Advancing Medical Education in a Mental Health Trust: Trainees' and Students' Perspectives – Focus Groups

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Aims: Medical education is a cornerstone of the NHS, influencing the continuous improvement of patient care. This study aims to explore the experiences of psychiatric trainees and medical students within a mental health trust, identifying opportunities to enhance medical education quality.
Methods: A qualitative focus group methodology was employed to capture detailed perspectives of participants. Four separate focus groups were conducted, categorized by the level of training: medical students (n=4), foundation doctors (n=4), core psychiatric trainees (n=8), and higher specialty trainees (n=4). Participants were recruited via internal mass email. Focus groups were guided by a standardized topic guide. Data were analysed using thematic analysis.
Results: Key findings reveal shared themes of issues in induction processes, access to information, rota issues, and facilities. Additionally, the study highlighted the importance of structured support for achieving psychotherapy competencies and the necessity for both clinical and non-clinical training. There is also a significant need for better supervision, support, and appreciation.
Conclusion: The study provides insights into the experiences of psychiatric trainees and medical students, highlighting key areas for improvement. Implementing the practical recommendations can enhance medical education quality within mental health trusts, benefiting trainees, educators, and patients.

Improving Lone Work Practice Within a Mental Health Trust: A Quality Improvement Project

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Aims: Ensuring resident doctors' safety during lone working is crucial, due to unique risks and challenges faced when working alone. Birmingham and Solihull Mental Health Foundation Trust's (BSMHFT) current lone working policy recommends local procedures based on risk assessment and site needs. However, gaps in implementation have raised concerns about the consistency and effectiveness of safety measures.

Aims were to:

1. Increase awareness and adherence to lone working policy amongst Resident doctors in inpatient and community settings by 20% by September 2024.

2. Standardise lone working processes across BSMHFT by September 2024.

Methods: Our quality improvement (QI) project worked alongside the Trust's QI team, utilising improvement methodology. A baseline survey was conducted to understand issues faced whilst lone working, alongside process mapping to analyse root cause. We followed the Model For Improvement model and initiated four Plan-Do-Study-Act (PDSA) cycles for the following interventions:

Incorporated Lone Work checklist into orientation checklist for all resident doctors rotating within Trust.

Lone work presentation at induction.

Created video on lone working, alarm use and policy guidance.

Sent clinical supervisors reminders to discuss lone work procedures with their trainees.

Data was collected via surveys alongside video views and returned checklists.

Results: 4 surveys were conducted amongst resident doctors in BSMHFT.

Before interventions:

Baseline survey (24 responses): 71% conducted lone working. 29% felt informed about policies, 43% received alarms with 66% of these trained to use them.

First pulse check survey (25 responses): 8% felt very confident in lone working, 32% had alarms, and 32% were "not confident" in following trust policies.

After interventions:

Second pulse check survey (17 responses): confidence improved with 35% feeling very confident, 65% had alarms, and all could follow trust policies.

Detailed post-intervention survey (19 responses): 68% conducted lone working, 63% felt well informed and received alarms, 72% felt confident using alarms.

Feedback on interventions:

83% found the lone working video guide helpful.

68% were unaware of or had incomplete induction checklists for local lone working policies.

Conclusion: We have been able to achieve our aim of improving adherence and awareness of lone working policy amongst resident doctors by over 20% (33.83%). Alongside, there is improvement in doctors' confidence in lone working and the number, and utilisation, of alarms issued. This cycle has highlighted ongoing challenges and a need for further PDSAs to continue to improve, for example, pathway of escalation for lone working incidents and named alarms for doctors. The second cycle commences March 2025.

NELFT Adult Autism Service Quality Improvement Project: Managing Demand, Capacity and Flow of Referrals for Adult Autism Assessments

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Aims: The team joined the Royal College of Psychiatrists Quality Improvement (QI) Demand, Capacity and Flow (DCF) Collaborative. The aim was to increase the discharge rate to 19 per month following specialist assessment by June 2024.
Methods: Participants: NELFT Adult autism Service multi-disciplinary team (MDT), NELFT QI advisor, Directorate Business

manager, referrers, autistic adult with living experience of the service and the provider improvement advisor.

Process: Using the NHS Quality Service Improvement and Redesign (QSIR) six-step approach (NHSE), the Learning Handbook (NHSE). A project driver diagram helped identify change ideas in the referral, screening, pre-assessment, assessment and post-diagnostic pathways.

