the role of policing in mental health service provision. Data were collated and presented in a local QIP showcase.

Results. A significant split was identified between answers to open-ended and closed questions. When offering Likert based responses, 66% of participants felt safe with the police and believed that the police had a role in keeping people with mental health problems safe; 50% felt the police role should be greater in the future.

When responding to discussion-based questions, participants were critical of policing in relation to managing mental crises. Participants offered elucidative answers covering themes ranging from feeling a lack of agency, and the traumatic nature of criminalising mental distress, to concerns about abuse of power, the desire to limit the policing role to criminality and lack of trust engendered from experiences of racial injustice.

Conclusion. Our results demonstrate that patient views on policing roles in mental health service provision are complex. The experiences of involuntary admission through the police are often traumatic, rooted in past police involvement in patient's lives. Although it is acknowledged that at times no feasible alternative is available in hostile situations, this QIP opened an important, previously avoided, discussion. This will hopefully lead to introduction of more trauma informed care in an inpatient setting.

Reducing the Pressure on Mental Health Team by Improving Post-Discharge Follow-Up of Self-Harm or Suicidal Patients in Primary Care

Dr Nafiz Imtiaz* and Dr John McLaughlin

Oakleaf Medical Practice, Londonderry, United Kingdom
*Presenting author.

doi: 10.1192/bjo.2022.307

Aims. Northern Ireland has had the highest suicide and self-harm rate in the UK since 2012 according to National Statistics Office with 12.5 deaths per 100,000 population compared to 10.5 in the rest of the country. Evidence shows that the risk of suicide hugely increases following self-harm, and the greatest risk is immediately after the self-harm episode. Better access to health care, especially to primary care, in this period, can actively reduce the risk to this vulnerable patient group. Patients assessed for self-harm in the emergency department are often followed up by the mental health/crisis team. Due to lack of resources and staff shortages this is often not possible in a timely fashion. NICE suggests that patients should be offered a follow-up appointment in primary care within 48 hours of discharge. We aimed to ensure 70% of patients discharged from secondary care following an episode of suicidal ideation or self-harm are contacted proactively by mental health practitioner (MHP) or GP within 48 hours of communication from secondary care.

Methods. The project underwent two PDSA cycles. An electronic workflow was created to provide easy patient identification, assessment and follow-up. A process mapping was done after discussion with the GPs, administrative team, practice nurses and MHP. Outcome was measured by finding out percentage of patients: 1) Contacted within 48 hours of communication following an episode of self-harm 2) Appropriately coded 3) Comprehensively assessed 4) Risk stratified and minimized following each cycle.

Results. Over a period of three months, following two PDSA cycles, the frequency of these contacts increased from 0 to 80% (median) with an average 3.8 (83%) patients reviewed per week. The patient experience and satisfaction also improved significantly.

Conclusion. General practice (GP) has long been known as the next of kin for patients in the health care system. As GP is mostly the first point of contact for the patients, it can contribute significantly to ease the rising pressure on the mental health team. Also, a small number of weekly contacts from each GP can make a huge difference in nationwide patient safety and experience. We hope this intervention will significantly improve patient safety and reduce further self-harm presentation to ED in the long run.

Evaluation of a Trauma Pathway Within an Increasing Access to Psychological Therapies (IAPT) Service

Dr Grace Jell[1]*, Dr Diane Kohl[2], Dr Alison Salvadori[1], Ms Annabel Beasley[3], Dr Tai Ken Ting[3,4], Dr Henry Collier[3,5], Dr Shruti Dholakia[3], Dr Verity Bushell[3,6], Dr Vijay Gill[7] and Dr Katherine Beck[3]

