Q Initiative Director, Improvement team | Q and Q Labs, The Health Foundation

Penny is the Deputy Director of Improvement and Programme Director of the Q initiative. She joined the Health Foundation in 2011. Before joining the Health Foundation, Penny worked at Newham University Healthcare NHS Trust in East London, where she was the Director of Strategy and Service Improvement. Penny has spent her career leading improvement work at local and national level in the NHS, with particular expertise in process and system redesign, leading strategic change across organisations, developing networks to support improvement, collaborative design and patient safety.

Improving mealtimes for patients and staff within an eating disorder unit; understanding of the problem and interventions during the pandemic

Lucy Gardner and David Hunt

Co-authors: Hayley Trueman, Ellen Tutisani Sharon Ryan Agnes Ayton

BACKGROUND: Mealtimes occur six times a day on eating disorder inpatient units and are a mainstay of treatment for eating disorders. However, these are often distressing and anxiety provoking times for patients and staff. A product of patients' distress is an increase in eating disorder behaviours specific to mealtimes. The aim of this quality improvement project was to decrease the number of eating disorder behaviours at mealtimes in the dining room through the implementation of initiatives identified through diagnostic work. METHODS: The Model for Improvement was used as the systematic approach for this project. Baseline assessment included observations in the dining room, gathering of qualitative feedback from staff and patients and the development of an eating disorder behaviours form used by patients and staff. The first change idea of a host role in the dining room was introduced, and the impact was assessed. A second change idea has also been implemented and we are currently looking at introducing a third. RESULTS: The introduction of the host role has reduced the average number of eating disorder

behaviours per patient in the dining room by 35%. Post-intervention feedback demonstrated that the introduction of the host role tackled the disorganisation and chaotic feeling in the dining room which in turn has reduced distress and anxiety for patients and staff. CONCLUSIONS: This paper shows the realities of a QI project on an eating disorder inpatient unit during the COVID 19 pandemic. The results are positive for changes made; however, a large challenge, as described has been staff engagement.

Lucy Gardner is a Specialist Eating Disorders Dietitian working at award winning Cotswold House Oxford eating disorders unit for adults. Previously she has worked in CAMHS, including outpatients and on a CAMHS inpatient unit, general mental health wards and prior to this was working for Imperial College Healthcare NHS Trust. Lucy's particular interests include CBT-e and using everyday research and audit to drive what we do.

Improving functioning of ward rounds on an inpatient rehabilitation ward

Dr Bojana Aleksic and Dr Rebecca Hatton

Co-authors: Dr Maja Ranger Dr Betty Xu Dr Bojana Aleksic Pavlina Papadopoulou Nick Bedford Sam Laryea Jess Merchant

What was the quality issue? The weekly ward round on Bluebell Lodge, an adult psychiatric inpatient rehabilitation unit, often significantly overran, to the dissatisfaction of both patients and staff members. The COVID-19 pandemic had added additional pressures regarding technology set up to ensure staff and family members could join virtually. The team wanted to improve efficiency and time keeping of ward round, without compromising on patient satisfaction. Who was in the team? The whole MDT was involved including doctors, nursing staff, music therapists, OT and psychologists. Weekly meetings were held, and we were supported by a QI coach to guide us through the process and ensure robust adherence to QI methodology. What did we do? Several change ideas were implemented including introducing new timings and making these available to patients and improving both room and technology set up. Staff began meeting with patients prior to the ward round to document what the patient wished to discuss in the review. This allowed a more focused but patient-centred agenda to be set in the ward round. Patient involvement An interactive QI board was set up in the patient area to inform patients of progress and ask for patients comments and ideas. Quick measures of patient satisfaction were taken weekly, and a more thorough pre and post project questionnaire was completed. Results From baseline of 0% of patients seen on time we are now regularly meeting or exceeding our target of at least 60%. However, there are still some weeks we fall short of the target. Next steps We plan to consolidate on current improvement and consider new change ideas to improve timings further. The project has reinforced the

benefit of patient involvement and we are considering other innovations such as patients having a greater role in running their own ward round.

Moving from peripheral project to integrated governance: Developing System Sustainability in Excellence Reporting

Dr Jennie Ledger and Dr Jessica Scott

Co-authors: Thomas Scobie Dr Helen Smith

Even prior to Covid-19 there was increasing recognition that healthy cultures within NHS organisations are key to delivering high-quality, safe care. (King's Fund) A focus towards developing systems which recognise and learn from excellence has been shown to improve services' safety and contribute to staff's morale (Kelly et al 2016) - issues pertinent during the pandemic. In late 2019 Secure Services developed an Excellence reporting system. Once successfully piloted, the intention was to extend to other departments - perinatal services the first. The aim was for the system to be embedded so staff could as quickly and instinctively report Excellence as they could an error. We developed our Theory of Change using Deming's theory of profound knowledge, ran a series of PDSAs, and introduced an Excellence system. We engaged early adopters, sent hand-written cards and shared data widely. Learning included understanding setting up the system, and the importance of a team rather than an individual holding the system. We took this forward to bring the system to Perinatal just as Covid-19 was dawning. We continued to run PDSAs. Across both sites staff were initially excited, reports submitted, feedback good, then a plateau and a slump. Despite an initial receptive atmosphere, something was stopping the system perpetuating. When staff received timely thanks, and others heard about it, staff would go on to promote excellence. However this was not possible without sufficient admin resources, something further stretched during Covid-19. We recognised the system's potential long-term impact on safety and staff morale, but we needed buy-in from those who allocate resources. In early 2021 data was presented to the Senior Directorate who recognised the value and agreed to support. Despite the many challenges of Covid-19, there has also been new-found flexibility to innovate; the pandemic allowed for a shake-up of values, and greater ease to negotiate, and instigate change.

Improving the number of Family and Friends test responses in a community psychiatric rehabilitation team

Dr Jianan Bao

Co-authors: Daksha Khunti, Dhiren Bohorun, Mehak Nagpal, Rory Ellwood, Stephanie Young

Background: The Family and Friends Test (FFT) gives patients an opportunity to provide feedback on their care. During the Covid-19 pandemic, paper tests were phased out and replaced with an online

questionnaire. Responses were initially very low, and so a quality improvement project was carried out to increase the number of responses. Most patients in our case load live in residential homes and we liaised with residential home carers to carry out this QIP Aim: Our primary aim was to increase the number of FFTs to 8 a month by July 2021 Methods: we carried out multiple PDSA cycles and kept a run chart of FFT numbers. Change ideas were identified during multidisciplinary meetings and by liaising with residential home carers. We identified ones that did not work in the past and voted on ones which we wanted to implement. Results: Prior to the QI project we collected around 1-2 responses FFT responses a month. Following the appointment of a FFT champion, responses increased to 8 per month. Multiple change ideas were implemented, including contacting residential homes about the FFT and weekly reminders at team meetings. This level of responses was sustained over the subsequent months. Reflections: 90% of patients required help in filling in their FFT responses, and residential home carers were crucial in doing this. One change idea identified with carers was for the FFT feedback to be incorporated into the annual CPA meeting progress report which carers were already completing. Although the number of FFT responses increased, there was little open-ended feedback that could be acted upon, and we reflect upon the difficulties in collecting meaningful feedback in this patient population

Oakley court Watching: Saving Time, Money and Reducing Waste

Charlotte Bonser and Satwinder Kaur

Co-authors: Anisah Khanum Elizabeth Thompson Charlotte Bonser Pauline Rochester

This piece of work reflects how the project team used QI methodology to save Time Money and Reduce waste enabling a 50% reduction in related spending. The project team came together through frustration of navigating a system that was inherently difficult to navigate. This developed a negative culture towards ordering clinical supplies resulting in waste of time and money. This is a story of courage to bring progress through practice of Quality improvement during the pandemic. This project is unique in that it embeds co-production, at the outset by empowering a first -time Lived Experience Coach to guide the team to use Quality Improvement. The project also involved an inpatient resident artist to draw the image for the change idea, to develop a behavioural shift in negative culture of ordering habits. The underlying factor that resulted in the successful outcome of this work was primarily the teamwork and commitment to keep up the pace of testing, data collection and maintaining a strong connected purpose to create a better process for ordering clinical supplies. 1. Weekly Tracking and Monitoring of orders. This has been implemented as part of business as usual. 2. A poster checklist for staff to be accountable for placing orders in a timely and cost- effective manner. The poster is a simple cost effective visual that has been scaled up and spread to other in-patient wards within the Trust. 3.A centralised stockroom, creating

greater efficiency and transparency to access clinical supplies required by in-patient staff. This change idea is progressing well and is reviewed on a regular basis to fine tune towards Quality Control.

