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Aims. -A service development project was developed to establish the current capacity in administrative support for the medical workforce and to understand if there are gaps in support that can be addressed to reduce the time medics spend completing administrative tasks. -The project aims to make practical recommendations to enable medical staff to increase the clinical time spent with patients and, therefore, less time on administrative tasks. Previously published data also show that extensive administrative tasks impacting the clinician" well-being can lead to burnout.
Methods. -Separate surveys were developed for Doctors and Administrators; each group completed the surveys separately.

- Results were analysed and shared with the relevant stakeholders
- Practical recommendations were made with a focus on cost-effectiveness and safety.
- Engagement sessions with medical colleagues and the administrative workforce to reflect on various options and ideas to improve administrative support for the medical workforce.
- A cost-effective approach was identified and recommended to the Trust Board for approval and implementation

Results. Doctors surveyed identified that almost half of the medical workforce share administrator with the whole team, type their letters, felt they had sufficient administrative support and were prepared to use a voice recognition IT package. However, two-thirds needed more administrative help for their additional roles.

- Administrators surveyed identified that almost two-thirds of the administrative workforce felt they should be providing full dedicated"Name" support to Consultants, SAS and Junior Doctors. Over three-quarters felt they needed more time to complete all the tasks outlined in their job description (such as typing Docto"s letters). In addition, almost three-quarters could not provide dedicated support to doctors.

Most agreed that new roles similar to Medical Secretary role would release Doctor time from administrative tasks.

Conclusion. -The project has improved relationships and understanding of roles and work pressures from a clinical and administrative perspective.

- The Trust has more transparent data and qualitative evidence gained through project meetings and surveys.
- Staff felt engaged in the process, and positive feedback was provided throughout the project.
- Understanding the problems experienced in practice and engaging peers was crucial to meeting the Trus"s vision of being a clinically led organisation.
- Care Group modelling undertaken with consideration of COVID-19 Lessons learnt around agile working included administration support, ensuring the appropriate numbers and skills relevant to service demand and ensuring Doctors have dedicated, full support rather than shared with teams.
- Voice recognition programmes will also be explored through the Agile Working Group to free up Clinical time.
- Communication to both Doctors and administrators to brief on findings and next steps distributed through various channels in the Trust.
- The Medical Staffing Board formally thanked the author.

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.

Review of Consent to Treatment Documentation in University Hospital Wishaw Inpatient Psychiatry

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Aims. To establish if the Mental Health Act Code of Practice was being followed in the mental health inpatient ward population in Wishaw General Hospital. Specifically, those who were subject to detention with a Compulsory Treatment Order (CTO) under the Mental Health Act and whether or not documentation of consent to treatment was being kept.
Methods. Over the course of one week beginning on 1st December 2022, we reviewed the inpatient population within acute psychiatric wards (Wards 1-3) at Wishaw General Hospital to determine the nature of patient admissions, informal or under detention, specifically Short Term Detention Certificate (STDC) or Compulsory Treatment Order(CTO). A total of 57 inpatient notes were evaluated, including those of 10 patients with STDC and 14 with CTO. From these 14 patients, we determined whether T2b(240) or T3b(240) forms were clearly documented in both paper and electronic records (MORSE).
Results. One of the three patients on Ward 1 who were subject to CTO had both electronic and physical documentation of the T3B form. In the physical notes of two patients, the T2B or T3B form, as well as the reason and specific treatment, were adequately described.

Seven of the eight patients subject to CTO in Ward 2 had adequate documentation of the cause and particular treatment, as well as clear documentation of the T2B or T3B form in their physical notes. None of these patient" electronic notes contained any documentation. As the last patient was less than two months into CTO, they did not fit the criteria for the T2B or T3B consent forms.

All three patients subject to CTO from Ward 3 had clear documentation of T3B forms in their physical notes, as well as appropriate documentation of their cause and treatment. There was no documentation on these patient" electronic notes.
Conclusion. Overall, the clinical documentation was accurate with strict adherence to mental health act code of practice. 100% of patients requiring consent to treatment documentation either via T2B or T3B form were completed and available for review in the paper notes. Of note however, only 1 patient had CTO documentation and consent to treatment documentation available on electronic records (MORSE) which would allow remote viewing.

We propose the practice to upload detention certificates and consent to treatment forms to Electronic data (MORSE within the "files" tab). This information will be shared with ward staff to encourage copy and filing of documentation within this section on MORSE (electronic records).

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