

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.

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.

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

Dr Lewis Kitchen and Dr Adam Flynn

Grangewood Hospital, WHSCT, Londonderry, United Kingdom

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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.

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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

Dr Palanivelu Sendhil Kumar, Dr Chao Tian Tang, Dr Ho Teck Tan, Dr Kar Yin Lee and Dr Su Yin Seow

Sengkang General Hospital, Singapore, Singapore

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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

Department of Psychiatry. The department has 9 specialists, 4 to 5 Junior doctors and is supported by Allied Health Professionals like Psychologists, Occupational Therapists, Medical Social Workers and Nursing Professionals. All the above-named professionals work together as a well-oiled unit caring for the mental health needs of the patients mainly in the North East of Singapore. Ward 45 in SGH where the psychiatric unit is located houses inpatients who are 18 years and above. The patients have varied diagnosis, present with different risk profiles and as expected in any inpatient unit have varied lengths of stay. The aim was to start an inpatient programme which would benefit the patients during their stay and help in their recovery as well as equip them to build on their recovery and get back to successfully living in the community.

Methods: At the outset a few sessions were arranged involving all the professionals to discuss the therapeutic needs of the inpatients and how they could be addressed. The main aim of the programme was to help in recovery and relapse prevention. A list was compiled and in subsequent sessions the different health professionals who could deliver that was then mapped out. Once this was clear the individuals took it back to their respective departments to finalise on the deliverables and scheduling. This whole process took about a month. Once we were clear on the individual roles, we submitted the manpower requirement and time requirement for the Hospital Finance to generate a service code based on which the charges could be implemented. In subsequent meetings with all the professionals the different dates on which each professional could deliver the inpatient activity was finalised. The programme went live in February 2024. After a 3 month period feedback was obtained from patients and also the professional;s involved and some minor changes were made. We have now completed a year of the programme. A sample of type of activity is given below:

Psychology:

My distraction plan (pleasurable activities + thinking of someone patient cares about).

Self-soothing plan (self-compassion).

Un/helpful thinking styles.

Sleep hygiene + plan.

Values + action plan.

Self-esteem (kindness meditation).

Coping statements.

Relaxation (deep breathing + PMR).

Occupational Therapist:

Painting.

Collage.

Craft.

Drawing.

Medical Social Worker:

Generic activities to improve interpersonal skills and functioning.

Therapeutic approaches like IPT and DBT.

Nursing:

Psychoeducation activities about their condition.

Psychoeducation around the medications the patient is on.

Personal care advice and training.

Results: The Programme was accepted and appreciated by majority of the patients. The healthcare professionals also enjoyed delivering various therapeutic aspects to the patients and took an active role to improve care of the patients. A survey was done which captures the patients' views on some aspects of the programme by different professionals. The results have been overwhelming and a high percentage of patients have rated the programme as appropriate, useful and recommendable to others. A brief tabulation of the survey has been posted below:

Psychology: 76% of the participants found the programme useful in their treatment journey; 73% of the participants would recommend the programme to other service users.

Occupational Therapist: 89% of the participants found the programme useful in their treatment journey; 93% of the participants would recommend the programme to other service users.

Medical Social Workers: 75% of the participants found the programme useful in their treatment journey; 75% of the participants would recommend the programme to other service users.

Nursing: 63% of the participants found the programme useful in their treatment journey; 69% of the participants would recommend the programme to other service users.

Conclusion: The response to the initiative and encouragement has been overwhelming. We would like to enhance and build on the progress. Another regional hospital in Singapore has expressed interest in learning from our model and we intend to assist them in any way and collaborate and build on what we have gained. We are in the process of collecting data to see if we have made any progress on relapse prevention. Some of the things we can improve on:

The duration of the sessions as some patients stay short periods hence miss out.

Some patients who are high risk are excluded and we need to devise ways to include them.

Increasing awareness and also devise means of reducing the financial burden for participation in the programme.

Constantly look at what is delivered and how a varied and broad category of interventions can be provided (prevent repetition).

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Clinician Perspectives and Practices in Addressing Substance Use Among Children and Adolescents in NHS Grampian CAMHS

Dr Praveen Kumar, Mrs Caroline McKay, Dr Nimisha Doval and Dr Samuel Nixon

City Hospital, Aberdeen, United Kingdom

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Aims: This study examines the perspectives, practices, and training needs of NHS Grampian CAMHS clinicians in addressing substance use among children and adolescents. The primary objectives are to:

Evaluate clinicians' attitudes towards adolescent substance use.

Identify perceived barriers to effective assessment and intervention.

Inform the development of an integrated substance use pathway within CAMHS.

Methods: A cross-sectional survey was conducted between September and November 2023 using SNAP software. The survey was distributed to 48 CAMHS clinicians across NHS Grampian and included structured and free-text questions on demographics, clinical practices, perceived challenges, and training needs. Quantitative data were analysed in Microsoft Excel, while qualitative responses underwent thematic analysis.

Results: The survey captured diverse professional representation: 50% psychologists, 25% nurses, and 14.5% medical staff. While clinicians acknowledged substance use experimentation as part of normal adolescent development, they emphasized that persistent or problematic use requires structured intervention. The majority supported a multidisciplinary, multi-agency approach for better integration between mental health and substance use services.

Significant training gaps emerged: 46.9% of clinicians lacked familiarity with evidence-based interventions, while 40.8% required further training to implement them effectively. Only 10.2% reported