The staff culture and behaviour towards ordering had become an issue on the Bedford & Luton Inpatient Wards. Together with a cumbersome procurement system which often led to price discrepancies and goods not arriving. The ward admin team felt strongly they wanted to change things and reduce wastage and overspend. We embarked on a Qi Project at the start of the pandemic. This project was a good example of co-production, working with a Coach with PPI experience and a service user who helped with one of our PDSA changes. The project ran for a year to April 2021 and impacted positively. We are continuing the good work, although the Qi Project is completed.

Charlotte Bonser: I started my working life in registry/clerical work admitting overseas students to the Luton College of HE, then went on to be the Faculty Administrative Officer for Applied Sciences, then PA to the Pro Vice Chancellor for Support Services (Student Welfare/Support/Accommodation/Catering and Estates/Facilities). I was also able to undertake some part-time study at this time and completed a BTEC HNC in Business Studies - Public Admin and Higher Certificate in Health Sciences with Psychology. In 2004, I changed directions and worked in the Third Sector, supporting volunteers/the public to have a voice in their health and care and to influence the commissioners and providers of these services. I am currently working for ELFT EA and Admin Lead for Bedford Inpatient Wards; I have been with the Trust since 2014.

Local Academic Programme Online: A Quality Improvement Project

Dr Indira Vinjamuri and Dr Christopher Bu

Aims and hypothesis To analyse the quality and satisfaction of our local Academic programme as delivered on a virtual platform since COVID-19 Background • As a result of COVID-19, education has changed dramatically, with the distinctive rise of e-learning, whereby teaching is undertaken remotely and on digital platforms. • Research suggests that online learning has been shown to increase retention of information, and take less time, meaning the changes coronavirus have caused might be here to stay. www.weforum.org • We had to deliver the mandatory MRCPsych course locally on a digital platform also, our chosen platform being zoom.org • We have attempted an analysis of the online delivery of the weekly local academic programme (LAP), reported here Method An online survey using Google forms was circulated to all LAP attendees including qualitative and quantitative questions about the virtual teaching. Attendance figures are collected weekly. Work was done with the Trust QI leads and we are on pdsa 4, making improvements along the way. Results Attendance on the virtual platform was significantly increased (mean values for face to face v virtual being 48 v 65; often about 80). Many appreciated the online chat function available to discuss issues and ask questions. Lack of need to travel, attend teaching

at a different site, ability to join even on zero days or whilst on nights were mentioned. A majority requested aspects of virtual teaching to remain available even after pandemic situation improves. 18% reported accessibility issues, some missed interacting with others during teaching and those sessions needing group discussion (e.g. journal club) were not satisfactorily captured by breakout groups on Zoom. Overall, teaching was reported to be well structured and our efforts much appreciated. Changes with the different pdsas will also be reported. Conclusions The online platform allowed our LAP to proceed smoothly with no gaps throughout 2020. Attendance was higher than usual and participation high. Technology and accessibility were noted to be difficult for a minority. Recommendations and improvements We have worked towards improving accessibility for all and attendance at current semester has been >90 per session. Efforts have been made to improve sessions needing group work, especially journal clubs by change of format. A trainee LAP lead has been appointed to support learning and improve satisfaction from virtual learning which has been received very positively. Clear instructions and expectations for online learning have been disseminated and the satisfaction survey will be repeated regularly to improve the programme.

Dr Indira Vinjamuri is a Consultant Psychiatrist working within a CRHT in Liverpool. She is the DME at Mersey Care NHS Trust and lead for the Local Academic Programme. She is Chair of the RCPsych General Adult Specialist Advisory Committee.

Poster Abstracts

1. Implementing traffic light system on Multidisciplinary Task List

Dr Ayesha Ahmad, Rupesh Adimulam, Consultant Ayesha Ahmad, SpR, Presenter Derya Nurlu, CT1

Motivation: During 2020-2021 covid -19 pandemic period, We, as a team, faced many struggles. These included low numbers of staff members due to sickness, increased amount of e-mails which were hard to catch up, decreased efficiency as a result and the questions of families regarding when they could see their relatives and how they could be part of ward reviews. One other reason why we wanted to implement this change was that to improve communication between professionals on the ward in crisis situation, robust actions with help of traffic light system and hence preventing delayed discharges which we faced during pandemic period. Methodology : First of all, we liaised with our IT department to grant access to all professionals for shared drives we created. This access was given to staff nurses, OT/PT teams, psychologists, doctors and ward secretaries who are working in our ward. Then we created a shared document which can be amended as the jobs get done. Under the name of every team, we documented what needs to be done during our weekly ward reviews which we conducted with one of the staff nurses. If the task is newly created we would put in a red box to highlight that it was newly decided and also to draw attention to it. We also asked every team to change this red colour into amber when they acknowledged the task. This also meant that they are working on it. As a last step, we wanted them to turn the amber box into green when they are finished with the task. This reduced immense time in reading/sending emails to other team members and chasing the results. It specially helped in covid as other team members who took over work of sick staff would know what was being done without lengthy handovers.

2. Quality Improvement in Video Consulting: Phase 2 Findings of the Welsh National Evaluation

Professor Alka Ahuja, Lees, M., Whistance, B and Johns, G.

Background: In March 2020, when the COVID-19 pandemic emerged, Technology Enabled Care (TEC) Cymru went into partnership with the Welsh Government and CWTCH Cymru to offer a safe solution to protect the NHS and the public by developing a new National Video Consulting (VC) Service on an 'All-Speciality, All-Wales' basis. Aim: The aim was to develop, roll-out and robustly evaluate a new Video Consulting Service across all primary, secondary and community care services in NHS Wales, and then into care homes, dentistry, optometry and pharmacy, and to understand its 'use', 'value', 'benefits' and 'challenges' to patients, families and clinicians. Methods The service adopted a quality improvement approach to capturing mixed methodology data of surveys, interviews, focus groups, photo research and more. The real-time and iterative quality improvement approach was invaluable as findings continually informed the approach and direction. Results: Based upon more than 45,000 participants, the results demonstrate that video consulting is consistently high in satisfaction, clinical suitability and acceptability across a range of patient demographics and clinical specialties in Wales. The key findings are: •

Large scale, national data over one year. • High in patient and clinician satisfaction (higher in patients). • Clinically suitable across specialties, care sectors and Health Boards/Trusts. • Consistent data patterns across clinical settings and patient demographics (age, gender, ethnicity, household income, disability, urban/rural location). • High acceptability of VC, which is believed to be associated to the 'Welsh Way' of digital implementation processes and combined expertise. Discussion: There is large appetite for video consultations in Wales, with high potential of sustainability and long-term use. The service is now working closely with local, national and international stakeholders, academics, clinical teams and policy makers to explore the long-term use and sustainability of video consultations in Wales, and together are starting to test efficacy and effectiveness in their Phase 3 research.

