errors, and controlled drug management. Follow-up audits conducted after the project's conclusion indicated that the reduced error rates were sustained over time, demonstrating the effectiveness of the interventions.

Conclusion: This QI project successfully reduced medication errors on West Ward through a multifaceted approach targeting multiple domains of medication safety. The combination of training, documentation improvements, process changes, and focused reviews. This project demonstrates that targeted QI initiatives can lead to significant and lasting improvements in medication safety within a busy mental health setting, ultimately benefiting patient care and safety. Further work will focus on exploring the factors contributing to sustained improvement and disseminating these findings to other wards and healthcare settings across the organisation.

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Quality Improvement Project: Introducing Pharmacy Input Into Consultant Psychiatry Outpatient Clinics

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Aims: This Quality Improvement (QI) Project aimed to enhance the overall level of care received/experienced by patients within the Havering Older Adult Mental Health Team (HOAMHT) through combining the clinical expertise of a Consultant Psychiatrist with the pharmacological acumen of a Specialist Mental Health Pharmacist, within a joint mental health outpatient clinic. Key areas tackled included: medication adherence, faster optimization of psychotropic medications, management of polypharmacy, de-prescription of drugs of dependence, physical health monitoring, and expediting patient discharge from HOAMHT back to the GP.

Methods: Our QI project utilised Plan/Do/Study/Act (PDSA) cycles. The first PDSA cycle took place in 2023/2024 over 6 months. The second PDSA cycle took place in 2024/2025 over 6 months. The 1st PDSA Cycle used patient satisfaction outcome scoring, which was randomly collected from 15 patients that had been reviewed within the joint clinics. The results from the 1st PDSA cycle led to a second PDSA Cycle being undertaken, in which the establishment of a ten minute pharmacist's corner feature was implemented within the joint clinic, and further patient satisfaction data was collected. Based on this data, in 2025/26 a third PDSA cycle will take place over 6 months, where there will be joint clinics consisting of junior doctors and pharmacists. This will serve to develop and refine teaching opportunities for the specialist clinical pharmacists. Then, the 4th PDSA cycle will look to expand and include other community mental health teams within our Trust, in order to see if improvements are possible to be achieved at scale.

Results: PDSA Cycle 1: There was a 38% improvement in patient satisfaction scoring for joint clinics vs stand-alone consultant/junior doctor clinics.

PDSA Cycle 2: Patient satisfaction scores increased further with the introduction of stratification, where the pharmacist was given protected time within the clinic to tackle medication-related queries, which patients found invaluable.

Conclusion: In England, there is just one Consultant Psychiatrist for every 12,600 people. Hence, the demands on clinical services for treatment have become unsustainable. Consequently, a novel and agile approach is required when organising community mental health services, so that all available clinical knowledge and expertise is exploited and geared towards maintaining a high quality of clinical care for patients, despite the resource limitations that are present. This QI project serves to demonstrate the value of effective collaboration between professionals in the pursuit of clinical excellence.

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Enhancing and Improving Resident Doctor Handover Practices at Black Country NHS Foundation Trust

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Aims: Effective handovers are essential for patient safety and continuity of care. Poor communication during shift transitions is a major contributor to medical errors and adverse events. Guidelines from the Royal College of Psychiatrists (RCPsych), British Medical Association (BMA), and National Institute for Health and Care Excellence (NICE) emphasise the need for structured, distraction-free handovers with clear documentation of key clinical information.

A review of handover practices at Hallam Street Hospital, Sandwell revealed reliance on informal unregulated communication channels, primarily WhatsApp, raising concerns about confidentiality, documentation consistency, and patient safety.

This Quality Improvement Project (QIP) aimed to evaluate existing handover practices to implement a more secure and structured system.

Methods: A baseline survey was completed by 21 out of 35 Resident doctors (Core Trainee Year 3 and below) participating in on-call and daily handover processes. The survey assessed satisfaction, confidentiality concerns, and patient safety risks associated with the existing WhatsApp-based handover system. Findings concluded:

62% were dissatisfied with the current WhatsApp-based handover process.

66.67% felt patient safety was compromised.

61.91% lacked confidence in receiving and reading handovers by the intended recipient.

Using the Plan-Do-Study-Act (PDSA) model, the intervention involved transitioning to a structured Microsoft Teams (MS Teams) handover platform, which was already successfully implemented at Bushey Fields Hospital, Dudley.

A standardised template was produced, including key information such as patient demographics, clinical status, outstanding tasks, and risk factors. Training sessions, user guides, and drop-in support were provided to facilitate the transition.

Results: Post-intervention data was collected via a follow-up survey after the implementation of MS Teams Handover channel. The results demonstrated a significant improvement in handover quality:

100% of respondents were either satisfied or very satisfied with the new system.

Confidence in patient confidentiality increased, with 100% of respondents being either very or extremely confident.

