the service is asked to achieve. A series of recommendations were made including three options for a NMOC. The options suggested different ways to redesign the pathway including an option where there would be a trauma only team within IAPT working exclusively on the ETP.
Conclusion. This evaluation highlights the challenges for the ETP and identifies NMOC to reduce their impact on the service. Further work is required to assess the NMOC once it has been implemented and to further evaluate the needs of the SUs presenting to this service.

Service-User Led Recommendations on Improving Medium to Low Secure Unit Transfer Experiences in East London During COVID-19; a Quality Improvement Project

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Aims. Forensic service-users (SU) are often transferred between units at short notice, with little information about their new ward and unaddressed concerns. The findings of our first Plan, Do, Study, Act (PDSA) quality improvement project exploring SU's transfer experiences from medium to low secure units during COVID-19 in East London. Whilst unsettling, it may also impact therapeutic progress due to difficulties in developing new relationships with clinicians and ward residents. Our second PDSA cycle explores SU concerns and identifies improvement recommendations.
Methods. Five SUs consented to take part in the experience-based co-design approach. Remote semi-structured interviews explored experiences and suggestions for improvement. Audio transcriptions were thematically analysed to assess information provision, transfer expectations, new ward perceptions, available support and overall reflections.
Results. Recipients of a tour prior to moving felt most informed about the transfer and reported not requiring further information. Without the tour, some SUs were unaware of the name or type of their future ward. Therefore, SUs recommended everyone should have a tour prior to transfer, or where not possible a video tour. Two weeks was felt to be the ideal amount of notice prior to transfer and in the absence of this, weekly updates during ward round. Being able to talk to an SU who had recently moved to the new unit would be ideal, or in lieu of this a pre-recorded question and answer (Q&A) video.

SUs were interested in the new ward policy regarding leave and mobile phone criteria. A recurring issue involved SUs being promised unescorted leave on the new ward, but this not taking place. Importance was also placed on the family being updated during the transfer and moving with a preferred staff member. Many SUs felt the process was smooth yet held concerns about forming new friendships. They felt their psychologist, primary nurse or ward manager were easiest to approach with concerns. On the transfer day, SUs benefitted from the encouragement and congratulations from the old team, however cited feeling rushed when moving.
Conclusion. Implementing a pre-recorded tour with unit facility highlights and a recent SU transfer Q&A video would improve the transfer experience. Having clear policies regarding leave and mobile phone criteria prior to moving improves clarity. Our approach to include SUs in the transfer meeting with both the new and old wards ensures transparent expectations. We continue to monitor the success of these interventions on transfer experience through further PDSA cycles.

Rehabilitation or Stagnation? a Six Month Mirror-Image Study Reviewing the Effectiveness of an Inpatient Rehabilitation Unit

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Aims. The Tony Hillis Unit (THU) is a locked rehabilitation unit for men aged 18–65 years with Treatment Resistant Psychosis, with or without mild personality disorders; drug and alcohol misuse; and challenging behaviour. The multi-disciplinary team including psychiatrists, psychologists, nurses, occupational therapists and specialist pharmacists offer service-users a holistic, personalised and pragmatic management plan to facilitate an improvement in their level of functioning. This service evaluation aimed to review the effectiveness of our intervention as a unit as defined by functional outcome at six months pre- and post-admission.
Methods. A retrospective, mirror-image study design was used to collect data. Data were obtained from South London & Maudsley's Electronic Patient Journey System (ePJS) records. All patients discharged from THU over a two-year period, from May 2019 to May 2021, were considered in the study (n = 25 patients). Two service users died during the evaluation period and were excluded. A further service user was excluded as he had an admission length less than 28 days. Variables recorded included patient demographics and the presence of biopsychosocial interventions at THU including Clozapine initiation, engagement in weekly 1:1 occupational therapy (OT) and 1:1 psychology sessions. The functional status at six months pre-admission and post-discharge was defined by placement type, graded in terms of level of support; 1 = Psychiatric Intensive Care Unit, 2 = Acute ward, 3 = Rehabilitation service/Prison, 4 = Care home, 5 = Supported accommodation and 6 = Independent living. The change in patient acuity pre- and post- THU was compared using Wilcoxon-signed rank test.
Results. 23 service users were included in this evaluation. The average admission length was 365 days, and average age at admission was 38 years. The difference in patient acuity before and after THU intervention was statistically significant ($P < 0.005$), with an overall reduction in level of placement support required. The most common placement prior to admission was an acute ward, compared to a rehabilitation service six months after discharge. 60% of patients (n = 13) were newly initiated or re-titrated on Clozapine during their admission, with a further 4 patients already on Clozapine. 82% of patients engaged with 1:1 weekly OT and 72% engaged with 1:1 weekly psychology sessions.
Conclusion. This study demonstrates the effectiveness of our role as a locked rehabilitation unit. It outlines some of the key biopsychosocial interventions likely contributing to this, including initiation of Clozapine.