patients, incorporating lived-experience priorities. Key components included: routine dual diagnosis assessment within seven days of admission; specialist consultation on integrated treatment planning; motivational enhancement and psychoeducation; liaison with psychology andsocial services; and early, structured signposting to community substance misuse and social support services prior to discharge. A phased QI methodology was adopted, supported by governance oversight and iterative service refinement. Process and outcome measures included staff-reported confidence, access to specialist advice, clarity of discharge pathways, and patient experience feedback. Workforce development was embedded through targeted training and ongoing specialist consultation.

Results: Early qualitative feedback indicates improved staff confidence in managing dual diagnosis presentations and increased clarity regarding referral, discharge planning, and community follow-up. Ward teams reported improved access to specialist expertise and enhanced collaboration with external services. Patients valued timely, non-stigmatising support addressing both mental health and substance use needs, particularly early engagement and psychological input. The pilot demonstrated feasibility, acceptability, and scalability within existing resources, directly addressing previously identified service gaps and aligning with national priorities for integrated care and reduction of avoidable hospitalisation.

Conclusion: This QI project demonstrates that an inpatient Dual Diagnosis Support Service can be implemented effectively without additional funding, delivering early improvements in staff capability, patient experience, and pathway integration. The structured, co-produced, and data-informed approach supports sustainability and scalability. Findings from the six-month pilot will inform refinement and planned expansion into community mental health teams, contributing to system-wide improvements in care for people with co-occurring mental health and substance use disorders.

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Preparing Doctors to Secure Services Through an Empowering Buddy Programme Initiative: A Quality Improvement Project

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Aims: St Andrews Healthcare in Northampton is a tertiary psychiatric hospital with multiple divisions, aiming to lead Complex Mental Health care. It includes secure units across 3 divisions, in varying security levels and specialist needs.

Resident doctors identified through a survey that the current induction process does not support new doctors. Three main areas of concern were identified: information about their job roles, feeling confident for on-calls, and feeling welcomed. Some doctors commented that it took up to one year for them to feel comfortable in their duties.

Methods: A Buddy programme was developed with formalised sessions to support a new non-consultant doctor. These included Speciality Doctors, Clinical Teaching Fellows and Associate Specialists and all eligible new doctors participated. It began as a 6-month pilot in Medium Secure Unit before launching to the whole of Northampton site. It ran between March 2024–December 2025. A comprehensive information booklet was created to support the Lead Buddies of each division on subjects to cover with their colleague. Feedback included pre-and post-intervention survey with binary answers, a Buddy feedback form, and additional feedback through e-mails. It was sponsored by one of the Associate Medical Directors and with the approval of all Clinical Directors.

Results: The pre-programme survey noted only 18% of Resident doctor shaving enough information during their induction.

Post-intervention survey increased this to 100%. Confidence about their role has increased from 25% to 100%.

Despite the increase of confidence for starting on-calls, there was still remaining anxiety noted about the complexity. All doctors scored for anxiety about the on-calls in the pre-questionnaire. Post-intervention feedback noted remaining anxiety due to the size of the site. The programme enhanced the preparedness for on-calls by 57%.

Feeling welcomed had increased from 60% to 100% by the end of the programme.

Conclusion: Buddy programme had an overwhelmingly positive effect for new Resident doctors. There are identified areas for future improvement. The organisational changes of the size of the site are likely to resolve one of these. The remaining areas include further analysis of the complexity of cases during on-calls and the turnover rate of non-consultant doctors.

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My MDT: Improving Service User Experience of Multidisciplinary Team Meetings Through a Person-Centred Approach

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Aims: Multidisciplinary Team meetings are essential to care planning, rehabilitation, and discharge. However, MDTs are often experienced differently by each service user. Each service user brings their own preferences, communication styles and expectations to the MDT setting. This quality improvement project aimed to explore their views on MDT and developed a sustainable process whereby patients' views are explored and the MDT process is adjusted to their needs and preferences.

Methods: We used the 6-step quality improvement approach and completed three Plan–Do–Study–Act cycles. Baseline insight was gathered using a structured Likert scale questionnaire to explore service users' views and experiences of MDT meetings. Responses were rated on a five-point scale from very satisfied to very unsatisfied.

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