We hope to use these findings to improve our local referral pathways and share this information to support other localities.

Project to Review the Medical Appraisal Policy in Tees Esk and Wear Valley (TEWV) NHS Trust and Implementation of the Outcomes

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Aims. The project aimed to review the Trust Medical Appraisal policy and offer a platform to update the Trust policy locally and align it to a National recommendation in the Medical Appraisal Guide besides gathering consensus for change for other relevant issues to the Trust.
Methods. The project was undertaken as a part of the 'Leadership and management fellowship Scheme' sponsored by the Tees Esk and Wear Valley NHS Foundation Trust and conducted in collaboration with the Royal College of Psychiatrists, UK and Faculty of Leadership and Management, UK 2022–23 with data collection lasting from January till August 2023. The methodology consisted of drafting a document comparing the information from the review of the existing Trust medical appraisal policy and the guidance in the Medical Appraisal guide, drafting a questionnaire which covered the complex issues in the appraisal process and where the Trust medical appraisal policy was identified as having gaps which required further opinions to be generated for a possible revision to the policy, and gathering consensus opinions from focus group discussions for different groups of staff which included appraisers who are not managers, consultants who are not appraisers, medical managers who are not appraisers, consultants who are appraisers and SAS doctors who are not appraisers. The focus groups were conducted virtually as well as face to face groups and consensus opinions were then synthesised with information available from the guidelines to draft recommendations. The recommendations were then presented to the senior managers in the Trust appraisal process to seek feedback and approval.
Results. The main recommendations that followed from the review were: to promote supportive and developmental nature of the appraisal process by making the process less document intensive by modifying appraisal portfolio and appraisal sections, educating staff on not duplicating information, promote verbal reflection, and modifying corporate supporting information section to reduce burden on doctors; maintaining 3 year appraiser turnover; avoiding line manager to be the appraiser of the appraisee; not sending appraisal summary to the line manager and considering how to facilitate communication and input of the line manager to the revalidation decision; clarifying requirements of supporting information for appraisal of particular group of doctors (Trust doctors, International Medical Graduates (IMG), academics, and on zero hour contracts); expand corporate supporting information to include General Medical Council (GMC)/Trust disciplinary and low level concerns; to promote wellbeing discussion by adding prompt for doctor to comment on their wellbeing; adding a wellbeing statement to the appraisal template and finally to add trainer accreditation statement to the appraisal template to facilitate reporting of trainer accreditation. Most of the recommendations were accepted by the Trust except one on expanding the corporate supporting information for doctors and addition of a wellbeing template in appraisal section.
Conclusion. The project served as a significant leadership experience in my training role to undertake a project driving a Trust-wide change in medical appraisal policy based on participative leadership, generating consensus and developing a phased action plan towards implementation.

Improving the Assessment of Memory and Cognitive Side Effects Post Electroconvulsive Therapy

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Aims. An April 2022 Electroconvulsive Therapy Accreditation Services (ECTAS) review of electroconvulsive therapy (ECT) services in the Southern Sector of the Western Health and Social Care Trust highlighted that the follow up of service users' memory and cognitive side effects post-ECT needed to be improved to deliver safer and more effective care. The aim of this MDT quality improvement project was to transform the follow-up process from a baseline of 13% of service users receiving memory assessment 1–2 months post ECT to 100% of service users receiving memory assessment 1–2 months post ECT over a 16 month period.
Methods. In June 2022, an MDT working group was established with key stakeholders from inpatient and community mental health services. Using driver diagrams, opportunities for improvement were collectively identified and innovative ideas proposed to overcome these barriers. The primary drivers for change were communication, resources, and education. Systems were established and PDSA cycles used to review our data and decide whether we needed to make a further change. 17 service users received ECT and were followed up within the 16 month period. Our third change brought about the most significant and sustained improvement to the process; establish ECT champions within community teams. The ECT champion's role was to improve communication between inpatient and community teams in regards to service users needing memory follow up post ECT.
Results. The introduction of three ECT champions within the community teams significantly improved communication between the inpatient and outpatient teams resulting in an improvement in the standard of care to our service users. Initial figures show 100% of service users having memory assessment follow up at 1–2 months post ECT in July 2023, October 2023 & December 2023. No service users required follow-up within the service in August/September/November 2023. Performance monitoring is ongoing as part of the service's governance meeting.
Conclusion. In conclusion, by improving communication, utilising resources more effectively and educating through ECT champions, the percentage service users receiving memory assessments at 1–2 months follow up post ECT achieved ECTAS standard of 100%. This will benefit our service users by enabling us to identify those who need further input. Looking into the future, we need to undertake a clinical audit to assess for a sustained improvement and ensure that no unintended consequences have been

introduced from this QIP. We have shared our learning within the wider trust and plan to spread and scale our changes across a wider area.

