that the approach to assessment and management was not consistent between locality teams. Two experts by experience who have a diagnosis of BD were invited to become involved with the development of the pathway. Meetings were set up to enable coproduction and elicit information from those with the diagnosis. The responses provided insight into the effectiveness of different approaches used nationally to inform the methods and resources that are most helpful and appropriate to comprehensively support those with the illness.

NICE guideline evidence was used to create two algorithms to streamline the care of those with BD in both primary and secondary care. These algorithms include pharmacological, psychological and social approaches. It also considers the junctions at which referrals should be made and the criteria on which decisions are based.

Result. One algorithm was designed for use in primary care and will be distributed to local GPs to clarify the initial steps for assessment and management of BD and the criteria for referral. A second decision tree will be made available to all doctors working in mental health services with detailed medication options, when they are appropriate and whether additional psychological intervention should be considered e.g. post-discharge groups. Other specialist options such as Early Intervention for Psychosis and Perinatal Mental Health Services were also included. An information pack was created to be offered to all those with a diagnosis or possible diagnosis of BD. This contains useful resources such as skills and exercises that patients may find of benefit, external resources and websites regarding additional support and further information on BD, its nature and management.

Conclusion. The approach and resources collated here will help to streamline the management of those with bipolar disorder whilst also ensuring a more consistent approach. The involvement of experts by experience and the incorporation of NICE guidelines ensures a well-rounded and comprehensive set of documents that will be helpful to both clinicians and patients.

Demystifying the pathway of assessment and treatment for bipolar disorder – utilising co-production and algorithms to personalise the approach

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Aims. To develop an evidence based, patient centred treatment pathway for people experiencing symptoms of bipolar disorder (BD), modifiable to include local resources.

Method. This project was developed in line with current approaches to service development such as coproduction, with patient and public involvement (PPI) and enhancing personalisation of treatment in medicine. As part of a local initiative, a multidisciplinary team was brought together to understand and analyse the current local pathway for those affected by BD. It was found that the approach to assessment and management was not consistent between locality teams. Two experts by experience who have a diagnosis of BD were invited to become involved with the development of the pathway. Meetings were set up to enable coproduction and elicit information from those with the diagnosis. The responses provided insight into the effectiveness of different approaches used nationally to inform the methods and resources that are most helpful and appropriate to comprehensively support those with the illness.

NICE guideline evidence was used to create two algorithms to streamline the care of those with BD in both primary and secondary care. These algorithms include pharmacological, psychological and social approaches. It also considers the junctions at which referrals should be made and the criteria on which decisions are based.

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Conclusion. The approach and resources collated here will help to streamline the management of those with bipolar disorder whilst also ensuring a more consistent approach. The involvement of experts by experience and the incorporation of NICE guidelines ensures a well-rounded and comprehensive set of documents that will be helpful to both clinicians and patients.

Where's the emergency? Improving emergency psychiatry experience for core trainees in Bath and North East Somerset (BaNES) and Gloucestershire Health and Care (GHC) localities

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Aims. The Royal College of Psychiatry advises that core trainees should be involved in 50 first-line emergency assessments during their core training. This includes assessment of suicidal risk following self-harm at least monthly. Trainees in Bath and Gloucester are not meeting these requirements. We set up an emergency experience rota, with the aim of increasing trainees' experience and confidence in assessment and management of emergency psychiatry.

Method. An emergency experience rota was implemented in Bath in September 2017. Trainees were surveyed before and after their 6 month rotations. In cycle 1, trainees spent two weeks with the Crisis team and an additional three days with the Liaison team per rotation. In cycle 2, we made some modifications to the rota so that it was more flexible. This system was then adopted in Gloucester where trainees were encountering similar difficulties. We hope to complete cycle 3 across the two localities by July 2021.

Result. From the initial two cycles conducted in Bath, post-change surveys showed an increase in trainees' confidence in assessments in acute settings and completing risk assessments in cases of self-harm and suicidal ideation. All of the trainees who took part would recommend the experience to other trainees (100% (7/7)). In Gloucestershire, only pre-change data have

been collected so far. A full analysis of all the results will be presented.

