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.

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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.

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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.

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Little is known about the prevalence of comorbid ADHD in adults under the care of early intervention for psychosis (EIP) services in the UK. A previous audit and quality improvement project examining all (adolescent and adult) patients (age 14–65 years) conducted in October 2022 showed a prevalence of 3.6% comorbid diagnosed ADHD in our EIP service.

Methods. Audit tools to identify the prevalence of ADHD in patients with First episode psychosis. Re-audit to monitor the the trajectory of the cases.

Measurable: Using EIP caseload cross-sectional data, data of monitoring and management from electronic patient notes system (SystmOne).

A clinical pathway was developed to integrate the diagnostic and treatment pathway to manage ADHD in an early intervention psychosis service.

Service evaluation

We identified all adult patients (between the ages of 18 and 65 years) on the caseload of the EIP service in Northamptonshire Healthcare NHS Foundation Trust, dated 5 September 2023. Data collected included age, gender, ethnicity, primary psychosis diagnosis, psychotropic and ADHD medication prescribed and risk profile that included a history or presence of substance use. Data was anonymised.

Quality improvement

Following from a previous ADHD service evaluation and QIP in EIP (2022) we identified further problem areas that included significant delays in suspected comorbid ADHD in adult patients under EIP care, as well as challenges for those already referred and attempts made by the adult ADHD service for screening and assessment (poor engagement), as well as challenges to patient functional recovery and outcomes in those with comorbid diagnosed and suspected ADHD and psychosis.

Results. 174 of 183 (95%) patients on the caseload at the time of the study review date were adults. Of the adult patients, 5 of 174 (2.9%) patients had a known diagnosis of ADHD, all dating back to childhood/adolescence. An additional 4 patients had been referred for ADHD assessment.

Conclusion. There are treatment challenges, and monitoring of physical health has differences with the Early Intervention Psychosis (EIP) standards following antipsychotic monitoring, hence why we have implemented in a lead-up ADHD in EIP Quality Improvement Project a NICE concordant care plan that includes physical health monitoring content and frequency.

Combined outcomes (symptomatic and functional recovery) may be worse unless ADHD related symptoms and functional impairment are addressed, in addition to psychosis, and addressing substance use is also important, given that in people with substance use disorder, the prevalence of ADHD is estimated to be as high as 21% (Rohner et al. 2023), with a lifetime prevalence of drug use disorder 27.7% (Anker et al. 2020). Of interest, in our cohort, 3/5 (60%) patients had a history of substance use (40% drug-induced psychosis diagnosis).

Our study patient profile included all young Caucasian males, with a mean age of 22 years (range 19–28 years). Of interest is that our current ongoing pilot case for the integrated clinical pathway is a young mixed-race female. Females are more likely to be undiagnosed, and clinical presentation can be different (Attoe & Climie 2023).

There are challenges with suspected ADHD and diagnostic assessment. In our Trust we have a stand-alone adult ADHD diagnostic assessment service for formal diagnosis, using DSM criteria with 3 phases of assessment. However, this service has significant referral rates, and due to capacity and resources, has a very long waiting list (18 months to 2 years).

As part of our quality improvement effort, we have collaboratively (with the adult ADHD service) worked towards an integrated pathway to improve efficiency and time to diagnostic assessment (reduce delays) for patients in EIP suspected with comorbid ADHD, with our first pilot case ongoing. We have developed a clinical pathway to aid clinicians in management of those with confirmed and suspected comorbid ADHD, to improve patient outcomes.

There are further training needs to effectively support and manage ADHD comorbidity in those with psychosis under the care of Early Intervention Psychosis.

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Project Whiteboard: A Quality Improvement Project Enhancing Patient Flow in an Acute Mental Health Setting

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Aims. We are a 17 bedded acute mental health ward in a busy inner-city hospital. A handover of all patients, with the multidisciplinary team, takes place every morning (Whiteboard round). The clinical team felt that the information provided during this meeting needed a review, to ensure relevant patient information is being disseminated, and right clinical decisions are being made in a timely manner.

The team decided to focus on improving links with Community Mental Health Hubs (CMHH) to ensure continuity of care. The challenge the inpatient team faced is the need to interface with community mental health teams from two London boroughs, as the unit became the main admission hospital for Kensington & Chelsea and Westminster (KCW) patients.

The main aim is that 80% of KCW patients' CMHH (including new referrals) will be contacted within 24 hours of them being admitted onto the ward by April 2024.

Methods. As part of this QI project, weekly meetings were commenced, with a team comprising doctors, nursing staff (both inpatient and from local community team) and an Expert by Experience (EbE). A questionnaire was produced and circulated to ward colleagues about their views on the quality of whiteboard. A more focused questionnaire was then sent out around CMHH involvement in a patient's admission journey. We took a deep dive into the structure of the local community teams (at least 10 identified) and how referral processes work, as it was evident that staff were unclear at times on who/how to refer.

From this, the first change idea was formed: "information sheets" were produced showing which GPs correspond to which teams, and that patients can be referred this way. The Plan Do Study Act (PDSA) was applied to make these sheets visible to all staff. The outcome measure used was how many patients had CMHH referral/contact within 24 hours.

Results. Data is being collected daily, by reviewing patients notes to see if CMHHs have been contacted. Since commencement of the first PDSA cycle in December 2023, of the twenty-three patients admitted, nineteen have been eligible. Of these nineteen patients, fifteen patients (79%) have had contact or referrals made to their CMHH within 24 hours.