[1]Berkshire Healthcare NHS Foundation Trust, Reading, United Kingdom; [2]Berkshire Healthcare NHS Foundation Trust, Maidenhead, United Kingdom; [3]33N, London, United Kingdom.; [4]Imperial College Hospital NHS Trust, London, United Kingdom; [5]Northern Care Alliance NHS Foundation Trust, Salford, United Kingdom; [6]Guy's and St Thomas' NHS Foundation Trust, London, United Kingdom and [7]South West London and St Georges Mental Health NHS Trust, London, United Kingdom
*Presenting author.

doi: 10.1192/bjo.2022.308

Aims. The Enhanced Trauma Pathway (ETP) at Berkshire Healthcare NHS Foundation Trust was established in 2018 to manage high demand on a highly specialist psychology team called the Berkshire Traumatic Stress Service (BTSS). The ETP is used to treat complicated cases of Post-Traumatic Stress Disorder (PTSD) within the IAPT service. However, because of the ETP there is now a cohort of Service Users (SUs) presenting to IAPT with a higher complexity than has been typical, presenting new challenges for the service. We aim to evaluate and redesign the ETP within IAPT to meet the needs of the changing population.

Methods. Clinically Led workforcE and Activity Redesign (CLEAR) is a workforce transformation methodology with four unique stages: i) Clinical Engagement: in-depth qualitative analysis of interview data from staff ii) Data Interrogation: cohort analysis using clinical and workforce data visualisations and analysis, iii) Innovation: developing novel solutions with insights from triangulated qualitative and quantitative data, iv) Recommendations: formulation of new models of care (NMOC) and smaller quick high impact service innovations. Thematic analysis was used for the qualitative data. Quantitative data analysis was conducted using the IAPT dataset.

Results. 27 semi-structured interviews were conducted with staff. SUs on the ETP had longer waiting times, their treatment took longer (18 sessions for ETP Vs 12 for core step 3) and they had lower recovery rates: 32.9% for ETP, 49.9% for core step 3 in IAPT and 57.3% for the whole IAPT service. SUs on the ETP presented with increased risk concerns, often not mitigated by stabilisation work offered. Thematic analysis also identified challenges with recruitment, a lack of qualified staff and inefficient use of skills across the pathway. Staff well-being was found to be paramount, however supporting staff was found to be challenging due to national constraints placed upon IAPT and the targets

the service is asked to achieve. A series of recommendations were made including three options for a NMOC. The options suggested different ways to redesign the pathway including an option where there would be a trauma only team within IAPT working exclusively on the ETP.
Conclusion. This evaluation highlights the challenges for the ETP and identifies NMOC to reduce their impact on the service. Further work is required to assess the NMOC once it has been implemented and to further evaluate the needs of the SUs presenting to this service.

Service-User Led Recommendations on Improving Medium to Low Secure Unit Transfer Experiences in East London During COVID-19; a Quality Improvement Project

Mr Hardeep Kandola[1]*, Dr Erin Vignali[2] and Dr Xuezi Bai[2]
[1]Barts and the London School of Medicine and Dentistry, London, United Kingdom and [2]East London NHS Foundation Trust, London, United Kingdom
*Presenting author.

doi: 10.1192/bjo.2022.309

Aims. Forensic service-users (SU) are often transferred between units at short notice, with little information about their new ward and unaddressed concerns. The findings of our first Plan, Do, Study, Act (PDSA) quality improvement project exploring SU's transfer experiences from medium to low secure units during COVID-19 in East London. Whilst unsettling, it may also impact therapeutic progress due to difficulties in developing new relationships with clinicians and ward residents. Our second PDSA cycle explores SU concerns and identifies improvement recommendations.
Methods. Five SUs consented to take part in the experience-based co-design approach. Remote semi-structured interviews explored experiences and suggestions for improvement. Audio transcriptions were thematically analysed to assess information provision, transfer expectations, new ward perceptions, available support and overall reflections.
Results. Recipients of a tour prior to moving felt most informed about the transfer and reported not requiring further information. Without the tour, some SUs were unaware of the name or type of their future ward. Therefore, SUs recommended everyone should have a tour prior to transfer, or where not possible a video tour. Two weeks was felt to be the ideal amount of notice prior to transfer and in the absence of this, weekly updates during ward round. Being able to talk to an SU who had recently moved to the new unit would be ideal, or in lieu of this a pre-recorded question and answer (Q&A) video.

