Methods: With support from pharmacy we retrieved a list of female patients prescribed valproate in our locality, which served as a central valproate register. We examined patient records to determine whether an ARA form was on their records and if the form was completed and up to date. We then produced a list of patients who required renewal/completion of the form.

The team met with Information technology system provider (RIO) to discuss creation of a digital central valproate register and using digital clinical reminders on patient's records to notify clinicians when the form was due for renewal.

Results: Reminders were sent to relevant clinicians/teams, requesting them to complete the required ARA form at earliest opportunity. The data from the central valproate register was shared with the RIO team who agreed to transfer this data to the electronic records intervention list in order to create digital version. They then agreed to create a valproate tab in patient's records, and link the ARA form to the tab. This link up will automatically act as trigger to warn clinicians that the ARA form is due for completion.

Conclusion: This project has created a central database for local service users who are on valproate. By doing so it has facilitated the tracking of ARA forms for the clinicians. Creation of automatic reminders will further help clinicians in completing the required form in timely manner.

Bridging the Gap: Improving Locum Rates at South West London and St George's Mental Health NHS Trust

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Aims: The 2023 GMC national trainee survey revealed that 33% of secondary care trainers reported that their trainees' education and training were adversely affected because rota gaps aren't always dealt with appropriately. This project aimed to improve locum rates within the South West London and St George's Mental Health NHS Trust (SWLSTG) to address these issues and enhance training conditions.

Methods: A Freedom of Information (FOI) request was sent to all London mental health trusts to gather data on locum rates at core trainee and registrar levels, escalation policies, and definitions of social and unsocial hours. The data was compiled and compared in a spreadsheet, then presented at the Medical Out of Hours Working Group (MOOHWG) meeting. A new policy was developed to amend out-of-hours pay for doctors based on the findings. This was presented in an executive meeting where it was approved, with changes implemented in August 2024. The process occurred from November 2023–July 2024.

Results: The FOI responses revealed that SWLSTG offered less favourable locum rates compared with other London mental health trusts. To bring SWLSTG in line with the local trusts, several key changes were made. The definition of unsocial hours was updated from 9pm–9:30am to the London consensus definition of 7pm–9:30 am on weekdays, as well as all day during weekends and bank holidays. An escalation policy was introduced for shifts first announced with less than 48 hours' notice, offering a 20% rate increase. Locum rates were also revised: CT1/2 social rate was increased from £40 to £45 per hour, and the unsocial rate from £45 to £54 per hour. CT3 rates were differentiated from CT1/2, with the social rate rising from £40 to £49.25 per hour, and the unsocial rate from £45 to £59.10 per hour. Additionally, the ST4–6 social rate was raised from £45 to £49.25 per hour, and the unsocial rate from £55 to £59.10 per hour.

Conclusion: The changes to locum rates and the introduction of an escalation policy at SWLSTG have successfully brought the trust in line with other London mental health trusts. These improvements are expected to reduce the negative impact of rota gaps on trainee education and training, helping to maintain high-quality service delivery and ensure more favourable working conditions for resident doctors. Further evaluation is recommended to assess the long-term impact of these changes on both trainee satisfaction and patient care.

Project 'BANGED' – A Bedside Tool to Aid Post Head Banging Reviews

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Aims: Project 'BANGED', a Quality Improvement Project (QIP) aimed to enhance confidence, consistency, and clarity, when completing post headbanging reviews (PHBR).

The world of psychiatry is often the first-time (and perhaps only time) resident doctors (RDs) are exposed to such behaviour thus request. This can be daunting, often inducing a 'CT head reflex reaction'.

A tool to strike balance between true neurology vs over medicalisation seemed pressing. Thus, the bedside tool 'BANGED' was created. A guiding acronym for RDs to use, designed for inpatient settings. Aimed at the general adult population, however, has relevance to other areas such as Intellectual Disability.

QIP carried out at Humber Teaching NHS Foundation Trust (HTNFT).

'BANGED'

Each letter represents key areas of focus for PHBRs and is as follows:

B – bruising, bumps (swelling), breakage of skin, bleeding (? active).

A – awareness – any LOC, GCS, awareness of triggers – reason for head banging if known (any ways of reducing this).

N – Neurological deficits – any red flags for head injury & Nausea/vomiting, are neurological observations required? Nursing engagements.

G – gross (motor) movements, gait.

E – eyes (pupils) equal and reactive to light, accommodation, any diplopia.

D – dizziness, drowsiness – don't forget glucose (if dizzy and oral intake concerns).

Methods: 2024 timeline.

August: Created the acronym 'BANGED' following brief narrative review, discussion amongst psychiatry trainees and own experience. Showcased tool via integration of 'BANGED' into poster and presentation.

