Methods: The survey was developed in collaboration with resident doctors and the College Tutor Committee (CTC). Initial planning took place in May 2024, with survey design and distribution occurring in July 2024. Data collection focused on themes such as induction, rota design, and supervision. Data were cross-referenced with the GMC National Training Survey and HEIW Core Psychiatry Training data for validation. Although our respondent numbers vary vastly from that of the GMC National Training survey, significant proportionate interpretation of concerns raised in CTMUHB were made. Results are currently guiding discussion with the CTC and Health Board executives to implement strategic interventions.
Results: Respondents highlighted several concerns, particularly in induction processes, rota design, facilities, and consultant availability. Governance-related issues, such as inadequate escalation pathways, were also evident. 22% of respondents strongly disagreed that they had received all necessary information during induction, compared with just 2% in the national GMC survey. 11% rated their induction as "very poor". Rota management was another major concern, with 33% of residents expressing dissatisfaction over unfilled rota gaps, which they felt resulted in missed learning opportunities. Additionally, 44% of CTMUHB residents reported working beyond their rostered hours, a figure substantially higher than the national rate of under 12%. Alarmingly, 22% of respondents were unaware of how to raise concerns about their training, indicating a critical gap in reporting mechanisms. Reports of discrimination, burnout, and negative workplace experiences further underscored the need for urgent intervention.

Despite these challenges, positive aspects were noted. All respondents agreed that their educational supervisor was easily accessible, and every trainee received formal feedback. However, 22.2% found this feedback unhelpful. Many residents highlighted teamwork and a supportive work environment as key factors contributing to overall job satisfaction.
Conclusion: The Health Board specific findings highlight the need for targeted interventions to improve training conditions. Recommendations include enhancing induction processes, redesigning rota management, increasing consultant availability and improving reporting systems. Addressing workplace discrimination and fostering a supportive environment remain critical priorities. Continued collaboration between resident doctors and the CTC is essential to drive meaningful improvements and ensure a better training experience for future trainees.

Effective Discussions of Affective Cases: A Survey of Attenders of the Mood Disorders Grand Rounds

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Aims: Specialist mood disorder services in the UK are diverse in structure and spread over different clinical-academic centres in the UK. Relationships between these centres are strong but often based on academic projects, with limited opportunities for clinical case discussions. The NIHR Mental Health Translational Research Collaboration, together with the ASCEnD trial team, has set up an online monthly meeting of tertiary mood disorder services: the Mood Disorders Grand Rounds (MDGR). The aims are: 1) to bring together people with expertise and interest from different centres across the UK; 2) to discuss complex and difficult to treat (or interesting) cases; 3) to consider treatment options. The format includes a 20-minute anonymised case presentation by a specialist, covering clinical and thematic aspects, followed by a 40-minute panel discussion focusing on case management, related themes, and relevant research studies. The presentership rotates between centres around the country and encourages a multidisciplinary approach.

Following the first 12 months of MDGR, we distributed a survey to evaluate and develop the meetings.
Methods: An evaluation form was developed and sent to all registered attendees over the course of six months, on a rolling basis. Participants were asked to both rate the effectiveness of various aspects of the programme and to submit suggestions for improvement, including suggestions for future speakers. Questions included both Likert scored items and free text responses.
Results: We received 21 responses (12% of those registered). 75% of respondents had not been to a similar regular collaborative programme previously. 50% of respondents stated that the MDGR had directly influenced their clinical practice, examples being of "Using MAOIs in a case where I hadn't considered it before" and "identification of a patient with likely autoimmune encephalitis". The remaining 50% stated that whilst the programme was relevant it had not had a direct result on practice.
Conclusion: A high proportion of respondents reported their clinical practice had been directly influenced by attendance. This suggests the MDGR is fulfilling the stated aim of focusing on clinical discussions and is of value to attenders. The rate of response is low and could be biased to those who found it more useful.

Simulation Training for Falls on the Older Adult Mental Health Wards

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Aims: Falls are the most commonly reported patient safety incident in all older adult (OA) inpatient wards, and studies suggest there may be up to three times as many falls in OA mental health, compared with physical health settings. Many factors present on the mental health wards may influence this, including higher levels of agitation, psychotropic side-effects, a culture of promoting recovery through activity and a higher prevalence of side rooms resulting in less direct observation. There are four OA mental health wards within South London and the Maudsley NHS Trust. Following an analysis of serious incidents, falls prevention and management was identified as an area for improvement. Work to date has included updating the clinical falls policy, promoting a 'falls awareness week' and introducing a mandatory falls e-learning module. However, concerns remained about the practical application of this learning. As such we developed and delivered a half-day simulation course, with the aim of engaging staff in a enjoyable, practical session which would allow for reflective discussions and embed the new falls policy within ward culture.
Methods: The simulation course is designed to reach approximately 100 multi-professional staff across the four wards. Eight deliveries have taken place, or are scheduled to take place, between December 2024 and March 2025. Learning objectives, which were informed by

trust protocols and incident reports, included increasing confidence with: identifying physical signs and symptoms of fractures and head injuries; initial assessments, management, ongoing review, and escalation process following a fall; the role of team working, handover and communication with family and colleagues; documentation and reporting systems after falls incidence, and increased awareness of the tools available to assist on the intranet.