3. Mental Health Services during the COVID-19 Pandemic in Abu Dhabi, UAE

Aisha Al Dhufairi, Mohamed Al Garhy, Hadir AbdulRahmand

Introduction We describe the experience of the largest admitting psychiatric facility in the capital city of united Arab Emirates, Abu Dhabi in managing patients with mental disorders during a pandemics. • Outpatient clinic department Implementation of Tele-assessment, Basic sanitation and social distancing guidelines were the major changes. face to face assessment was restricted to newly referred patients or, if requested. Medication home delivery was initiated, by mental health professionals at patients' homes. There was 20% drop in clinic visits compared to 2019, specially in geriatric and in child psychiatry clinics. • Inpatient service Mental health staff were equipped and trained to use PPEs. All admissions were screened with a PCR test10 11. One inaptient unit was converted into an isolation ward for suspected and confirmed COVID-19 cases. Integrated teams with internal medicine managed those cases. From March to June 2020, the facility treated 33 COVID-19 patients with simultaneous psychiatric conditions. There was a drop, 20-40%, in admission rates and Psychiatric ER visits compared to 2019. • Liaison consultation service-LC Expansion of medical services during the COVID-19 pandemic and the added emergence of several quarantine centers and field hospitals dedicated to COVID-19 patients led to a 52% increase in psychiatry consultation. Patients were triaged over the phone and assigned to different categories based on the urgency. • Psychology and Social workers Psychosocial service was initially limited to cases at imminent psychiatric risk in BSP inpatient and outpatient departments. Psychosocial staff focused on COVID-19 related support programs, including a public awareness and education service to the community via a toll-free number, in addition to novel supportive services for COVID-19 admitted cases in the general hospital and healthcare workers during the pandemic.

4. The impact of the first wave of the covid-19 pandemic on health workers in Old Age Psychiatry

Dr Clearine Alexander, Dr. Smita Saxena - Consultant Psychiatrist Dr. Adebayo Adeoti – MTI Doctor Dr Abigail Robinson – Clinical Psychologist Neil Srivastava – Medical student

Background COVID-19 is caused by severe Acute respiratory syndrome coronavirus 2. In December 2019, the first COVID-19 outbreak emerged in Wuhan, the Hubei province of China. Currently, the pandemic has spread to 198 countries. As per the 9 February 2021, WHO recorded 106,125,682 confirmed cases of

COVID-19, including 2,320,497 deaths. Health workers have not only had increased workloads as a result of the COVID-19 pandemic, but they are faced with increased physical and psychosocial issues linked to their roles in patient care. This also include an increased risk of infection and death due repeated exposure to patients. Objectives To determine the impact of the first wave of the COVID-19 pandemic on NHS Health workers in Old Age Psychiatry at Walton hospital from April to August 2020. Method A 27-question paper survey was anonymously completed by Walton Hospital staff over a 5-month period. Also, reviews of online literature related to the effect of the COVID19 pandemic on healthcare staff was done. Conclusion · This study demonstrated that health workers were faced with physical and psychological distress and increased workloads in the first wave of the COVID-19 pandemic. · Although support from the Trust was available, almost half of the staff were not aware of this. This shows an urgent need to provide adequate support for the wellbeing of NHS health workers. Recommendations · Reflective practice groups and psychological first aid · Increase the availability of clinical supervision if required · Regular staff breaks during work hours · Increase the awareness of support systems at work and externally ·Provide Nursing and HCA staff with training in physical health · Highlight the role of the Freedom to Speak Up Guardian · Repeat the survey with staff, once support mechanisms are implemented, to determine the effectiveness and staff response.

5. Audit for gatekeeping assessments done by IHBTT from December 2020 till January 2021 (to see the progress during pandemic effected months)

Dr Taha Anjum, Dr Chandrashekar Bachu

Audit for gatekeeping assessments done by IHBTT from December 2020 till January 2021 (to see the progress during pandemic effected months) Introduction: · The trust policy for gatekeeping assessments says that: Service users requiring admission to an acute inpatient bed should be assessed (face to face) by the Intensive Home Based Treatment (IHBT) teams or its equivalent as 'gatekeepers'. December's gatekeeping assessments showed 93% of assessments were carried out face to face. The 7% of assessment that was not carried out face to face had the following presentation: · Service user declined any further assessment and had the capacity to consent for treatment. Simultaneously showed improvement · Presentation again changed very quickly necessitating MHA · AMHP liaised with KHBTT over the phone. Face to face assessment for gatekeeping didn't happen. Patient was admitted under section 2 of MHA. January's gatekeeping: 88% of assessments were carried out face to face Cases where gatekeeping did not take place face to face · Very frequent history of admission to mental health hospital. Current admission was after assessment on MAU following an impulsive overdose · Well known to mental health services with a diagnosis of Paranoid Schizophrenia. Current admission under section 2 of MHA following deterioration after stopping clozapine. AMHP contacted IHBTT to request bed identification and gatekeeping. Overall impression · Results are promising and guidelines are being followed even during the pandemic which reflects co-ordinated team effort. · However, the room for improvement exists albeit the factors mentioned that make face to face

assessments not practically possible for IHBTT • It would be useful to include similar criteria across all teams to have a uniformity of pre admission assessments.

6. Driving and dementia

Dr Irum Bibi, Manorama Bhattarai

Introduction: Driving is not a simple task and involve thinking, hearing, vision and motor skills. The ability to drive can be effected by dementia. The diagnosis of dementia is not an absolute contraindication to driving but it needs to notify to driving and vehicle licencing authority (DVLA). It is the responsibility of the health professionals to discuss this with the patients so that they inform DVLA and safety measures in place. Method: We carried out a retrospective audit by using the electronic record of patients with a diagnosis of dementia in order to check whether the patients with the diagnosis of dementia was given advice about notifying DVLA and whether it was documented in the clinic letter. Results: 50 patients (29 females and 21 males) were chosen randomly from the last 2 years data of 2020 and 2021, and their clinic letters checked. 39 patients (78%) were already not driving at the time of diagnosis, while 11(22%) patients were driving at the time of diagnosis. Of these 11 patients 9(82%) were advised about notifying DVLA and this was documented while 2(18%) were not advised and this was not documented in the clinic letters. Conclusion: Dementia can potentially effects the ability to drive safely and accidents can occur. It should be a safe practice to advise all patients with diagnosis of dementia to notify to DVLA and this need to communicated verbally and in written to the patients and their families.

7. Improving Responses to Medical Emergencies in Forensic Psychiatry during the COVID19 Pandemic

Dr Angharad Campbell, Dr Tracy Chan, FY2, NHS Lanarkshire Dr Fiona Mohammad, Consultant in Forensic Psychiatry, NHS Lanarkshire

Introduction There are almost 500 current inpatients within Scotland's Forensic Mental Health Services. These complex patients have a disproportionately high burden of physical health co-morbidities. The Resuscitation Council (UK) advises that mental health facilities should be able to respond to medical emergencies with adequate skill and equipment. This is especially important given the distance that many psychiatric facilities are from secondary or tertiary medical facilities. The vulnerability of this patient group to COVID-19 has highlighted the importance of effective medical responses to critically unwell patients. Methods The initial stages of this project comprised an audit of the availability and suitability of on-site medical emergency equipment, and a staff survey to assess knowledge and confidence in managing medical emergencies. A multi-disciplinary Short Life Working Group was established to co-ordinate this work. The Group is now developing a new Standard Operating Procedure (SOP) for managing medical emergencies. This will be combined with a training programme for staff. Results The equipment audit identified some areas of variance from clinical guidance in relation to medication formulations and appropriateness of equipment for the clinical area. Following this, additional Automated External Defibrillators (AEDs) have been provided, and the medical emergency equipment bags are being

updated. There were 27 responses to the staff survey, which were proportionately distributed across on-site services and disciplines. A need for further training for all staff was identified, in order to develop skills in managing medical emergencies. It was highlighted that the relatively infrequent nature of such events was a factor in maintaining these skills. Conclusion There is a lack of clear and bespoke protocols for the management of medical emergencies in Forensic Psychiatric Services in Scotland. Further quality improvement work is ongoing in NHS Lanarkshire to improve training, equipment and guidance to this end.