September: Gathered baseline data via pre-intervention questionnaire – sent out to all HTNFT psychiatry RDs – initial confidence, understanding, applicability of tool. Presented tool in

teaching session. Distributed poster and displayed in staff facing areas on HTNFT inpatient units.

November: Shared results of pre-intervention questionnaire. Re-shared tool. Post Intervention questionnaire – gathered feedback regarding tool implementation into practice.

Results: Pre-Intervention Questionnaire:

Delivered face to face.

31 doctors responded of mixed grades.

Around half had never completed a PHBR (coincided with beginning of rotation).

19.4% selected 'Not confident at all' with such task.

93.5% were unaware of any helpful tools.

100% answered yes to 'Would a tool such as an acronym help your approach?'.

Post-Intervention Questionnaire:

Delivered online.

9 doctors responded of mixed grades.

Most used the tool.

100% would recommend.

Comments: easy to use, relevant to clinical practice, clever acronym, improved confidence.

Conclusion: PHBRs remain a daunting yet apparent task for psychiatry RDs. The bedside tool 'BANGED' shows promise for improving approach, by offering guidance for key areas of focus.

Future practice – further cycles required, delivered in person – better response rate.

Quality Improvement Project Investigating the Quality of Completed Section 5(2) Forms

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Aims: This quality improvement project aims to investigate the quality of completed Section 5(2) forms in a large, acute NHS hospital in England. It seeks to establish a current data baseline and identify common errors. The statutory section 5(2) form can be confusing for those who are unfamiliar with it, especially the section requiring correct deletion of options to identify the completing doctor's status. Incorrectly completed Section 5(2) forms may later need rectification or can lead to the invalid detention of a patient, in which case the patient may be able to claim financial compensation.

Methods: The most recent twenty (n=20) Section 5(2) forms across adult and paediatric medicine from November to December 2024 were analysed against a created proforma containing twelve criteria needed to correctly complete the form and provide rationale for detention.

Results: On average Section 5(2) forms were 84% correctly completed with a total of 202/240 criteria met. Of the twenty forms surveyed, 100% were legally valid. Furthermore, 100% recorded diagnoses, symptoms, or behaviours suggestive of a mental health disorder and were legible, signed, and dated by the relevant parties. 70% identified risks to the patient or others if the patient were not detained and 55% contained correctly deleted phrases to reflect the status of Registered Medical Practitioner (RMP), Approved Clinician (AC) or Nominee. However, the majority (55%) contained medical abbreviations and only 40% indicated detention was necessary to allow a Mental Health Act Assessment (MHAA) to occur.

Conclusion: Overall Section 5(2) forms are completed well by doctors in this survey with all citing evidence of a mental health condition and the majority including an assessment of risk. Increased physician education and awareness of key information may increase the documentation of risks, the need for a MHAA and promote the avoidance of abbreviations which can cause errors. The ongoing work reviewing the new Mental Health Act could consider simplifying the pre-determined options, which may increase the correct completion of the RMP/AC/Nominee status section. Meanwhile, doctors may benefit from an aid with clear examples of the correctly deleted phrases being issued alongside the Section 5(2) forms. The surveyed hospital is currently revising Section 5(2) guidelines and preparing example templates for doctors to use. After allowing time for the implemented changes to take effect this project will aim to re-audit and measure impacts.

A Quality Improvement Protocol for Assessing the Quality of Assessments for Children and Adolescents in Crisis

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Aims: Berkshire Healthcare NHS Foundation Trust utilises a Quality Management Improvement System (QMIS) which facilitates a culture of continuous improvement across the Trust. This system includes regular "Huddles" where all staff are encouraged to participate in identifying areas for improvement. Through a Huddle within the Berkshire Child and Adolescent Mental Health Service (CAMHS) Rapid Response Team, concerns were raised about the variable quality of assessments for children and adolescents in crisis. This project was designed to address this concern.

Methods: We designed a multifaceted approach to accurately map out the scale of the issue from multiple perspectives to help identify training needs and direct future interventions involving:

1. Designing a quality framework and rating system for reviewing assessments looking at domains agreed by the senior multidisciplinary team (psychiatry, management, psychology and nursing) and informed by existing assessment guidelines. Domains agreed:

Comprehensiveness.

Accuracy and clarity.

Formulation.

Sensitivity and cultural competence.

Document quality.

Rated from 1–5 (1 – poor, 2 – needs improvement, 3 – satisfactory, 4 – good and 5 – excellent).

2. A rating exercise using the framework is to be completed by all assessing clinicians split into two groups (for anonymity), facilitated by senior clinicians. A total of 36 assessments (18 per group) completed in the preceding three months are to be reviewed.

3. Finally, the systemic family therapist would arrange to observe all assessing clinicians in at least one initial assessment to identify and note any other areas for improvement or concern within the assessment itself.

Following the above, information will be collated and analysed to identify specific areas of need within the team's assessments.