Conclusion. The introduction of working time regulations such as the European Working Time Directive (2003) as well as local service reconfigurations leading to nurse-led liaison services and home treatment teams, have reduced the opportunity for trainees to undertake emergency assessments. Across the Severn Deanery, there is a discrepancy in the opportunity core trainees' have to undertake emergency assessments – depending on their rota, stage of training, and services available. This difference in trainee experience, depending on locality, has been further impacted by COVID-19 and the introduction of cohorted wards.

Trainees in Bath and Gloucester are predominantly covering the wards during on-calls and, therefore, we set out to ensure that they are regularly rostered to obtain emergency experience, helping them meet their core training competences. Initial results from two cycles of an emergency / out-of-hours experience rota suggest increased experience and confidence in first-line emergency assessments, enabling them to work towards meeting their core training requirements.

West Midlands region less than full time training survey

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Aims. To more fully understand the training experience of less than full time (LTFT) trainees working in psychiatry in the West Midlands Region with the aim of identifying areas that would improve the training experience.

Background. LTFT training has grown in popularity since its formal introduction in 2007. The greater participation of women in medicine and generational changes in lifestyle expectations are some of the factors behind this trend. Approximately 13% of psychiatry trainees in the UK are training LTFT, bringing the benefit of allowing trainees to balance caring responsibilities or health conditions with continuing their postgraduate training. However it is not without its challenges for trainees which we aimed to explore in this survey.

Method. An electronic survey was sent out to all trainees via email, LTFT trainees of all training grades were invited to respond. Trainees were contacted in the five mental health trusts making up the region. The survey contained 32 questions that covered a range of topics including educational opportunities, perceived attitudes to LTFT trainees and training experience. Data were collected over a six month period in 2019. There were 22 responses to the survey region-wide.

Result. 86% of respondents were working reduced sessions in full-time posts with implications for their clinical workload and 14% responded that their clinical contact time was not adjusted to reflect their working hours. 36% of respondents experienced difficulties attending their formal teaching programme while 82% had attended educational commitments on non-working days. 14% of respondents felt training LTFT did not allow them to meet training requirements while 23% would not recommend LTFT training in the West Midlands to others. Trainees cited difficulties managing a full time workload and not having support from supervisors as reasons for these views. 40% of respondents reported experiencing negative attitudes from seniors and 50% felt isolated from other trainees due to LTFT training status.

Conclusion. The survey has developed our understanding of the challenges faced by LTFT trainees and it has been communicated regionally and to employing trusts to promote action. For example, at a trust level, the use of personalised work schedules can address some common difficulties. More effectively communicating sources of support to trainees, sharing best practice and providing networking opportunities are suggested as next steps regionally. New administrative processes to maintain an accurate list of LTFT trainees is vital in implementing this. Improving the information given to trainers is another development area.

Survey of junior doctors' perspective of serious incident reviews

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Aims. Serious incidents according to NHS England (2015) are incidents where the consequences to patients, families and carers, staff or organisations are so significant or potential for learning are so great that a heightened response is justified. There is anecdotal evidence that this process is potentially difficult for junior doctors and the primary purpose of learning may be lost due to the stress involved.

Our aim was to evaluate junior doctors perspective of serious incident reviews. A secondary aim was to organise local and regional workshops based on the outcome of our findings to address misconceptions around serious incident investigations.

Method. A survey was developed using survey monkey and distributed to all trainees across the Mersey region through the Medical Education teams.

The junior doctors range from core trainees to higher trainees. The survey encouraged the use of free texting if necessary.

Results from the survey were then analysed

Result. 18 junior doctors across the 3 mental health Trusts in the Mersey region responded.

12 respondents have been involved in a serious incident investigation in the past and 9 of the respondents stated that they did not recieve any support during the process. Out of the 3 that were supported, one rated the support as poor and frightening.

55.56% af all respondents found the process of serious incident reviews hard to understand.

66% of all respondents admitted that they are aware that the purpose of the review is for learning purposes.

100% of respondents agreed that a workshop to discuss the purpose and process of serious incidents investigation to aid their understanding would be useful.

Conclusion. From the survey, we concluded that junior doctors do have some understanding of incident reviews process but they still do not feel comfortable with the idea of being under 'investigation'.

It is also important that formal support is made available during the process.

We organised a workshop in one of the 3 Trusts which was well attended and junior doctors asked if they could sit on review panels for experiential learning. This is to be presented to govenance teams across the mental health trusts in the region.

Further workshop across the 2 remaining Trusts could not be organised due to COVID-19 pandemic.