SUs were interested in the new ward policy regarding leave and mobile phone criteria. A recurring issue involved SUs being promised unescorted leave on the new ward, but this not taking place. Importance was also placed on the family being updated during the transfer and moving with a preferred staff member. Many SUs felt the process was smooth yet held concerns about forming new friendships. They felt their psychologist, primary nurse or ward manager were easiest to approach with concerns. On the transfer day, SUs benefitted from the encouragement and congratulations from the old team, however cited feeling rushed when moving.
Conclusion. Implementing a pre-recorded tour with unit facility highlights and a recent SU transfer Q&A video would improve the transfer experience. Having clear policies regarding leave and mobile phone criteria prior to moving improves clarity. Our approach to include SUs in the transfer meeting with both the new and old wards ensures transparent expectations. We continue to monitor the success of these interventions on transfer experience through further PDSA cycles.

Rehabilitation or Stagnation? a Six Month Mirror-Image Study Reviewing the Effectiveness of an Inpatient Rehabilitation Unit

Dr Adisha Kapila[1,2]*, Mr Eromona Whiskey[1], Dr Mehak Nagpal[1,2], Dr Patrick Davey[1] and Ms Rebekah King[1]
[1]South London & Maudsley NHS Foundation Trust, London, United Kingdom and [2]Institute of Psychiatry, Psychology & Neuroscience, London, United Kingdom
*Presenting author.

doi: 10.1192/bjo.2022.310

Aims. The Tony Hillis Unit (THU) is a locked rehabilitation unit for men aged 18–65 years with Treatment Resistant Psychosis, with or without mild personality disorders; drug and alcohol misuse; and challenging behaviour. The multi-disciplinary team including psychiatrists, psychologists, nurses, occupational therapists and specialist pharmacists offer service-users a holistic, personalised and pragmatic management plan to facilitate an improvement in their level of functioning. This service evaluation aimed to review the effectiveness of our intervention as a unit as defined by functional outcome at six months pre- and post-admission.
Methods. A retrospective, mirror-image study design was used to collect data. Data were obtained from South London & Maudsley's Electronic Patient Journey System (ePJS) records. All patients discharged from THU over a two-year period, from May 2019 to May 2021, were considered in the study (n = 25 patients). Two service users died during the evaluation period and were excluded. A further service user was excluded as he had an admission length less than 28 days. Variables recorded included patient demographics and the presence of biopsychosocial interventions at THU including Clozapine initiation, engagement in weekly 1:1 occupational therapy (OT) and 1:1 psychology sessions. The functional status at six months pre-admission and post-discharge was defined by placement type, graded in terms of level of support; 1 = Psychiatric Intensive Care Unit, 2 = Acute ward, 3 = Rehabilitation service/Prison, 4 = Care home, 5 = Supported accommodation and 6 = Independent living. The change in patient acuity pre- and post- THU was compared using Wilcoxon-signed rank test.
Results. 23 service users were included in this evaluation. The average admission length was 365 days, and average age at admission was 38 years. The difference in patient acuity before and after THU intervention was statistically significant ($P < 0.005$), with an overall reduction in level of placement support required. The most common placement prior to admission was an acute ward, compared to a rehabilitation service six months after discharge. 60% of patients (n = 13) were newly initiated or re-titrated on Clozapine during their admission, with a further 4 patients already on Clozapine. 82% of patients engaged with 1:1 weekly OT and 72% engaged with 1:1 weekly psychology sessions.
Conclusion. This study demonstrates the effectiveness of our role as a locked rehabilitation unit. It outlines some of the key biopsychosocial interventions likely contributing to this, including initiation of Clozapine.