8. Establish a process to maximise patient safety in making psychotropic medication reductions related to STOMP (Stopping over-medication in people with learning disability, ASD or both) during COVID -19 pandemic for patients with Intellectual disability

Dr Anushka Dissanayake, Dr Nicholas Davey Dr Rupal Patel Paul Shanahan Samantha Berge

Establish a process to maximise patient safety in making psychotropic medication reductions related to STOMP (Stopping over-medication in people with learning disability, ASD or both) during COVID -19 pandemic for patients with Intellectual disability in Richmond Neuro-Developmental Service. This quality improvement project was designed during the COVID-19 pandemic to overcome the challenges we faced in implementing STOMP initiatives for patients with Intellectual disability. STOMP is a national initiative launched in 2016 to help clients with Intellectual disability who are taking psychotropic medicines for the right reasons and to ensure that they are not overmedicated. Even before the COVID-19 pandemic, there were challenges in carrying out STOMP initiatives, especially when reducing the psychotropic medications as these clients have been on these psychotropic medications for many years. However, after COVID-19 pandemic there were much more reluctance from care homes and families for the psychotropic medications to be reduced by professionals in fear that with the this changes the clients may become more unsettled and not knowing how they will cope with these challenges. We conducted focus groups with the care homes to identify the challenges in reducing medications on stable patients who were on psychotropic medications, where there was potential to reduce the medication. We then collated this information and designed a Standard Operating Procedure (SOP) with detailed guidance on how to reduce psychotropic medications in stable patients in safe manner. This SOP will be implemented for clients who meet the criteria for psychotropic medication reduction. The progress will be monitored to see if this process will help to overcome the challenges that were imminent during COVID-19 pandemic.

9. “I would like to understand more": Developing a Carer Support Programme at Robin Pinto Unit

Becky Grace, Dion McNicolls, Zaliya Musah, Omolola Oginni, Laurencia Chirapa

Robin Pinto Unit (RPU) is an 18-bed, low secure NHS forensic mental health ward in Bedfordshire. In order to better meet QNFMHS Standard 53 for Forensic Mental Health Services (Carers have access to a carer support network or group) and improve the quality of support for carers of patients at RPU, a multidisciplinary working group was formed with staff from across the unit. Drawing on co-production

principles, carers were contacted (n = 9), and telephone interviews were conducted with those agreeing to act as consultants (n = 6). Patients were consulted at a community meeting (n = 9), highlighting potential accessibility issues for carers. Following these discussions, a Carer Support Programme is being launched at RPU during Carers Week 2021. The pilot will comprise monthly 90-minute sessions, for three months. The first half of each session will have a psychoeducational theme (chosen to be responsive to carers' requests); with the first session exploring relapse prevention. Future sessions will include multi-agency working, with agreements in place with local carer support charities and a charity supporting people with housing and benefits. The second half of each session will involve peer support. Carers expressed the importance of sessions being friendly and informal, with a preference for in-person support. RPU is able to facilitate sessions in a socially-distanced manner and remote attendance will also be possible for carers or speakers. Qualitative and quantitative feedback will be sought after each session, with the aim of developing a future long-term programme supported by the multidisciplinary team. This presentation will outline the development of this quality improvement project, reflect the challenges and successes we encounter, and discuss future plans. It is hoped that attendees will be able to draw on this learning to support quality improvement projects for carers in their own services.

10. Quality improvement project realted to the process of handover on transfering inpatients between psychiatric wards

Dr Mohamed Hamid, Lead: Mohamed Hamid Participated in data collection: Dr Mythreyi Thepar Dr Rehma Ahmed Dr Mohammed Hossain Dr Joana Male

Since COVID 19 pandemic, acute mental health admissions were initially in 2 main admission wards for Adult and old age mental health inpatients, then after satisfaction of negative COVID tests and an isolation period patients are tranferred to their main wards, this resulted in missing a few physical and mental health issues due to change of care teams and there was no clear standards of a handover process to ensure continuity of care. This is a quality improvement project aiming at improving the standards of handover on transfering patients in both adult and old age inpatient wards. Initially we collected data regarding the presence or absence of a medic handover for 60 patients and the degree of covering important topics in the handover. A newly created checklist made by junior doctors and consultants was used to compare the current practice against the desidred standards. Then the checklist was implemented, then we collected the data again with a noticeable improvement observed in the total number and the quality of the handover. We are currently closing the loop and doing a re-AUDIT and the project will be finalized by the end of May 2021, this will be followed by writing of final conclusions and discussion of the findings in the local trust teaching meeting and to make further recommendations to raise the quality of handover and ensure consistency of implementing the checklist, especially when junior doctors changeover during each rotation.

11. Improving the quality of liaison psychiatry inpatient referrals for low mood on wards A512 and A528 at the Bristol Royal Infirmary.

Dr Olga Karkanevatos, supervised by Consultant Dr Jonathan Olds

When I rotated to the covid care of the elderly ward for my second FY1 rotation, I realised many patients were struggling with the effects of the pandemic – initially being isolated in their homes and now isolated on a hospital ward for weeks, sometimes months, with no visitors allowed. We seemed to be making a lot of referrals to the liaison psychiatry department for low mood. The referral process is via the trust online system, and when I spoke to one of the liaison psychiatry consultants he mentioned that most referrals had similar brief information, usually details such as "not engaging, low mood" but not much else. Now that the frequency of referrals had increased, this made it very difficult to prioritise patients based on urgency. Therefore, I carried out a project to improve the quality of referrals on my ward and another ward, by encouraging healthcare staff to include the ICD-10 criteria in their referrals. A patient meeting a higher number of criteria would better indicate they were higher risk and needed urgent assessment. I encouraged referrers to include the ICD-10 criteria in their referrals through putting up posters and educating staff every 2 weeks for the first month followed by every 4 weeks. I analysed the referrals before and after this intervention, and found a positive change in number of ICD-10 criteria mentioned pre and post intervention: Pre-intervention (31/10/20 – 30/12/20) 8 referrals: 3 or less criteria mentioned: 8 4-6: 0 7-10: 0 Post-intervention (18/01/21 – 10/05/21) 8 referrals: 3 or less criteria mentioned: 4 4-6: 4 7-10: 0 Going forward, I would like to make this intervention more long-lasting, for example by altering the online referral form to include mandatory inclusion of ICD criteria. This would then mean I could extend the intervention to other wards in the hospital.

12. High dose and combined anti-psychotic medication monitoring in the physical health clinic

Umama Khan, Tracey Green, Senior Mental Health Pharmacist Dr Banerjee, Senior House Officer

Background: High dose antipsychotic treatment (HDAT) should be initiated only when standard treatments have failed, as it can cause serious side effects including sudden death. Close monitoring and documentation are essential, as is reviewing patients regularly as per NICE guidelines. Method: Retrospective audit of fifty case notes of patients under the Community Mental Health Team (CMHT) were randomly selected and analysed with ensuing presentation to the Quality Meeting of the Mental Health Directorate. This led to service development of regular physical health patient monitoring. Audit data showed areas of good practice; most patients being on monotherapy (90%). All patients on high dose or combined antipsychotics had clear management plans as outlined in their clinical records. However, the audit highlighted areas that needed improvement, for example regular physical health monitoring. From February 2020, patients on HDAT were reviewed at a physical health clinic. Blood pressure, pulse, temperature, ECG and blood tests including urea and electrolytes and liver function tests were done every three months. Clinical progress was monitored using the Glasgow Antipsychotic Side effect Scale (GASS). There were a few instances, identified by key workers, which required home assessments, so from November 2020, physical health assessments of patients unable to travel because of physical and mental health problems were seen at home. Findings were recorded on the electronic system and communicated to General Practitioners. In our service, Covid -19 impacted physical health monitoring;

monitoring was reduced for a couple of months and all home visits were postponed during lockdown. Over the course of the year, as the project has developed, we have recruited an Associate Specialist who assesses HDAT patients regularly. Conclusion: Regular physical reviews of patients on High Dose Antipsychotic Treatments are essential and can be integrated successfully into currently available mental health services within an audit cycle.

