

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

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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

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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