across a broad distribution list. In a high-secure forensic setting, where patients have complex comorbidities and legal restrictions, communication failures carry heightened clinical and governance risk.

Rather than modifying the email format alone we aimed to redesign the entire handover processto ensure up-to-date information, improve accountability, enhance data security and promote combined verbal and written handover.

Methods: We conducted a Quality Improvement Project using feedback and systemic redesign, we surveyed all regular recipients of the handover email (resident doctors, consultants, site management and physical health nurses). The baseline results showed low satisfaction with the handover email, with 73% reporting dissatisfaction to extreme dissatisfaction, citing safety, accuracy, layout and confidentiality concerns.

Our intervention replaced free-text email handover with a structured process. We introduced an Excel template stored in a secure shared drive which is attached to the email, separate tables were created for acute issues, monitoring needs, seclusion status and tasks. Full patient names were removed and replaced with the initials and hospital numbers. We also introduced a requirement of both verbal and writtenhandover and added a step for the on-call doctor toconfirm seclusion status with site management by the end of their shift. We also reviewed all patient lists for regular monitoring to remove outdated patients. The new process was introduced via hospital-wide presentation.

Results: Post-implementation feedback showed marked improvement, up to 80% of responders reported satisfaction to extreme satisfactionacross domains compared to the baseline dissatisfaction. Staff reported clear structure, more reliable seclusion information, fewer missed tasks and improved confidentiality. The combination of structured documentation and verbal handover reduce reliance on memory during busy shifts and improved multidisciplinary communication. Removal of outdated patients increased clinical relevance of the handover list.

Conclusion: System redesign of the medical handover improved safety, clarity and information governance in a high-secure forensic setting.Structured templates, verbal reinforcement and reduced identifiable patients' data created a more reliable process.

This low-cost interventiondemonstrated how addressing system factors can strengthen communication, accountability and patient safety across acute and secure psychiatric services.

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Reducing Morning MDT Handover Duration Through Structured Communication: A Quality Improvement Project

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Aims: Effective handover of patient care is essential for patient safety. In psychiatric inpatient wards, morning multidisciplinary team (MDT) handover is used to communicate information from previous shifts; however, this process was criticised locally for lack of structure, prolonged duration and omitted information. This quality improvement project aimed to reduce the duration of morning handover through implementation of a structured handover tool. A secondary aim was to explore the relationship between the number of attendees and handover duration.

Methods: The Model for Improvement methodology was used. Initial qualitative discussions with both junior and senior MDT members identified perceived problems with the existing handover process and informed potential change ideas. Baseline data were collected over approximately 1 month (N=17), recording total handover duration and number of attendees. Comparable data were also collected from four other inpatient wards where structured handovers were already implemented, providing benchmarking.

A structured morning handover tool based on the SBAR framework was developed and implemented, then disseminated to nursing staff responsible for leading the handover. Following implementation, handover duration and attendance were measured over a further one-month period (N=19), with additional data collection (N=5) during two separate weeks in subsequent months to assess sustainability. Qualitative feedback was obtained from the MDT to assess attitudes to the intervention.

Results: Mean handover duration decreased from 68 minutes (range 35–102) to 52 minutes(range 38–78)following implementation, representing a 24% reduction. During months three and four, one-week samples showed mean handover duration of 53 and 48 minutes respectively, demonstrating sustained improvement.

With an average attendance of 9 staff members per handover, this reduction equated to 720 minutes (12 hours) of MDT clinical time released per week. Qualitative feedback was positive, comments included 'continuous positive influence', 'a huge improvement' and 'concise without sacrificing thoroughness'.

Baseline handover duration on comparator wards, using alternative structured approaches, ranged from 35–47 minutes, suggesting that using a structured handover rather than the specific format used was the key factor associated with decreased duration, although ward differences likely also contributed.

Correlation coefficients between attendance and handover duration ranged from +0.13 to +0.69 across wards and time points, however no intervention targeting this was implemented.

Conclusion: Implementation of a structured morning handover was associated with a sustained reduction in handover duration and improved perceived quality. The findings suggest that implementing any structured approach is more important than the specific framework used. Increased attendance was associated with longer handover duration.

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Improving the Quality, Accuracy and Consistency of Capacity Assessments Across Inpatient Psychiatric Wards at the Harbour (FC Locality)

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Aims: To improve the quality, accuracy, and consistency of capacity assessments and their documentation in line with the Mental Capacity Act (2005) across inpatient psychiatric wards at The Harbour. The project aimed to ensure assessments were decision