13. Developing Occupational Therapy Led Interventions in a Memory Clinic During a Pandemic

Judith Kimber

Prior to the pandemic Occupational Therapy led interventions in the Anglesey and Gwynedd Memory Clinic were being reviewed and developed in order to respond to the large rural geographical region covered, variable group uptake, resources and skill mix within the team, current recommendations of evidenced based practice, and in response to feedback from service users and their supporters. Planned roll out of the Home Based Memory Rehabilitation Programme (HBMR), group and individual Cognitive Stimulation Therapy (CST) at the start of 2020 was cancelled due to service suspension and staff redeployment. On resuming the service under a new hybrid model in May 2020, this was revisited. Given the Alzheimer's Society Covid-19 Impact Report (2020) on the detrimental effects of the pandemic and our own experiences of working again with our client group it was felt essential that the service was able to proceed with developments in order to best support our service users. ICST was piloted using remote methods, either telephone or video call, with feedback gained from service users and their supporters at every stage in order to refine the process. This has now been rolled out as an active offer of post diagnostic intervention, in Welsh and English languages, and run by experienced health care support workers under OT supervision. Feedback has been extremely positive, with clients' confidence, language skills, autonomy and engagement notably improving as the sessions progress. The HBMRP was also piloted using remote methods and continues to run bridging as a pre-post diagnostic intervention led by OT. Client feedback has been positive, with weekly goals set working towards improved confidence and independence. The intervention programmes have provided enhanced opportunity to offer active ongoing support, and to encourage continued engagement on their conclusion through appropriate signposting to local tertiary and commissioned services.

14. Improving cardiovascular monitoring for older adult patients on anti-psychotic medication by using domiciliary 12-lead ECGs

Dr Rachel Levett, Raymond Leemon (RMN)

Many antipsychotic medications are known to prolong the QTc interval, leading to an increased risk of arrhythmias and even sudden cardiac death. This is just one of the reasons for the life expectancy being 15-20 years lower in those that have severe mental illness (SMI) and those that do not. NICE recommend that ideally every patient on antipsychotic medications will receive an annual ECG. Despite this, even vulnerable older adult patients do not receive adequate cardiovascular monitoring and this has been a particular challenge during the covid pandemic. In our community mental health team, in a sample of 38

care-coordinated patients on antipsychotic medications in April 2021, only 12 (32%) had a recorded ECG within the last year. We aim to improve the compliance with the recommended annual ECGs to 75% by the start of August 2021. Many barriers were identified from discussions with service users and colleagues such as: • Many housebound patients who have difficulty attending appointments arranged for them by GPs, partcularly during the covid pandemic • Lack of knowledge amongst patients as well as staff about the requirement • Availability of trained staff to perform ECGs • Lack of record transfer between mental health services, GPs and acute hospitals (where we acknowledge many of our patients will be receiving ECGs unknown to us) We hope to address some of these factors by training care co-ordinators (nurses, occupational therapists and social workers) to use a portable ECG machine on domiciliary visits for some of their patients in combination with making requests of GPs, and setting up an administrative system to ensure future compliance is tracked.

15. Using Microsoft teams to improve the management of physical heath in older age psychiatric inpatients

Dr Katie Lockwood, Dr. Simon Davidson Dr. Catherine Railton

Old age psychiatry patients often have complex physical health needs. Several reports, including one commissioned by the King's fund and another by the Royal College of Psychiatrists, highlighted the importance of moving towards an integrated model of care; with a focus on viewing mental health admissions as an opportunity to improve the physical and mental wellbeing of psychiatric patients. Nurses working within old age psychiatry often have limited physical health training and may feel under-equipped to do this. In addition, the doctors overseeing care may have outdated medical knowledge. This could contribute to delays in diagnosis and in accessing care; ultimately leading to poorer treatment outcomes, increased emergency admission and longer lengths of stay. The Coronavirus pandemic has raised additional challenges. At times, one has needed to question the appropriateness of transfer to the acute hospital considering the potential risks of spreading the virus. The ability to safely assess physical health problems on a psychiatric inpatient ward is thefore even more important. We utilised the boom in the use of remote teaching via MS Teams to provide dermatology teaching. Skin disease is associated with many systemic diseases and can cause significant physical and psychological morbidity. The initial session focused on the management of red legs, which is a common problem in older people and has a broad differential diagnosis. For example, bilateral red legs are seldom caused by cellulitis but are often misdiagnosed as such; resulting in inappropriate use of antibiotics, delays in correct diagnosis, and risk of causing harm. Teaching was provided by a medical trainee, in conjunction with a tissue viability nurse and delivered during the monthly learning and improvement group. We used a pre and post teaching questionnaire to assess the value added from this session, with a view to providing more in the future.

16. Piloting a digital junior doctor handover

Dr Phoebe Lyons, Dr Mirza Beg Dr Ayesha Rahim

Effective handover between health professionals improves efficiency and reduces adverse events thereby improving patient safety. Within the trust a number of difficulties with the existing process for handover had been raised at junior doctor forums. A period of consultation was undertaken to explore the underlying problems through these forums, focussed interviews with representatives, as well as a survey being completed by all junior doctors at the selected pilot site. This feedback was then used to do a cause and effect analysis, allowing meaningful interventions to be planned. It was identified that a digital handover format would provide a potential solution to a number of issues, including the handover being able to be accessed by those working off-site. Due to its functionality Microsoft Teams was used as the software to host the handover files. The digital handover was implemented as an initial trial, with further feedback obtained in order to improve the process. The aim was to roll this out across the trust.

17. Looking at missed opportunities in prescribing of anti-dementia medications

Dr Palwasha Mukhtar, Dr. Bronwen King

The aim of the project was to look for missed opportunities in the provision of ideal care in terms of treatment for patients with dementia. This was carried out by retrospective examination of clinical letters for patients referred to the Older Peoples Crisis Team within a specific time period with an existing diagnosis of dementia and not started on any treatment. There was a total of 28 referrals received by the team, and 1 patient was excluded for not fulfilling the criteria. Of the remaining 27, 16 patients had already been started on cognitive enhancers by the diagnosing team. Of the remaining 11 patients: -4 had an initial diagnosis of vascular dementia of which, 3 patients were felt by our team to have an actual diagnosis of mixed dementia and started on cognitive enhancers. -3 patients had previously been tried on various cognitive enhancers which were discontinued because of either side effects or the medication being ineffective. -1 patient had an initial diagnosis of mild cognitive impairment and was started on rivastigmine after being referred to our team. -No reason could be identified for 2 patients not on any cognitive enhancers. Both were started on memantine. -1 patient had initially been started on donepezil which had to be stopped due to a heart problem. However, after he received a pacemaker, it was recommended this could be restarted, but was noted not to be. NICE recommends early prescribing of cognitive enhancing medication if a decision has been made to start a drug therapy for dementia in the primary or secondary care. We feel that by missing the opportunity of prescribing these to the eligible patients, they are at a disadvantage in no intervention being taken in delaying the disease progression and missing out on years of potentially good quality life.

