measures to mitigate some of the difficulties for trainees in such posts:

We have created a standardised handover sheet which is advised to be used and updated routinely, so that patient safety and continuity of care is maintained.

We suggest to assign a clinical supervisor to each post within a split-post placement, to ensure a trainee has ease of access to their weekly supervision in either setting, outside of the usual daily clinical discussions.

The Effects of Suicide and Homicide on Clinicians

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Aims: The effects on professionals following the death of a patient by suicide can be phenomenal and life changing. The Royal College of Psychiatrists has developed guidelines to promote operational strategies and adequate pastoral care for professionals affected by patient suicides. Recognizing the profound impact on mental health, burnout, retention and career progression, these guidelines aim to foster a supportive culture. Enhanced support could facilitate genuine reflection and learning from such incidents, ultimately leading to improved patient care.

The aim was to discuss the impact of suicides and homicides on clinicians while exploring available support structures and understanding relevant psychological processes.

Methods: On October 25, 2024, a one-hour medical webinar hosted 87 participants, including doctors, medical students, and nursing staff. Led by Dr Rachel Gibbons, an experienced consultant psychiatrist, the session focused on clinician vulnerabilities and defensive mechanisms. Pre- and post-workshop surveys evaluated areas of interest and effectiveness for future planning.

Results: The pre-survey results revealed that 34% of respondents were primarily interested in the potential blame associated with incidents, while 16% sought guidance on supporting colleagues. Notably, 65% had experienced a Serious Untoward Incident (SUI), predominantly suicides and homicides (92%), with many professionals expressing self-blame and feelings of failure. They struggled to support affected families and felt the review process often emphasized blame rather than learning.

In the post-survey, 77% of responders reported involvement in an SUI, with 88% linked to suicides or homicides. Support perceptions varied: 36% felt supported by fellow doctors, and 20% by their trust, while colleagues (52%) and family and friends (56%) were highlighted as key sources of support. Most learned about incidents through emails, phone calls, or word of mouth (64%), and only 40% were satisfied with how they were informed. Respondents emphasized the importance of sensitive communication and individualized support plans in enhancing their experiences.

Conclusion: Overall feedback was overwhelmingly positive, with 93% of attendees expressing interest in future events. An impressive 97% found the seminar very or extremely helpful, while 93% wanted webinars on supporting clinicians, bereaved families, and attending coroner's court. Many reported significant emotional impacts from suicides, affecting performance in 41% and prompting 27% to consider leaving psychiatry. Attendees emphasized the need for better support systems, compassionate communication, and debriefs to alleviate blame culture and improve coping with immediate effects.

Upcoming webinars will utilise feedback, ensure wider participation, engage senior management, and raise awareness of pastoral support strategies.

Mind Over Medical School: A QIP on Wellbeing Interventions for Medical Students on Their Psychiatry Rotation

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Aims: The mental wellbeing of medical students has remained a pressing issue. A recent longitudinal study named 'less supportive' educational environments as a contributing factor to this ill-health. Anecdotally, authors of this study have found topics taught within psychiatry can be emotionally affronting for students. During their psychiatry placement, 4th-year medical students at the University of Birmingham and Aston University were offered voluntary interventions with the aim to foster an environment of wellbeing. These included 1) an Open-Door Policy with Clinical Teaching Fellows (CTFs), 2) a formal Drop-in Session, 3) a Psychiatry Film Club Evening, and 4) a Creativity Prize, for students to submit reflective pieces in any artistic medium. A mandatory final wellbeing lecture included personal testimony from two CTFs on their own mental health journeys.

Methods: All students were asked to complete pre- and post-placement questionnaires accessed online on their first and last day, no matter their participation with interventions. During the placement, interventions were promoted after plenary lectures and on an ad-hoc basis. The post-placement questionnaire ascertained student participation in interventions. Questionnaires used a forced Likert scale to measure agreement with various statements. Statements were developed by adapting validated tools (such as ATP-30 and MICA-4) to cover three domains: perceptions of psychiatry's culture of wellbeing; stigma toward others' mental health; stigma toward one's own mental health. 117 responses were gathered. All responses were anonymous and could not be linked to individual students.

Results: Of the 177 respondents: 99% attended the mandatory wellbeing lecture, 11% attended the formal CTF drop-in, 9% participated in the creativity prize, 7% joined the film club, and 3% used the informal open-door policy. Across all domains, there was a general shift toward more favourable perceptions. Notably, responses to the statement "Psychiatry prioritises the wellbeing of its clinicians" improved from a median of "agree" to "strongly agree". This was a statistically significant change. Stigma toward personal and colleagues' mental health remained more resistant to change.

