psychiatry as a speciality to medical students. Larger sample sizes and additional data collection may be needed to detect more nuanced effects of these interventions: particularly in areas concerning self-stigma. Incorporating free-text responses in future evaluations could provide valuable qualitative insights into students' experiences.

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Westminster CAMHS Happy Doc Spread Reducing Initial Assessment Time: Freeing Up Time for Treatment

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doi: 10.1192/bjo.2025.10365

Aims:

Main outcome: To reduce the total time taken for Initial Assessments (IAs) in CAMHS by 10% by January 2025.

Process measure: To reduce time taken to complete the Initial Assessment Form and Care Plan letter.

Balance measures: To improve service user experience of the assessment process; to improve clinician experience of completing Initial Assessments (IAs).

Methods: PDSA 1: Developmental and medical history form collected ahead of Initial Assessment.

PDSA 2: Happy Doc Initial Assessment Proforma and automated Care Plan Letter.

PDSA 3: Dictation software.

PDSA 4: Locally developed wild card PDSA – parents offered a "Pre-assessment" session, initially trialled as a phone session (PDSA 4 i) and subsequently in person (PDSA 4 ii).

A parent QI Team member offered Expert by Experience advice on design and implementation. Parent views on the Care Plan Letter and Pre-assessment session are being collected by questionnaire. Qualitative and quantitative data has been collected from clinicians on each PDSA cycle.

Results: PDSA 1: Medical & Developmental History forms were not returned to the clinic ahead of assessment. To implement differently within PDSA 4.

PDSA 2: Process measure indicated 35% reduction in Time to complete IA Form and Care Plan Letter.

PDSA 3 and 4: No change to Total Initial Assessment Time yet. Possible early suggestion of reduced variation between assessments.

Parent feedback: Face to face Pre-assessment Clinic rated as positive and useful experience. Parents appreciate a space to share information without their children present.

Clinician feedback: "The assessment has felt so much quicker with the Pre-assessment session. Usually it feels unfinished after 2 appointments but I feel that I have enough information to conclude the assessment."

Conclusion: The significant reduction of time from PDSA 2 (35%) reflected by the Process Measure has not yet impacted significantly on the Total IA Time.

Subsequent introduction of dictation software (DragonMedical1) was difficult for clinicians, with low satisfaction and negative impact on time. With further use and individual adaptation, feedback improved. Implementation of a technology to aid workflow may require more time for learning before benefits become evident.

Parent engagement in telephone Pre-assessment Clinic (PDSA 4i) was poor. Following further iteration to in-person format (PDSA 4ii), engagement and feedback have improved.

The Pre-assessment Clinic has reduced assessment related tasks for clinicians who report this as a positive experience.

Positive staff stories about the Happy Doc Initial Assessment Proforma and Care Plan Letter led to the whole service deciding to adopt it.

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Supporting Non-Psychiatric Trainees to Engage with Reflective Practice and Attend to Their Wellbeing Through Balint Group

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doi: 10.1192/bjo.2025.10366

Aims: Doctors in training report high rates of burnout. The Balint group lends itself to addressing emotional stress and hence the associated risk of burnout. However, Balint group attendance among GP trainees and foundation doctors locally has been poor compared with psychiatric trainees. A Quality Improvement project was undertaken to explore and address barriers to attendance with the aim of improving GP trainees' and foundation doctors' engagement with the Balint group.

Methods: QI methodology was used throughout 2024. We implemented a quantitative, cross-sectional design using anonymous online surveys. We used purposive sampling by sending the surveys to GP trainees and foundation doctors on psychiatric placements within Kent and Medway NHS and Social Care Partnership Trust (KMPT). The survey was semi-structured, with closed and open-ended responses. The survey explored their understanding of the Balint group, how important they perceived it to be, and the barriers they experienced to attending.

Data gathered informed several 'change ideas' which were implemented through consecutive plan-do-study-act (PDSA) cycles. The timing of Balint groups was changed to ensure that less-than-full-time doctors had options to attend and that groups were less likely to conflict with clinical commitments. Improvements were made to the induction process to better socialise non-psychiatric trainees with the Balint group. A face-to-face format was trialled, replacing the previous virtual format.

Post-intervention surveys were administered, which included validated measures of burnout (Abbreviated Copenhagen Burnout Inventory).

Results: Resident doctors' understanding of the Balint group's function and process has improved. In parallel, attendance has increased in some Balint groups; for example, 75% attendance in June 2024 compared with 25% in March 2024. However, with frequent rotations of GP trainees and foundation doctors, each cohort having its own needs and preferences, we have found that improvements are not consistently sustained. Barriers still exist, such as conflicts with clinical commitments and the format feeling 'alien' and unhelpful to others. Changes to the degree of burnout through attending the Balint group are inconclusive and will be clarified with the results of a follow-up survey in March 2025.