18. Reducing restraints in inpatient units - summary of pilot evaluation audit and proposed mixed methods research

Dr Sophia Pillai

Background; Restrictive practice (include physical restraint, seclusion or chemical restraint) is widely known to occur as part of practice in mental health inpatient settings, but guidelines recommend physical restraint should be only used as a last resort in situations where if de-escalation or other

preventative strategies have failed, people may be a risk to themselves or others (NICE, 2005) Department of Health recent guidance on positive and proactive care on reduction of the restrictive interventions recommends involving patients and families in planning care, leadership and accountability, transparency and accuracy of data on progress against restrictive interventions, and monitoring on compliance with the regulations on the use of restraints. Aim; The authors carried out pilot audit during three month period in 2020, to evaluate the practise of restraints across five acute adult and rehabilitation inpatient units in LPFT. The findings has instilled interest to carry out research to identify factors such as social, clinical and demographic associated with restrictive practice. Methodology; The project involved devising a tool for audit to measure data from RIO inpatient records on type and duration of the restraint, timing and precursor, whether verbal de-escalation tried, use of prn medication, outcome of restraint, post incident reporting and reflection that include positive behavioural support planning and recurrence of restraints. Proposed research will involve quantitative and qualitative research designs latter involving focus groups and semi-structured interviews with patients and families who have either been involved or witnessed restraints while as an inpatient. Results; The overall number of restraint that occurred during the three month period in 2020 was of 256. The main results indicated that there were 30% of restraints occurred without involving verbal de-escalation measures, duration of the restraint was not recorded in 20% of restraints that included prone restraints, and about 60% restraints did not have positive behavioural support or collaborative care planning with patients or carers. Action / recommendation for implementation; 1. Clinical audit data measuring data on restraints to be presented regularly in monthly inpatient MDT meeting, trainings to reduce restrictive practice , clinical directorate, and board meetings , creation of visual dash board 2. Authors planned research will identify patients are at greater risk, and service related issues that can be modified to promote positive therapeutic environment reducing the risk of restrictive practice.

19. Screening and management of Covid-19 in a psychiatry inpatient hospital

Dr Shambhavi Pranoy, Dr Shambhavi Pranoy, FY1

I would like to nominate my QI project that I single-handedly designed and led, after experiencing first-hand a need for updated Covid-19 related guidance for junior doctors at the Redwoods Centre (Psychiatry inpatient hospital). I undertook 5 PDSA cycles and communicated with a variety of professionals from different areas of the MDT to create a robust guide that promotes holistic care. It was identified that Covid-19 guidance for junior doctors in the Redwoods Centre (Psychiatry inpatient hospital) had not been updated in the past 12 months. The aim of this project was to limit time wasted in seeking advice from various sources and keep the guide updated. This was crucial as Covid-19 management and protocols are constantly evolving as we learn more about the virus and as the country goes through different phases of the pandemic. Baseline data showed that 67% of the junior doctor cohort found the guide only “somewhat helpful” or “somewhat unhelpful”. Feedback showed 92% more junior doctors find the new guide “very helpful” and up to date. As an FY1 this was a challenging project to complete within a short time-frame, particularly since I had been told by peers that an FY1 cannot create/update guidelines for a

hospital. I would like this project to be shared with the cohort as an example that the label of "foundation doctor" should not and does not limit our capabilities and to encourage my colleagues that taking part in quality improvement projects can lead to marked change, even in the short term. Many thanks for your consideration.

20. Patient and carer experience and satisfaction with remote memory assessment during COVID-19 pandemic

Gosia Raczek, Dr Stephanie Daley Dr Nicholas Farina Ms Emma Porter

Background: The suspension of memory services during the COVID-19 pandemic delayed dementia diagnosis and access to early intervention. Our service responded to the challenge by developing a remote memory assessment pathway to comply with reduced social contact measures to protect vulnerable patients. We designed a study to establish whether remote model is a satisfactory experience within the context of the COVID-19 pandemic and to understand factors associated with patient and carer satisfaction of remote pathway. Method: 73 participants recruited from patients referred to memory clinics in West Sussex, Surrey and South London, who were assessed over a video or telephone. Participants completed an 11-item questionnaire capturing satisfaction across a range of elements, contextual items (the impact of the pandemic, loneliness, previous experience of using teleconference technology and diagnosis), as well as 3 dimensions from Patient Experience Questionnaire. Results: 73 participants were typically older adults (M=68.5, SD=13.3) and female (n=40, 54.8%). The patient was more likely to be older, feel lonely and to have used video call software when compared to the carer ($p > 0.05$). Participants were generally satisfied with the remote pathway with 95.8% (n=69) agreeing or strongly agreeing with the statement “Overall, I was satisfied with the assessment”. Patients and carers did not significantly differ on any satisfaction response, apart from the ease of use of technology, in which carers were more likely to find the technology easy to use. Worry about contracting COVID and communication experience was positively associated with overall satisfaction, whilst perceived communication barriers were significantly negatively associated with overall satisfaction. Conclusions: remote memory assessment was a positive and satisfactory experience for most patient and carers. The remote pathway should be considered as an option available during and beyond the pandemic to improve access and patient choice of assessment modality.

21. The Cygnet Journal- Encouraging staff and service user participation in quality improvement

Naresh Rasquinha, Raf Hamaizia, Sarah Ashworth, Bobbie Turnbull

Background: The Cygnet Journal is a co-produced peer reviewed journal due to be published in August 2021 and as far as we are aware, it will be the first peer reviewed journal published by a mental health provider in the UK. Aim: To ensure that Quality improvement(QI) projects, innovative practices, research, audits etc completed by staff and patients within the organisation is published in the Cygnet Journal and best practice shared in order to improve quality, avoid duplication and increase efficiency across the organisation. It is expected that the journal would encourage and increase staff and patient

involvement in QI projects and other academic projects. Methods: The Cygnet Journal editorial board was established in January 2021. It includes 3 staff members and the Expert by experience lead (Patient representative). The editorial board has been meeting regularly since then and introducing and testing out changes using the PDSA cycle. Information regarding the journal was published on the organisation's intranet in February 2021. There was a call for peer reviewers and a deadline for submissions with instructions for authors attached. Results: There has been overwhelming response to the journal. We received a large number of peer reviewer applications from staff and we appointed the peer reviewer team in March 2021. We currently have 14 peer reviewers from various disciplines(1 support worker, 1 nurse, 2 occupational therapists, 2 occupational therapy assistants, 2 psychologists, 2 psychology assistants, 2 specialty doctors and 2 consultant psychiatrists). The double blind peer review process was also established and a peer reviewer template developed. We have received a large number of submissions related to QI, audits, research, patient led projects, expert opinions and innovative practices that are going through the anonymised peer review process. The Cygnet journal is expected to be published online and in print in August 2021. Word count: 300 words

22. Enhanced physical care: Covid -19 Remote Inpatient Support Team (CRIST)

Jonathan Richardson, Dr Bruce Owen Dr Joe Thorne Rachel Bryce Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW)

CNTW already has Standards for the Assessment and Management of Physical Health; which were developed as People with a Learning Disability or Mental Health problems are more likely than other citizens to have significant health risks and develop major physical health problems. https://www.cntw.nhs.uk/about/policies/trust-standard-assessment-management-physical-health-policy/ There was also collated guidance within the CNTW Covid-19 workbook https://weblive.ntw.nhs.uk/COVID19_resources/?index&=view_cards&id=2 From discussions with inpatient teams we were aware that managing patients within inpatient services who were Covid -19 positive can create significant challenges. This was a particular issue out of hours where there is reduced access to support, and many of the services providing this out of hours support are under significant pressure. With this is in mind the Covid-19 remote inpatient support team (CRIST) was established for Inpatients with Covid-19 within CNTW. CRIST aimed to provide support to ward/teams dealing with patient who are Covid-19 positive, and ensure physical health needs are discussed and a plan is in place. The CRIST was a multi-disciplinary team and has number of senior clinicians, both medical and nursing from a number of specialties. The main role of the CRIST was to provide support on daily basis during the weekend to inpatients diagnosed with Covid-19. This allowed the ward team to review patients with diagnosed with Covid-19 with a team of clinicians at weekends without routinely needing to link with first on call medical staff. The intention was for the CRIST to support wards to review current physical health needs, provide guidance on restraint and segregation for non-cooperation with physical health care checks and provide guidance on IPC. There was also the option of a weekly enhanced MDT. The use of

Microsoft Teams was a key enabler. We adopted the principles of a PDSA cycle to continuously improve the CRIST processes.

