

psychosis in the community. In line with national and trust guidance, physical health checks are completed at baseline, 3 months, 6 months and annually, through a weekly physical health clinic run by the core trainee (CT). This is an essential opportunity to assess and monitor patients' physical health and aid decisions regarding psychotropic medications, which is particularly important given the increased morbidity and mortality in this group and their reduced engagement with health services. It was noted that attendance to the clinic was poor and there was no guidance about how to communicate the results to the General Practitioner (GP).

Method. Data on the number of clinic appointments booked and attended were collected over 3 defined 9 week intervals between 17/09/18 and 29/07/19. The interventions were implemented prior to the third round of data collection and included an educational session to the STEP team and a protocol for booking and running the clinic to be used by the CT. We devised a physical health questionnaire to be completed by patients on arrival, which includes a summary of the Maudsley guidelines for anti-psychotic monitoring. Finally, we created a template letter to communicate the results to the GP.

Result. Following the interventions, the percentage of available clinic slots booked increased from an average of 27.8% to 100%. The proportion of slots attended reduced from an average of 80% to 50%. However, the absolute number of patients booked into clinic increased from an average of 10 patients over 9 weeks pre-intervention, of which an average of 8 patients attended, to 36 patients post-intervention, of which 18 attended.

Conclusion. We observed full utilisation of available clinic slots post-intervention and an increase in the absolute number of patients attending. Given the ongoing use of the protocols developed, we expect these changes to be sustainable. The number of patients attending could be further increased by training additional staff to run the clinic more often and more flexibly. The number of Did-Not-Attends could be reduced by care-coordinators sending reminder texts prior to the appointments.

Investigating sleep quality on an inpatient psychiatry ward

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Aims. Sleep is essential for optimal physiological functioning, but often interrupted in hospital settings. Disturbed sleep is associated with relapse of mood disorders and multiple comorbidities including impaired immunological function and increased cardiovascular risk. There are unique environmental challenges on psychiatry wards, such as overnight monitoring. Recent studies highlight the importance of evaluating and managing inpatient sleep disturbance. Aims include exploring the extent to which patients' sleep is impacted by inpatient admission, elucidating causes of sleep disturbance and determining ways to improve sleep during admission.

Method. Patients aged 18–65 years, who consented and were expected to be inpatients for a week, were approached after 72 hours of admission (n = 35). Quantitative and qualitative data, including on pre-hospital and hospital sleep quantity and quality, were gathered, as part of a cohort characterisation. Questionnaires using Pittsburgh Sleep Quality Index elements were used to gather data. Offering earplugs as a sleep-aid intervention was

implemented, with sleep quantity and quality reassessed 72 hours post-intervention. In response to feedback, sound monitoring at regular intervals overnight was undertaken using a decibel-metre to determine noise baseline and variation.

Result. All patients approached agreed to participate. Pre-hospital average sleep quantity was 5.2 hours, with restedness score of 4.3, and 71% patients rating their sleep as 'bad'. After 72 hours post-admission, average sleep length was 6.5 hours and restedness 5.3. Of patients who accepted earplugs (59%), there were improvements to mean sleep quality and quantity (7.6 hours), with 86% patients rating earplugs helpful. All patients surveyed thought that earplugs should be offered routinely on admission. 70% of patients were prescribed benzodiazepines or z-drugs as required. Self-reported factors affecting sleep included noise, psychiatric symptoms and medication side effects, with 13 patients mentioning the former. Sound monitoring recorded an average decibel level with a range of 35–75 dB, with peaks reaching 95 dB.

Conclusion. Poor sleep in hospital is widespread. There is a need to understand and address modifiable environmental and ward factors implicated in sleep disturbance within inpatient settings. Pharmacological options for sedation are common, but it is important to focus on alternative options of low-cost, non-pharmacological interventions which promote sleep optimisation and enhance inpatient care.

Developing a local service to improve the provision of palliative care to people who use substances

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Aims. To develop a new service model that engages and improves the provision of palliative care to PWUS.

Background. Although people who use substances (PWUS) continue to die prematurely compared to the general population, they are now more likely to die from chronic diseases rather than from drug-related deaths. Challenges to providing palliative care to PWUS include delayed care-seeking behaviours, complex drug interactions and lack of healthcare provider experience.

Method. An informal factorial analysis elucidated population needs through: a review of local databases to estimate the prevalence of palliative need, a thematic review into the deaths of patients in specialist drug services and, a survey of health practitioners' knowledge and attitudes. These informed the service development phase which involves three key components: 1. A systems approach to increasing patient identification, incorporating key multi-disciplinary stakeholders across hospital- and community-based care 2. Targeted training of healthcare providers and 3. Medicines management for symptom palliation amidst concurrent substance use (including substitution treatments).

Result. The palliative needs of PWUS are under-identified: the local substance service was not partaking in the palliative referral pathway. Only 7% of a local hospice's annual caseload was recognised as having substance use problems. The care pathway was described as fragmented. Although >80% of surveyed palliative care practitioners had experienced caring for PWUS, confidence