Conclusion: Results suggest that these interventions had a meaningful impact on students' perceptions of psychiatry as a supportive specialty. Aside from obvious personal benefit, integrating wellbeing initiatives into clinical placements may be key in promoting

psychiatry as a speciality to medical students. Larger sample sizes and additional data collection may be needed to detect more nuanced effects of these interventions: particularly in areas concerning self-stigma. Incorporating free-text responses in future evaluations could provide valuable qualitative insights into students' experiences.

Westminster CAMHS Happy Doc Spread Reducing Initial Assessment Time: Freeing Up Time for Treatment

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Aims:

Main outcome: To reduce the total time taken for Initial Assessments (IAs) in CAMHS by 10% by January 2025.

Process measure: To reduce time taken to complete the Initial Assessment Form and Care Plan letter.

Balance measures: To improve service user experience of the assessment process; to improve clinician experience of completing Initial Assessments (IAs).

Methods: PDSA 1: Developmental and medical history form collected ahead of Initial Assessment.

PDSA 2: Happy Doc Initial Assessment Proforma and automated Care Plan Letter.

PDSA 3: Dictation software.

PDSA 4: Locally developed wild card PDSA – parents offered a "Pre-assessment" session, initially trialled as a phone session (PDSA 4 i) and subsequently in person (PDSA 4 ii).

A parent QI Team member offered Expert by Experience advice on design and implementation. Parent views on the Care Plan Letter and Pre-assessment session are being collected by questionnaire. Qualitative and quantitative data has been collected from clinicians on each PDSA cycle.

Results: PDSA 1: Medical & Developmental History forms were not returned to the clinic ahead of assessment. To implement differently within PDSA 4.

PDSA 2: Process measure indicated 35% reduction in Time to complete IA Form and Care Plan Letter.

PDSA 3 and 4: No change to Total Initial Assessment Time yet. Possible early suggestion of reduced variation between assessments.

Parent feedback: Face to face Pre-assessment Clinic rated as positive and useful experience. Parents appreciate a space to share information without their children present.

Clinician feedback: "The assessment has felt so much quicker with the Pre-assessment session. Usually it feels unfinished after 2 appointments but I feel that I have enough information to conclude the assessment."

Conclusion: The significant reduction of time from PDSA 2 (35%) reflected by the Process Measure has not yet impacted significantly on the Total IA Time.

Subsequent introduction of dictation software (DragonMedical1) was difficult for clinicians, with low satisfaction and negative impact on time. With further use and individual adaptation, feedback improved. Implementation of a technology to aid workflow may require more time for learning before benefits become evident.

Parent engagement in telephone Pre-assessment Clinic (PDSA 4i) was poor. Following further iteration to in-person format (PDSA 4ii), engagement and feedback have improved.

The Pre-assessment Clinic has reduced assessment related tasks for clinicians who report this as a positive experience.

Positive staff stories about the Happy Doc Initial Assessment Proforma and Care Plan Letter led to the whole service deciding to adopt it.

Supporting Non-Psychiatric Trainees to Engage with Reflective Practice and Attend to Their Wellbeing Through Balint Group

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Aims: Doctors in training report high rates of burnout. The Balint group lends itself to addressing emotional stress and hence the associated risk of burnout. However, Balint group attendance among GP trainees and foundation doctors locally has been poor compared with psychiatric trainees. A Quality Improvement project was undertaken to explore and address barriers to attendance with the aim of improving GP trainees' and foundation doctors' engagement with the Balint group.

Methods: QI methodology was used throughout 2024. We implemented a quantitative, cross-sectional design using anonymous online surveys. We used purposive sampling by sending the surveys to GP trainees and foundation doctors on psychiatric placements within Kent and Medway NHS and Social Care Partnership Trust (KMPT). The survey was semi-structured, with closed and open-ended responses. The survey explored their understanding of the Balint group, how important they perceived it to be, and the barriers they experienced to attending.

Data gathered informed several 'change ideas' which were implemented through consecutive plan-do-study-act (PDSA) cycles. The timing of Balint groups was changed to ensure that less-than-full-time doctors had options to attend and that groups were less likely to conflict with clinical commitments. Improvements were made to the induction process to better socialise non-psychiatric trainees with the Balint group. A face-to-face format was trialled, replacing the previous virtual format.

Post-intervention surveys were administered, which included validated measures of burnout (Abbreviated Copenhagen Burnout Inventory).

Results: Resident doctors' understanding of the Balint group's function and process has improved. In parallel, attendance has increased in some Balint groups; for example, 75% attendance in June 2024 compared with 25% in March 2024. However, with frequent rotations of GP trainees and foundation doctors, each cohort having its own needs and preferences, we have found that improvements are not consistently sustained. Barriers still exist, such as conflicts with clinical commitments and the format feeling 'alien' and unhelpful to others. Changes to the degree of burnout through attending the Balint group are inconclusive and will be clarified with the results of a follow-up survey in March 2025.