23. Improving the Quality of Discharge for Acute Adult Inpatients in North Manchester During the COVID-19 Pandemic

Dr Eleanor Riley

The COVID-19 pandemic has increased bed pressure, with fewer community resources available. Poor discharge planning, documentation and communication increase relapse risk and crisis readmission; delaying recovery and increasing pressure on healthcare resources. Concerns have been raised locally that the quality of inpatient discharge has deteriorated. We aimed to assess the quality of discharge locally, feedback to relevant parties, and lead process improvements. Consultant Psychiatrists' input regarding service users (SUs) on Care Programme Approach (CPA) was combined with the local "Standardised Operating Procedure" protocol to define fourteen discharge standards. These include completed assessments (mental state and risk), communication (with SUs, relatives and other healthcare professionals), and followup planning. A target of 100% compliance was set. Discharges from five acute adult inpatient wards over a one month period were retrospectively reviewed. Business Intelligence provided lists of SUs. A random number generator sampled five SUs per ward. 23 SU electronic records were assessed for compliance with the standards. Demographical data showed a representative sample (age and gender). Most SUs were informal (70%), the remainder formally detained under the Mental Health Act, 1980. No discharge met all standards. Only one standard was met for all discharges; providing a discharge prescription where necessary. Discharge plan communication to SUs was good (96%). 91% had 72 hour and 7 day followup arranged. 54% of SUs on CPA received care coordinator input regarding discharge. 48% of discharge summaries were authorised within 7 days. 18% of SUs received a copy of their crisis plan. 0% received the feedback satisfaction survey. Results were shared at senior and junior doctor, management, and nursing staff meetings, which allowed discussion and suggestions for improvements. This triggered production of discharge checklist posters which have been positioned visibly in each nursing office. We plan to reassess over a one month period in June 2021.

24. Let's Get Moving! Improving physical activity amongst Rehabilitation patients

Dr Ruth Rowland, Dr Ruth Rowland, CT1 Psychiatry Dr Laura Somerville, ST4 Psychiatry Sarah Dorman, Occupational Therapist Dr Mark Finnerty, Consultant Psychiatrist

This Project aimed to improve physical activity amongst patients in a 16-bedded, low secure unit in the Downshire Hospital, Northern Ireland. We introduced an exercise programme, aiming to increase minutes of physical activity per week. Secondary outcome measures were weight, mood and energy levels. This took place in the context of Covid-19 restrictions reducing opportunities for off-ward activity and subsequent deconditioning and weight gain amongst the cohort. Baseline data was collected prior to programme introduction, including weekly activity levels and weights. A questionnaire explored patient confidence and attitude towards physical activity. Focus groups were held with patients and

staff in order to identify how best to introduce the programme, discuss content, and identify potential barriers. We introduced an eight-week programme of weekly, thirty-minute, mixed ability exercise sessions, led by the multi-disciplinary team. Patients actively participated in programme design, choosing session soundtracks and contributing to content planning. Likert scales measured self-report mood and energy levels pre- and post-sessions. Staff engaged in a weekly post session de-brief, identifying challenges and suggesting solutions. Weekly qualitative feedback was sought from participants. The sessions were thus reviewed and adapted according to patient and staff feedback. Following the 8-week programme, activity levels and weight were re-measured and pre-programme questionnaires repeated. Patients reported increased enjoyment and confidence engaging in physical activity, as well as improved overall self- confidence and a sense of ownership of the sessions. Staff reported a more cohesive team environment, greater sense of work-place fulfilment and improved therapeutic relationships. Comparing pre and post session ten-point-Likert scales showed a 153% mean increase in self-rated energy levels and a 98% mean increase in self-rated mood. This reflected a mean score increase of 3.8 in both. Minutes of physical activity per week increased for all session participants, although remained below national guidance. Weight reduction did not occur.

25. Care Trust Way Business Continuity App

Dr Dr Sarfraz Shora, Dr Sarfraz Shora Dr Mahmood Kahn Chris Hunt

The Care Trust Way (CTW) is a people-focused and coaching driven, engagement and quality improvement methodology, delivering our strategic intent enabled by strategy deployment, improvement, innovation and growth. The vision of The CTW is to engage and empower staff; create an honest, inclusive, and open culture supporting purposeful conversations, where everyone has a voice and opportunity to improve and develop how and what they deliver. The CTW offers practical tools and support to help staff make a difference in their everyday working environments. During the pandemic the CTW was used to showcase improvement work in several areas: • Live Executive Broadcast • COVID Home Visiting Team • MS Teams Wellbeing Platform • Innovation Stories • Let's Chat Podcast • Learning week with the Voluntary Care Sector • Rapid Process Improvement Workshop on Care Planning A great example of the CTW in action and how combining our QI tools with coaching and empowering people is our in-house built Business Continuity Plan (BCP) App The app was born from a collaborative workshop between teams from across the trust discussing the real day to day challenges teams faced during the start of the pandemic. This resulted in the development of a live reporting, ordering and SitRep tool, the Personal Protective Equipment (PPE) App, for live monitoring of PPE throughout the organisation. The Success of the app quickly highlighted the possible uses in other areas and after further collaboration workshops the App in now used by all teams to: • Report daily staffing figures • Report Service BCP status • Report status of PPE • Inpatient Bed State • Out of Area beds • Ability to escalate concerns to Bronze, Silver and Gold command. The accomplishment of the app is such that we're now working with teams to

develop this further to become the centre of our daily lean management structure for cascade in business as usual.

26. Improving Isle of Wight liaison services through a pandemic

Lesley Stevens, Jo Tucker, Service Manager, Integrated Mental Health Hub

There are a number of challenges associated with delivering mental health services on an island. The scale of services is small (serving a population of 140,000), and we are geographically isolated. This isolation has been more evident through the pandemic as the frequency of ferries has been reduced. We have to be innovative and flexible to deliver safe and sustainable services. Before the pandemic we had three very small liaison services, providing adult mental health, dementia and learning disability services in office hours only. This was clearly an unsustainable model, but a full multidisciplinary liaison service is unaffordable – there simply isn't the demand for it to justify the investment, and recruitment of nursing and medical staff is challenging. Through the pandemic we have made significant improvements to our liaison service. What did we do? - We freed up some specific and effective leadership time for the team – a team leader who had experience of working in both ED and mental health services. - We combined the various liaison functions into one team – maintaining the specialist functions, but providing mutual support and increasing sustainability - We recruited 5.5 senior support workers, who work flexibly across the service, supporting people in ED and on wards who are waiting for a service, and liberating clinical time. - We have developed a triage tool to enable us to prioritise and allocate resource appropriately. - We have worked with colleagues in the system, and now have a Substance Misuse Liaison Nurse in the team. These changes have enabled us to improve sustainability of the service, extend hours to 7am to 9pm every day, improve responsiveness and effectiveness of the service. 4 and 12 hour breaches due to mental health delays are now very rare, and relationships between ED and mental health services have significantly improved.