Priorities: Change ideas in the screening, assessment and post-diagnostic stages were prioritised and three Plan, Do, Study, Act (PDSA) cycles. PDSA1, to increase the number of assessments conducted, PDSA2, to reduce screening time by removing first stage, PDSA3, to complete reports and discharge within 4 weeks of assessment.

Results: PDSA 1: Assessments

Data collected: assessment waiting time (years), appointments completed (Jan–Mar 2023).

Assessment waiting time from 3+ years to 2 years.

Assessments completed from 6 (Jan–Mar 2023) to 20 (Apr–Jun 2024).

PDSA 2: Screening

Data collected: time referral screening in meetings (minutes), adding to waiting list from meeting (days), adding to waiting list from referral (days), Qpack postage (days).

Referral received to client being added to waiting list in days: 42.4 to 37.5.

Average days between referral meeting and being added to waiting list: 51.5 to 1.7.

Time to screen referrals in meetings (per referral, sample of 20): 16 minutes to 10 minutes.

Referral to Qpack posted: 26 to 3 days (sample of 20).

PDSA 3: Post-Assessment

Data collected: additional appointments needed (number), time to write report (hours).

Number of additional appointments needed following assessments: 1.8 to 1.6.

Time to write reports from 5.5 hours to 4.5 hours.

Conclusion: These results show that DCF has increased across the pathways, but further PDSAs i.e. digitalising reporting need to be implemented to achieve the overall aim. The processes highlighted some of the challenges such as client complexities, maintaining staff morale and adjustment to change. There were also some unintended consequences such as the impact of improving one part of the pathway creating blockages in another.

Opportunities for learning from collaboration with key partners such as clients and referrers has been positive and inspired a more co-produced and creative approach to the methodology. The service will continue to utilise the PDSA cycles to test change new ideas and the QSIR framework to continually improve DCF.

Enhancing Handover Quality and Continuity of Care: Implementation and Evaluation of a Digital Handover System in Grangewood Hospital, Northern Ireland

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Aims: To improve the quality of the handover process among resident doctors at Grangewood Hospital, Northern Ireland, through a digital handover system, targeting universal adoption (100%) of electronic documentation.

Methods: A digital handover system was implemented and evaluated over two months. A standardised pro forma was designed to allow for structured documentation for new and existing inpatients, covering patient demographics, legal status, clinical history, provisional diagnosis, and a management plan, including any outstanding tasks. The document was securely uploaded daily to a designated Digital SharePoint, ensuring compliance with local General Data Protection Regulation (GDPR) mandates. The digital system functioned as a dynamic and editable document and was designed to supplement verbal handover.

Data collection focused on evaluating adherence to handover completion and the presence of key clinical details: patient demographics, provisional diagnoses, brief histories, and management plans, including outstanding clinical tasks. Given the absence of a formalised handover framework prior to implementation, baseline assessments concentrated on measuring compliance and data completeness.

A driver diagram identified key enablers for successful implementation, and a Plan-Do-Study-Act (PDSA) cycle supported iterative refinements. Two structured educational interventions at Weeks 1 and 4 reinforced engagement. Additional sessions after Week 2 addressed emerging challenges.

Results: Of 50 potential handover episodes, 42 were successfully completed. Compliance rates improved from 40% in Week 1 to 80% in the final week, with an overall mean compliance rate of 84% over the 10-week period. The completeness of handover documentation averaged 76.72%, with the following component-specific inclusion rates:

Patient demographics: 68.25%.

Provisional diagnosis: 74.76%.

Brief patient history: 82.29%.

Outstanding tasks: 80.98%.

An improvement in documentation quality was observed following the second-week educational intervention, highlighting the importance of structured training.

Conclusion: Continuity of care is central to medical practice, as outlined in Good Medical Practice (2023). The digital handover system enhanced accuracy, completeness, and consistency, benefiting patient safety and workflow efficiency. While compliance rates indicate engagement, sustained adherence depends on continued education and refinement. Future efforts should focus on optimising usability and embedding digital handover into routine clinical practice to ensure long-term adoption.

Psychiatric Inpatient Services in a General Hospital Setting in the City State of Singapore: An Attempt to Improve the Inpatient Experience of Patients with Multi-Disciplinary Approach

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Aims: Sengkang General Hospital (SGH) is one of the newest government hospitals in the city state of Singapore. This busy 1000 bedded hospital has a 14 bedded psychiatric unit managed by the