Assessing Clinical Coding Compliance in a Mental Health Inpatient Unit: An Audit and Intervention Study

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Aims. Clinical coding (CC) is the translation of medical terminology into a coded format that is recognised both nationally and internationally. NHS trusts must record the clinical care given to inpatients and the resources used for inpatients while they are in hospital care. CC ensures accurate patient records, communication and data exchange between providers and can aid in epidemiological research, healthcare planning and quality as well as cost control. An audit was carried out in a mental health inpatient unit to assess whether CC was completed as per the local and national CC guidelines, followed by an intervention to improve compliance.

Methods. 2 inpatient wards were identified, 1 male and 1 female, and 10 patients from each ward were selected at random on the 15th of December 2023. Their notes were assessed to determine whether: the CC has been updated during their current admission, CC has been updated if new diagnosis, CC had been completed on last discharge, physical health conditions were included in the CC and the number of physical health diagnosis changes and their documentation. Intervention was carried out and a re-audit completed on the 31st of January 2024.

Results. Out of 20 patients: 5 (25%) had a completed CC during their admission and 4 had a diagnosis change but only 1 (25%) CC was updated. 9 had a physical health diagnosis but only 3 (33%) were included on CC. 16 (89%) had a completed CC on last discharge and 2 were admitted for the first time.

Doctors on the wards were informed about CC, how to access the form on the system and the importance of updating CC. This was communicated in teaching sessions and doctor communication groups.

The re-audit showed some improvement. Out of 20 patients: 10 (50%) had a completed CC during their admission, 4 had a diagnosis change and 3 (75%) CC were updated. 7 had a physical health condition and only 2 (29%) were included on CC. 12 (75%) had a completed CC on last discharge and 4 were admitted for the first time.

Conclusion. The audit showed a lack of awareness of CC and its importance. The intervention helped to improve compliance of CC in current inpatients. Further intervention and improvement is required for physical health CC and can be attempted with posters in the doctor's rooms and regular reminding during group sessions.

Are Patients Aware of Clozapine Side Effects?

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Aims. Patients should have a comprehensive understanding of the side effects, and monitoring requirements of the medications prescribed to them. Making the patient aware of serious side effects is important for patient safety and informed consent. Patients should know when and how to seek help for side effects. Health literacy also increases patient autonomy and shared decision making.

As an inpatient, a psychiatric patient's medications are closely monitored, and there is frequent contact with healthcare professionals who can identify any health needs. Within our trust, there is a side effect checklist to be completed by community staff each time a community patient has clozapine monitoring. However, in our clinical practice, we have observed that some patients have needed prompts regarding need for re-titration if dose missed for 48 hours.

We aimed to assess medication safety information awareness in a small sample of patients open to forensic community team who are prescribed clozapine.

Methods. A 26-point questionnaire was used to assess the participant's depth of knowledge of clozapine. A combination of 3 open and 22 closed questions were used. Patients were scored for their answers to the closed questions, using a predetermined marking scheme, being awarded 1 point per appropriate answer. We set the standard as maximum score of 22.

All participants (n = 7) were male and had been prescribed clozapine for at least one year.

Results. All participants were able to accurately state why they were prescribed clozapine. The mean score was 16. Zero participants scored 22. Lowest score was 14. One participant omitted two questions (Do you know what to do if you take more clozapine tablets than you are supposed to? Do you know what to do if you forget to take clozapine?). He stated that he was very careful regarding his medication and therefore, will not forget or miss any doses.

71% of patients were unsure what they should do if they were to accidentally take more tablets than prescribed.

Five out of seven participants were able to cite at least one side effect of clozapine without prompting.

Two patients were not able to spontaneously recall the monthly blood test requirement.

Conclusion. There was a range of knowledge deficits about clozapine in our sample. After including reminders of safety information about clozapine at quarterly care coordination reviews, we plan to re-assess in a year's time.

Clinical Supervisors' and (Junior) Doctors' Experiences of Breastfeeding Risk Assessment, and Where We Go From Here

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