statistically significant improvement to self-reported knowledge and confidence.

We have adapted the teaching based on participant feedback and with involvement from Experts by Experience and Experts by Training. We have enriched teaching with video submissions from Experts by Experience. We have continued to engage with stakeholders, including partners at The LGBT Foundation and Indigo (GP-based Manchester gender service). To grow further, we have trained a faculty of 10 GPSTs to provide teaching, with 11 sessions now delivered to over 300 GPSTs and 5 sessions upcoming. We are planning a nationwide virtual training day.

A Picture of Health? *A Review of the Quality of Physical Healthcare Provided to Adult Patients Admitted to a Mental Health Inpatient Setting*

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Aims. To identify and explore remediable factors in the clinical and organisation of the physical healthcare provided to adult patients admitted to a mental health inpatient setting.
Methods. Data from 291 clinical, 56 Trust-level and 224 Hospital-level organisational questionnaires were completed; 285 sets of case notes were peer reviewed; 168 service user and 79 carer surveys were reviewed to assess the care provided to patients aged 18 years and older who were admitted to a mental health inpatient setting in the UK for at least one week during 01/11/2018 to 31/10/2019, and who:

- Had existing chronic obstructive pulmonary disease/ asthma/ cardiovascular disease/ diabetes
- Had experienced a transfer to a physical health hospital
- Died in the mental health inpatient setting or within 30 days of discharge
- Specialist commissioned mental health services and suicides, homicides and self-harm related deaths were excluded from this study.

Results. The report highlighted 5 key messages:

1. Assess patients for acute physical health conditions on arrival at a mental health inpatient setting and then undertake a detailed physical health assessment once the patient is admitted A detailed physical health assessment was not undertaken appropriately for 28/126 (22.2%) patients.
2. Develop a physical healthcare plan for patients admitted to a mental health inpatient setting A plan for physical health observations was not documented for 48/217 (22.1%) patients.
3. Formalise clinical networks/pathways between mental healthcare and physical healthcare Local care pathways or pre-existing arrangements with physical healthcare providers were used as part of the care plan for 71/291 (24.4%) patients.
4. Involve patients and their carers/friends/family in their physical healthcare and use the admission as an opportunity to assess, and involve patients in their general health In 100/188 (53.2%) sets of notes reviewed, there was no record that the physical health review had been discussed with the patient's family/ carers.
5. Include mental health and physical health conditions on electronic patient records and allow sharing across healthcare providers
6. 20/56 (35.7%) organisations reported that all elements of the clinical record were available in the electronic patient record

Conclusion. The NCEPOD report provided an in-depth review of the quality of physical healthcare in mental health inpatient settings and found that there is room for improvement in physical healthcare of patients. Key aspects of care requiring improvement were treatment of long-term physical health conditions (62/119; 52.1%), documentation of physical health observations (61/119; 51.3%) and delays in identifying acute deterioration (19/119; 16.0%) patients.

The report makes twelve recommendations for clinicians and management to implement in practice.

Introducing an Equality, Diversity and Inclusion (EDI) Champion to Address Unconscious Bias Within the Clinical Intake Meeting Selection Process in a Community Psychotherapy Adolescent Department

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Aims. It is widely recognised that the performance of the health care system falls far short of its potential on a wide range of quality indicators, particularly for racial and ethnic minorities and other disadvantaged groups. Within the Adolescent and Young Adult Service, data from the clinical intake meeting have been previously collected and stratified, identifying disparity conditions and populations based on gender (accepted females to males ratio = 7:1); ethnicity (low proportion of Black/Asian/Mixed background represented within the service); age (vast majority of accepted being in their 17s); disability (low proportion of disabled seen). Primary aim for this project was to evaluate whether the introduction of an EDI champion plus an EDI discussion within the intake clinical meeting could improve our department performance in terms of Equality, Diversity and Inclusion (EDI) quality indicators comparing to historical data.
Methods. A comprehensive Excel spreadsheet has been designed. All new referrals from November 22 till January 23 were included (N=29). Data collection included: non identifiable patients details, gender, date of birth, occupation, ethnicity, language, disability, outcome of the meeting, details of outcome, reason if outcome being negative. A further column on EDI comments.
Results. Following the introduction of the EDI champion for this cohort of patients, a decreased percentage of females (73.9% vs 69.2%) and increased percentage of transgender males (4.3% vs 15.4%) were offered an assessment. In terms of ethnicity, the number of Black/Asians/Mixed rejected for an assessment decreased. Respectively, 36.4% vs 11.1% (chi-square = 4.14, p-value = 0.47); 18.2% vs 11.1% (chi-square = 0.08, p-value $\approx$ 0 being statistically significant); 18.2% vs 0% (chi-square = 2.47, p-value = 0.26). An increased number of White people were

rejected for an assessment which was also statistically significant (27.3% vs 66.7%; chi-square=1.96, p-value ≈ 0). Reasons for rejection have been recorded. More age groups (19, 20, 22 years old) were more widely represented in the new cohort of patients.
Conclusion. The introduction of an EDI champion and an EDI discussion, within the clinic intake meeting selection process, seems a valuable instrument to tailor intervention for disparity groups (e.g. ethnicity), assessing both quality and disparities at the same time aiming for a Culturally Competent Quality Improvement within the service. This findings can be easily applied to other departments and implemented more broadly.