27. Improving Support and Engagement with Carers in a Psychiatric Intensive Care Unit (PICU): A Quality Improvement Project

Dr Rachel Stores

Background: Due to the potential risk to their own mental health and the benefits to patients when their relatives are involved in their treatment, carers of those with mental illness are an important group to both engage and support. Aim: To improve support and engagement with carers in contact with Hawthorns 1 Ward, Parklands Hospital, between September 2019 and December 2020. Methods: A questionnaire was co-produced assessing feelings experienced by carers during an admission, and change ideas tested using PDSA cycles. The number of documented contacts between staff and carers were recorded, and the length of ward rounds with and without carers present. The project was suspended at the start of the first COVID-19 national lockdown, and was restarted in July 2020. Interventions: E.g. phone and video calls to carers during ward rounds; electronic versions of Carers booklet; initiation of two Carers Groups. Results: Both positive (e.g. supported) and negative (e.g.

stressed) words were used to describe carers' experience of an admission. Following an initial surge, contact between staff and carers reduced in the first lockdown. Since then, there was an increase back towards the original average. Ward round timings increased by more than 3 times when carers were able to attend. Conclusions: The COVID-19 pandemic has created a frequently changing environment with conflicting staff priorities, providing a difficult platform for establishing changes. It is also a time when contact with relatives and friends is all the more important. Carer group feedback has shown the importance of peer support, and the individuality of patients and their support networks has been highlighted, illustrating the need to give patients and carers the authority and resources to control their level of involvement.

28. Evaluation of Vitamin D deficiency in patients of Mental Health during COVID 19 pandemic

Dr Indu Surendran, Dr Tessa Myatt, Consultant Child and Adolescent Psychiatrist Dr Sandeep Ranote, Consultant Child and Adolescent Psychiatrist Lorraine Prescott, Chief Pharmacist, Northwest Boroughs Healthcare

COVID 19 has been a turning point in the global delivery of health care. The pandemic exposed numerous drawbacks in our health systems, highlighting heightened mortality in patients with pre-existing physical & indirectly mental health issues. Long studied for it's role in physical health, Vitamin D insufficiency/ deficiency has been queried to be one of the agents that contribute to the increased susceptibility to and mortality from COVID 19, given the important role it has in immunomodulation, immunity against viral infection, cardiovascular health etc. It is also of importance in mental illness, with impact on mood & cognition and has been studied to be more frequently deficient in patients with mental illness. These important observations w prompted the NWBH Trust to release a new Vitamin D prescribing guideline (based on the NICE guidance) in August 2020 aimed at improving assessment and supplementation of Vitamin D, in an effort to protect our patients from COVID 19 & to improve their overall health. The authors also carried out a quality improvement project to understand the levels of Vitamin D insufficiency/ deficiency in the inpatient wards in the Trust. It was a cross-sectional evaluation that included inpatients admitted under the 5 Boroughs of NWBH from 1/8/2020 to 30/9/2020. It was noted that out of 170 patients, 122 patients (71.7%) had their Vitamin D levels assessed during admission. 21 of the 122 patients whose levels were available were found to be deficient (17%), 47 were insufficient (39%) while the levels were sufficient in only 54 patients (44%). The evaluation raises awareness regarding the high levels of Vitamin D deficiency in patients with mental illness. As a consequence, we have been able to launch the Vitamin D protocol with the aim of correcting insufficiency/deficiency and improving overall health.

29. Virtual Tours for Real Results; a multi-site online induction Quality Improvement Project

Dr Michael Tai, Dr Mehmet Gaz Dr Edward Clark Dr Tomasz Tyszczuk Smith

Problem Infection and rota risks posed by large cohorts of doctors being given joint site tours led to the August 2020 cohort of North-West London trainees arriving at their first day of work without knowledge of key areas, with potential knock on effects for patient care. This was especially significant for community

based doctors arriving for on calls. Aim To provide tours that minimise infection risk, while ensuring new doctors have a safe knowledge of hospital facilities. Methods The August 2020 cohort was given questionnaires to assess their self ratings of: ability to find on call patient assessment locations, knowledge of where to go and whom to contact for card access, ability to find doctors' facilities, ability to navigate the hospital on their first day. Rating were on a scale from 1 to 5 (not at all confident to very confident). Lastly, trainees indicated whether they had self-arranged a tour of facilities. A video tour of two trial hospital sites was then filmed and incorporated into the March 2021 cohort's induction, who were polled after 1 month using the same questionnaire. Results From the August 2020 to the March 2021 (26 responses), average responses were as follows: navigating the hospital rose from 2.87 to 3.38, locating patient-assessment areas rose from 2.8 to 3.5, gaining card access rose from 2.93 to 3.63, and finding doctors' facilities rose from 2.87 to 3.4; the proportion of trainees arranging their own private tours also fell from 53% to 38%. Next steps More focus will be given to patient assessment areas in future inductions given it has the lowest rating, the videos will be made available via intranet to help with on boarding of future trainees and locums, and this can be expanded to other sites to ensure a pandemic-proof induction.

30. Improving the physical health monitoring of South Kensington and Chelsea Community Mental Health Team (CMHT) patients on clozapine during the Covid-19 Pandemic

Dr Bethan Waskett, Dr. Edward Clark (CT3 Psychiatry) Dr. Ana Canoso (CT1 Psychiatry)

Despite increasing awareness and efforts, there remains a significant mortality gap between people with severe mental illnesses (SMI) and the general population, with the life expectancy of patients with schizophrenia still 20 years below the general average. This disparity is driven by multiple factors, including: lifestyle choices, side effects of antipsychotic medication, diagnostic overshadowing and recurrent failures of public physical health interventions to engage these patient groups. The latter challenge has been magnified by the Covid-19 pandemic, which has presented new obstacles to delivering adequate physical health monitoring and interventions to patients with SMI in primary and secondary care. In response to the Covid-19 pandemic, the South Kensington and Chelsea Community Mental Health Team MDT used 'Plan-Do-Study-Act' quality improvement methodology to implement a new physical health clinic for patients taking clozapine. By scheduling clinic appointments in conjunction with patients' existing monthly clozapine reviews, we aimed to improve physical health monitoring whilst minimising additional Covid-19 exposure to this vulnerable group. Retrospective baseline data collected for all patients on clozapine (n=41) showed that only 24% patients had an up-to-date annual ECG and 34% had up-to-date routine blood tests in line with NICE guidelines for patients on clozapine. Our clinic, run by junior doctors, aimed to increase both parameters to 80% over a 5-month period and to ensure 80% of patients completed an annual physical health questionnaire, with outcomes relayed to the patient's GP. Following implementation of the clinic over 5 months, 88% of patients had an up-to-date annual ECG, 98% had up-to-date routine blood tests (including the addition of Vitamin D level) and 90% had completed an annual physical health questionnaire. These results emphasise that secondary mental

health services can play a significant role in engaging patients with SMI in physical health monitoring, both during and, hopefully, beyond the Covid-19 pandemic.

31. Delivering Excellence Care in Learning Disabilities service – A QI initiative to reduce violence and aggression in inpatient setting

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Following the Winterbourne Scandal, the use of inpatient services for people with Learning Disabilities (LD) have been under intense scrutiny. In addition, the Coronavirus Pandemic has highlighted issues such as staff taking sick leave or working from home, visitors not being allowed on the unit and reduced access to recreational facilities resulting in patients spending more time in the unit etc. All of these have impacted on care delivery and patient experience. In order to reduce levels of violence and aggression from inpatients in our Specialist Assessment and Treatment service we have embarked on a ward-based Quality Improvement project to positively impact on interactions between staff and patients. We have utilised the continuous quality improvement methodology and highlighted the project priorities in a driver diagram. The team identified that better implementation of treatment plans which are often designed by the MDT and executed by front line support workers would be key component of this model (driver). It is acknowledged that front line support staff are often unable to access training and development that draw them away from them away front-line duties. A collaborative training programme devised by Health Education England called 'Delivering Excellence in LD services' was implemented following initial consultation with staff. The programme included one-and-a-half-day reflective training and three MDT mentoring sessions. The mentoring element of the programme is an exciting new way of working that are believed to improve partnership between MDT and ward staff, as well as better understanding of the treatment plan. Front line staff are encouraged to demonstrate a change in practice which is recorded in a workbook and discussed with their mentor drawn from within the qualified professionals in the ward MDT.