clarify which wards were covered and ensure timely, effective allocation of tasks.

B) A formal, face to face "weekend handover" was introduced at 15:30 in the Conference Room every Friday afternoon.

A survey was sent to twelve Junior Doctors to gather formal feedback both before and after these interventions.

Results. Following these two interventions:

1. 91.67% feel there is now a structured and comprehensive daily handover. 91.67% felt this was not the case before.
2. 63.64% feel there is now always a successfully completed morning handover. 0% felt this was the case before.
3. 83.33% feel there is now always a successfully completed weekend handover. 41.67% felt this was not the case before.
4. 75% feel they are always aware of sick patients when On-Call. 25% felt they were not at all aware before and 66.67% felt they were only occasionally aware before.
5. 91.67% feel they are always aware of outstanding bloods to chase. 8.33% felt always confident before.
6. 83.33% feel they are always aware of outstanding investigations to chase. 16.67% felt always confident before.
7. 90.9% feel they know which wards are covered and uncovered when carrying On-Call bleep. 9.09% felt they knew before.

Conclusion. The implementation of a formal handover process has significantly improved Doctors' awareness of outstanding tasks and ward cover, which is likely to benefit patient safety moving forward. Further action is necessary to improve communication between medical and nursing colleagues regarding physical investigations performed and appropriate, timely follow up.

Healing and Hope for Forced Migrants in Norwich: The SHIFA Clinic for Asylum Seekers and Refugees

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Aims. The poster will discuss our Quality Improvement project around improving access to mental health assessments for asylum seekers and refugees and why this model of care proved to be useful in reducing barriers to accessing specialist mental health services for these patients.

The clinic was launched as part of the Advancing Mental Health Equality (AMHE) Collaborative, which is a 3-year programme run by the National Collaborating Centre for Mental Health at the Royal College of Psychiatrists, and Norfolk and Suffolk NHS Foundation Trust (NSFT) was one of the organisations that signed up to this initiative.

Methods. The clinic was named SHIFA, which stands for (Supporting Holistic and Integrated Forced Migrants Assessments). SHIFA means 'Healing' in Arabic, Turkish, Urdu, Kurdish and Pashtu (languages spoken by many patients accessing this clinic) and the name was selected in collaboration with staff and service users.

What are the objectives of the SHIFA clinic?

- To offer a trauma-informed approach to the assessment of forced migrants. This is an essential objective of the SHIFA clinic as the trauma-informed approaches are guided by trust, rapport and offering person-centred care.
- Reduce barriers to mental health care for people seeking asylum, refugees and people forced to migrate.
- Work collaboratively across the systems to bridge the gap among different services to improve the person-centred and continuity of care and avoid the re-traumatising effect of re-telling their stories.
- Co-production and putting the voice of our service users and carers at the heart of everything we do.
- Share learning and embed inclusive practice within the mental health services in NSFT and other organisations.

Results. We will provide data on patients seen in the clinic, the diagnosis and treatment. We will also give examples of the feedback we received from professionals and service users and why this model successfully provided collaborative and joint working opportunities with various services working with these patients.

Conclusion. The QI project represented in this clinic has provided a local solution to meeting the needs of forced migrants in our community, reducing mental health inequalities. It ran without funding initially and was successful in receiving funding due to the clear difference it made in providing good quality care for these patients.

Similar projects can be easily implemented in various mental health trusts.

Improving Quality of Care for Patients With Attention-Deficit/Hyperactivity Disorder in an Early Intervention for Psychosis Service

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Aims. Attention-deficit/hyperactivity disorder (ADHD) is frequently associated with other psychiatric conditions, including psychotic disorders. There is evidence for shared genetic susceptibility to both conditions (Hamshere ML, Stergiakouli E, Langley K, et al. Shared polygenic contribution between childhood attention-deficit hyperactivity disorder and adult schizophrenia. Br J Psychiatry. 2013;203(2):107–111) and first-degree relatives of people with ADHD have twice the risk of having schizophrenia compared with healthy controls (Larsson H, Rydén E, Boman M, et al. Risk of bipolar disorder and schizophrenia in relatives of people with attention-deficit hyperactivity disorder. Br J Psychiatry. 2013;203(2):103–106)

There are treatment challenges, and monitoring of physical health has differences with the Early Intervention Psychosis standards following antipsychotic monitoring.

Combined outcomes (symptomatic and functional recovery) may be worse unless addressing ADHD in addition to psychosis, and addressing substance use is important.

Primary objective/aim:

To create an integrated pathway through a clinical practice guideline for patients with ADHD in early intervention for psychosis service.

Secondary objectives/aims:

Identify the prevalence of ADHD in EIP service.