Concerns regarding patient safety decreased from 66.67% to 20%.

Confidence in handovers being received and read improved significantly.

100% of doctors felt the new process met medico-legal requirements.
Conclusion: Transitioning from an informal Handover system to a structured MS Teams platform led to substantial improvements in documentation quality, patient confidentiality, and Resident Doctor satisfaction. The standardised approach reduced the risk of errors, improved information transfer, and aligned with national best practice guidelines. Further refinements, including optimising accessibility and ensuring sustained engagement, will be explored in future cycles of this project.

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Improving Women's Sexual and Reproductive Health in a Psychiatric Inpatient Setting Quality Improvement Project: Development and Implementation of a Women's Physical Health Clinic in a Psychiatric Hospital in North London

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Aims: Following a pre-clinical survey of psychiatric female inpatients, it was highlighted that they found it challenging to access obstetric, gynaecological and sexual health investigations and management. It was also found that mental healthcare professionals in the same psychiatric unit had limited knowledge and awareness of women's physical health issues. The aim of this QI project were to develop and establish a monthly women's physical health clinic (WPHC) on an inpatient psychiatric hospital site, offering assessment, investigation and treatment by obstetricians and gynaecologists.
Methods: We have established a monthly WPHC occurring, since January 2024, on every 3rd Thursday of the month 1–5 pm at a psychiatric hospital in North London. It was run voluntarily by two local obstetrics and gynaecology (OBGYN) specialist registrars with a special interest in mental health. Specialised clinical equipment was sourced through central procurement. We developed a detailed referral pathway. This involved creating a referral form which would be emailed to all female wards and later screened. Patients accepted into the clinic were booked for roughly 45-minute slots based on priority. The OBGYN involvement included specialist investigations, treatments and liaison with patients' GPs. In order to raise awareness of the WPHC with psychiatric inpatient staff and patients, we designed posters and information leaflets, sent weekly email reminders to the clinical team about the clinic referral procedures and raising awareness through trust induction, academic teaching, and the Resident doctors' WhatsApp group.
Results: Referrals increased from 8 before May 2024 to 28 after implementing targeted interventions totalling 36 overall. While numbers increase initially, fluctuations occurred in subsequent months due to leave, strikes and staff shortages. Patient qualitative feedback obtained via surveys included requests for more frequent clinics (unmet need was even greater than anticipated), positive experience of a smooth service and complaints related to clinic delays linked to multiple factors. Staff feedback included satisfaction with the simplicity of the referral form, swift replies. Virtual clinics were suggested as a way of improving the access further, especially for advice regarding acutely unwell patients.
Conclusion: Our QI project data has demonstrated the importance of providing women with physical health care in a female psychiatric inpatient setting. The large increase in referrals following introduction of the WPHC highlights the unmet medical need for female psychiatric inpatients accessing obstetric, gynaecological and sexual health services. Our next steps will include securing funding for more regular, biweekly clinics, as the unmet need identified is greater than expected.

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Improving Rates of Capacity Assessment in an Acute Psychiatric Ward in London

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Aims: Capacity is a decision and time dependent construct and assessing capacity regularly is a core tenet of ethical practice, particularly in a psychiatric setting. However, on our ward we found that these assessments were not formally recorded for all patients. We felt it was pertinent to assess the proportion of patients for whom capacity assessments for consent to treatment and to admission were documented, and to trial interventions to improve these rates.
Methods: We collected retrospective data from electronic medical records of 40 patients admitted on an acute men's psychiatric ward between 1/10/2023 and 2/2/2024. For each patient we identified whether their capacity to consent to admission or treatment was recorded on their clerking, or on any subsequent ward-round documentation. Further to this we recorded whether each patient had a capacity assessment recorded on the dedicated Rio capacity form. We then implemented changes including the circulation of a standardised proforma for ward-rounds and clerkings, which included a capacity assessment. After 6 months we re-recorded these metrics for 29 patients admitted between 15/8/2024 and 24/10/2024 and compared the results of each metric using a chi-square test.
Results: We found that there was an increase in the proportion of patients receiving an assessment of their capacity to consent to treatment between cycle 1 and 2. However, this did not reach statistical significance ($p=0.66$). Similarly, in comparing rates of assessment for capacity to consent to admission on initial clerkings, there was an increase which was not statistically significant ($p=0.94$). For ward-round documentation, we found an improvement in rates of capacity assessment for treatment which was not statistically significant ($p=0.68$), and a decrease in rates of capacity assessment for admission which was not significant (0.94). However, there was a statistically significant increase in the proportion of patients who had a formal capacity assessment documented using Rio forms ($p<0.05$).
Conclusion: We did not find any statistically significant increase in the recording of capacity assessment on doctor's notes, either on initial clerkings or in ward-round documentation following our intervention. However, we did see a significant improvement in the