Each delivery is co-facilitated by simulation faculty and ward staff. The course features four simulated patients, portrayed by actors. The scenarios are designed to each include different risk factors, mechanisms and consequences of falls. Each scenario is followed by a reflective modified diamond debrief.

Results: Pre and post-course questionnaires currently show increased confidence with regard to all the learning objectives. A thematic analysis of free text comments will also be presented, alongside reflections from the facilitators.

Conclusion: Simulation using live actors is an under-utilised medium for training in situations where physical and mental health presentations co-occur, and can be instrumental in embedding new policies or learning from serious incidents.

Addressing the Complexities of Physical Health Monitoring in ADHD and Autism in Oxfordshire: Implications for Overall Well-Being and Psychiatric Treatment

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Aims: Individuals with ADHD and autism may face increased risks of cardiovascular issues or metabolic disorders influenced by both their neurodevelopmental traits and prescribed treatments. Ensuring consistent monitoring can help manage these risks and support better long-term outcomes. This paper explores the challenges of physical health monitoring in ADHD and autism and presents a quality improvement project aimed at enhancing monitoring practices in clinical care.

Methods: Challenges in physical health monitoring for individuals with ADHD and autism include variability in practice, limited access to medical equipment, space constraints in clinical settings, and the need for clearer guidelines. To address these issues, we conducted an assessment within the ADHD and autism service in Oxfordshire to identify essential materials for comprehensive monitoring of ADHD medications, antipsychotics, and antidepressants, alongside overall physical well-being.

Results: Key materials identified included blood pressure monitors, ECG machines, height and weight measurement tools, blood glucose and cholesterol testing kits, liver and kidney function tests, electrolyte testing kits, drug screening tests, and nutritional assessment tools. The assessment identified several challenges in physical health monitoring within ADHD autism service. Out of 12 assessed items, 58.33% had the necessary materials available, though essential equipment was not always present, and time constraints made integration difficult. Among those, 85.7% had functioning equipment, while 14.3% had non-functional equipment.

Conclusion: In ADHD and autism services, where psychopharmacology plays a central role in treatment, the importance of physical health monitoring becomes even more critical due to the side effects of medications such as stimulants, antipsychotics, and antidepressants. Inconsistencies in equipment availability, maintenance, and staff training were noted, leading to potential risks to patient safety, reduced efficiency, and increased costs. Recommendations include improved maintenance, acquisition of additional equipment, and enhanced staff training to ensure effective monitoring across services.

Breaking the Silence: Exploring Barriers to Raising Concerns in Psychiatry

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Aims: Raising concerns is an important duty for those working in medicine, which can have a broad impact on factors including safety, training, and wellbeing. This project aims to explore resident doctors' experiences of raising concerns in psychiatry, including establishing awareness of available processes, and identifying barriers to utilising these. This work has been conducted as part of a wider Quality Improvement Project, aiming to improve resident doctor awareness and engagement with the process of raising concerns by overcoming identified barriers.

Methods: Resident doctors of various grades working in psychiatry within a six month period were invited to attend focus groups to gather information about their perspectives of raising concerns. Thematic analysis of focus group discussion was conducted. Quantitative data was obtained from an online survey which was sent to all resident doctors working in the trust for anonymous completion.

Results: 19 resident doctors attended focus groups. Thematic analysis of this content demonstrated five key themes with additional subthemes:

Repercussions (impact on career + feedback, wellbeing, reputation).

Futility.

Uncertainty (culture, acceptability, process).

Division (hierarchy, staff groups).

Variability (receptiveness, response, supervisor relationship).

25 resident doctors responded to the survey: 52% felt unfamiliar with the process for raising concerns; 5 respondents had raised a concern within the trust; 9 had experienced concerns that they had wanted to raise but could not.

Most concerns related to training (56%), supervision from seniors (31%), patient safety (25%), bullying/harassment (19%), and resident doctor wellbeing (13%). 16% of respondents felt that a barrier to raising a concern was related to race, sexuality, gender, or any other protected characteristic. 57% felt they were not taken seriously when they had raised a concern. 71% felt they had not received adequate feedback after raising a concern.

Conclusion: Resident doctors are experiencing a range of concerns, but many find that barriers prevent them from raising these. These barriers generally relate to uncertainty regarding the process, futility