Conclusion: To ensure the on-going provision of the Mentalization Based Art Psychotherapy Group the facilitators recommend the following:

Group provision is continued on a weekly basis.

The availability of a practitioner with a background in psychological therapies/psychiatry is essential to co-facilitate alongside the art therapist (and this must consistently be the same person).

Dedicated specialist clinical supervision for group facilitators is provided monthly.

Active planning takes place in relation to provision of a suitable therapeutic group space and facilities.

There is provision of staff training and supervision based on mentalizing principles.

Co-Producing Neurodivergence-Informed System Change: Establishing a Novel Trust-Wide Medical Specialist Neurodivergence Advisory Role and Framework in Mental Health Services in Essex

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Aims: Autistic and other neurodivergent people experience substantial health inequalities, including poorer mental health outcomes, barriers to accessing care, and premature mortality (autistic people are 7 times more likely to attempt suicide than non-autistic people). These preventable outcomes reflect systemic inequities rather than autism itself. There is, therefore, need for a radical new approach to ward-, service- and organisational-level change to address this profound, unmet need within mental healthcare systems.

Aim: to create a novel Trust-wide Neurodivergence Specialist Advisor role within Essex Partnership University NHS Foundation Trust (EPUT), to improve quality, safety and across all services and age groups through co-produced partnership working to drive professional development, system transformation and an essential cultural shift around all neurodivergence.

Methods: This service-development initiative involved partnership working between an Autistic/ADHD psychiatrist and a lived-experience expert, grounded in participatory and co-production principles. Activity domains will include: bespoke patient and service clinical consultations; supporting Patient Safety Incident Investigations, Inquest, LeDeR panels, and Prevention of Future Death processes to turn learning into transformational change; delivery of co-produced training addressing workforce knowledge gaps (e.g. National Autism Trainer Programme – additional and complementary to Oliver McGowan Mandatory Training); service development aligned with organisational governance quality priorities; and collaborative partnership working with local authority and system partners to address interface gaps where neurodivergent people are excluded from support and care pathways.

Results: Significant drive leading to the successful implementation of this new frameworkand advisory role is an outcome of sustained lived-experience advocacy and campaigning, reflecting the influence, expertise, and leadership of the co-authoring lived-experience partner, reinforcing the value and principles of participatory and co-production in healthcare design.Experiential knowledge is essential to shaping equitable systems, not as an adjunct perspective.

Structured evaluation is planned at six months, including audit of activity and service impact (including patient safety data), thematic analyses, and review through executive governance processes as defined by EPUT's "Working with Neurodivergence" group. This will explore perceived accessibility, workforce ability and confidence, system responsiveness, and identification of previously unrecognised gaps across service pathways. Findings will inform iterative refinement of the role and contribute to organisational learning regarding scalable neurodivergence-informed service transformation.

Conclusion: Embedding neurodivergence expertise and lived experience at organisational level represents a scalable approach to addressing structural inequities in mental healthcare for neurodivergent people. This model emphasises transformational co-production, workforce development, and cross-system collaboration as mechanisms. Early implementation insights will guide wider adoption and contribute to improving outcomes for neurodivergent populations.

Developing the Current General Practitioner Programme to Improve Effectiveness

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Aims: Previous project conducted within the trust hypothesised and found that a tailored General Practitioner (GP) teaching programme was preferred by trainees and met GP training needs when given in addition to the general teaching programmethat is available to all psychiatric and GP trainees. The recommendation at the time was to develop a wide range of topics within this programme that were aligned with the GP curriculum for psychiatry.

The aims of this project were to evaluate if the current programme is useful and relevant to GP trainees as well as aligned with GP curriculum. To make amendments to the programme to ensure this and therefore, improve the overall quality.

Methods: I conducted two cycles with two GP trainee cohorts. In cycle 1: edited PowerPoints from previously designed GP programme with pre-chosen topics, delivered 6 teaching sessions and collected post session feedback on relevance, usefulness as well as qualitative data on what went well and what could be improved.

In cycle 2: Made changes to topics from previous cycle feedback and mapped topics against GP curriculum, formalised a timetable and information letter which was disseminated for smoother process, delivered 6 teaching sessions, modified feedback forms to collect both pre session feedback on confidence in topic and expectations and post session feedback on confidence in topic, expectations, relevance, usefulness and qualitative data on what went well and what could be improved.

Results: The results in cycle 1 showed 88% found the teaching on risk assessment useful and100% found it relevant. However, it reached 100% positive response for usefulness and relevance by the end of cycle 2. Furthermore, the teaching on Balint groups was rated relevant by 50% of trainees and 0% found it useful. Therefore, it was replaced with teaching on personality disorders, which reached 100% positive response for usefulness and relevance in cycle 2.