Induction Folder for New Doctors in Psychiatry in North Wales- a Quality Improvement Project to Make Life Easy for Junior Doctors

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Aims. The purpose of induction is to welcome our new employees and also ensure that they have the information and support to carry out their roles effectively. A robust induction not only benefits the doctor but also helps employers to ensure the delivery of high-quality patient care, increases retention, reduces absenteeism, and will promote the organization as a good employer. Doctors need to be supported in the workplace to provide safe, high-quality patient care. Induction as a minimum should introduce doctors to employer procedures and rules, arrangements for clinical governance (patient safety, clinical errors, clinical risk management, complaints, and litigation), orientation, and support. We have developed a new Induction folder containing all the necessary information for a beginner in Psychiatry in North Wales
Methods. We initially arranged for a preintervention questionnaire for the Junior doctors in Psychiatry in North Wales. That included Core trainees, Foundation year doctors, Senior house officers (LAS CT- SHO, JCF- non-training post), and GP trainees.

The QIP started in 2019 August with Audits followed by PDSA cycles. Over a period of 2 years, various doctors both from the present and from the last 3 years were contacted via email and google forms. We completed 3 PDSA cycles.

During these 2 years, we included certain topics that were missed, such as medication during an emergency, contact details from the deanery, etc. We have been following up on the Induction folder with the new doctors as and when there is new recruitment.
Results. The first PDSA showed promising results. Following the first PDSA, we amended a few changes in order to improve the response which resulted in an overwhelmingly positive response from the new doctors/ old doctors in Psychiatry. Following the third PDSA, we included details from the deanery contact and updated the contact details from our own trust.
Conclusion. 2 years of work on this project has yielded good results. However, the sustainability of changes is questionable. This indicates continuity in changes. We are hoping that the new trainee doctors, either junior or senior trainees can consider working on this project and continue to amend changes on yearly basis.

The amended version of the folder can be completed at least 4 weeks prior to the major induction that happens every August.

We will consider sharing the Induction folder as handbooks/ pdf versions to all the trainees and non-trainees in our trust. Apart from this, we will continue to keep the information at a high quality and standards. We will achieve this by ensuring feedback from the new doctors.

Medical Emergency Drills: An Essential Component of Inpatient Psychiatric Care

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Aims. At Farmfield Hospital, medical emergency drills are conducted monthly, as well as at all other Elysium Healthcare sites. Managing medical emergencies is an expected component of inpatient care, though without regular practice of Immediate Life Support (ILS) skills they can degrade rapidly. We propose that medical emergency drills should be considered an essential component of inpatient care, and explore how we have used them to create targeted teaching and to build skills after significant events.
Methods. We reviewed all medical emergency drills at Farmfield Hospital over the previous 12 months, looking through standardised event reports and feedback on quality and timing of response. We explore and compare qualitative feedback from involved staff members, and detail methods by which medical emergency drills can be used to create targeted teaching and training where skill gaps are noted.
Results. Staff fed back that these drills are key to building their confidence in managing medical emergencies. Core reports include that without these drills, for some staff the only regular practice would be at annual ILS recertification, and reports that they would feel considerably less confident to manage medical emergencies without regular practice and feedback. We use a case study exploring human factors and leadership skills being highlighted in one emergency drill as needing improvement, and how through targeted training and reassessment through subsequent drills we improved this skill gap and enabled staff to become more confident leaders in emergency situations as measured by direct feedback and assessment in subsequent drills.
Conclusion. Medical emergency drills are not currently standard practice across psychiatric inpatient services, and this creates several challenges. While ILS recertification is annual, these are perishable skills, and without regular practice confidence falls rapidly. Moreover, specific skill gaps such as leadership or even technical competencies such as familiarity with specific emergency equipment may go unnoticed until needed in a live medical emergency call. Organising these drills does not require a significant time investment, and we have found the increase in quality of response and staff confidence in managing emergencies makes these drills an essential part of our standard practice. We propose a simple structure for drill design and assessment as part of an ongoing Quality Improvement architecture.

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