Overall, in cycle 2, confidence rating increased after the teaching session for all trainees. In the qualitative feedback, overall satisfaction

was high and some minor adjustments were asked for, mostly to include more sessions with more sub-speciality specific teaching.
Conclusion: Possible direction for the future would be to take the recommendations from qualitative feedback forward into the next cycle. All topics to continue into the next cycle with additional topics, if possible on subspecialities. Another would be to continue mapping learning objectives to GP curriculum to maintain relevance.

Improving Resident Doctors Confidence in Navigating Pay, Rota and ARCP Requirements When Transitioning to Less Than Full Time Training at South West London and St George's NHS Trust

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Aims: To increase the confidence of resident doctors in navigating pay, rota and ARCPrequirements, related to LTFT training following a targeted educational intervention at the August 2025 induction.
Methods: Around 25% of resident doctors in the UK now work LTFT (Less Than Full Time). However, many face issues with navigating training requirements, pay and rota arrangements.

A Quality Improvement (QI) approach was used to identify and address knowledge gaps among LTFT trainees.

A baseline questionnaire was first distributed to resident doctors at South West London and St George's NHS Trust between June and July 2025 to identify common challenges. In response to these findings, a comprehensive induction presentation was delivered in August 2025 covering essential topics such as pay (nodal points, hourly rates, and flexible training premia), rotas (pro-rata leave and on-call obligations), and ARCP requirements (pro-rata assessments and adjusted completion dates). To evaluate the intervention's impact, a post-induction questionnaire was subsequently administered to the August 2025 cohort of resident doctors at the Trust to measure improvements in trainee confidence levels.
Results: Prior to the introduction of the Less Than Full Time (LTFT) induction session (June–July 2025), resident doctors reported low baseline confidence across all three areas of LTFT training evaluated, with mean scores of 2.3/5, 2.3/5 and 2.2/5 for pay, ARCP requirements and rota domains respectively.

Following the implementation of the LTFT induction session (August 2025), confidence levels showed a marked improvement among respondents. Mean confidence in navigating pay issues, ARCP requirement and the rota rose to 4.29/5, 3.9/5, and 4.3/5, representing an 86%, 68% and 95% increase from baseline respectively.

Qualitative feedback from the post-induction cohort was overwhelmingly positive, with 100% of trainees describing the presentation as "very clear and informative".
Conclusion: Providing a dedicated LTFT session during induction significantly improves resident doctors' confidence in navigating the administrative hurdles of non-standard training. We are developing further guidance for resident doctors to be published on the Trust's intranet.

Reducing and Improving Patient Observations in a London Psychiatric Ward: A Quality Improvement Project

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Aims: Over an 18-month collaborative at CNWL, Thames Ward an acute mental health ward at St Charles Hospital in the Royal Borough of Kensington and Chelsea, aimed to reduce high-level observations by 50% and decrease the frequency of continuous observation. Baseline data showed 18 high-level observations per week and use of continuous observation every 2.5 days.
Methods: With support from an Improvement Coach and workshops, the team tested three PDSA-cycle changes: safety huddles including all staff in observation decisions, prioritising risk assessments over automatic observation for new admissions, and improving patientcommunication. Seven in-depth interviews by an Expert by Experience informed communication practices.
Results: The project achieved a 50% reduction in high-level observations (18 instances down to 9) sustained from January–September 2025. Continuous observation frequency decreased, with up to 43 days between episodes. Violence and aggression incidents did not increase, and bank staff costs fell to £0 in September 2025.
Conclusion: This work demonstrates that restrictive practices can be reduced without compromising safety, highlights the importance of challenging entrenched routines, and shows that Expert by Experience involvement is central to meaningful improvement.

Surviving Psychiatry On-Calls: A Peer-Led Video Intervention

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Aims: A peer-led video intervention aimed at boosting trainee confidence in handling psychiatry on call tasks.

Assess what trainees are most worried about before starting out their psychiatry on-calls.

Assess baseline trainee confidence of handling on call tasks.

Design a targeted video intervention aimed at junior resident doctors (both core and foundation trainees) to boost confidence in handling their on-call requirement and assess its impact on trainee confidence.
Methods: We produced an eight-minute introductory tutorial video for core and foundation trainees for their first on calls at Kendray Hospital in Barnsley, to improve their confidence on handling on-call tasks. This video covered key areas of common tasks such as how to clerk a new patient, how to complete a section 5(2) form or a seclusion review. Kendray Hospital specific information such as where to find the on-call pager, and on-call rooms was also included. Microsoft video editing software (Clipchamp) was used for video editing. A survey was sent to assess trainee confidence before and