psychiatric community unit. External factors including seasonal patient changes, variations in referral practices, or limited staff training regarding the triage poster may have acted as confounding variables. The short data collection period (three weeks pre- and post-intervention) may not account for realistic variability, which potentially contributed to the observed increase in re-admissions. Further understanding the impact of confounding factors is needed to improve the intervention's ability to satisfy the QIP's aim, which is to reduce patient re-admissions related to polypharmacy and multimorbidity.

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Quality Improvement Project on Mental Health (Self-Harm) Care Provision in an Emergency Department

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Aims: In 2022, the Royal College of Emergency Medicine (RCEM) published an updated toolkit for Mental Health in Emergency Departments (EDs), outlining clinical standards to improve care for mental health patients. These standards, based on guidance from the National Institute for Health and Care Excellence (NICE) and the Royal College of Psychiatrists, focus on (1) the ED mental health triage process, (2) observation of patients at risk of self-harm or absconding, and (3) the quality of ED clinicians' assessments. The toolkit also emphasises collaboration with mental health teams to facilitate parallel assessments. This quality improvement project evaluated Darent Valley Hospital's ED performance against these standards and tracked service improvements over two years.
Methods: Data was collected retrospectively from October 2022–March 2023 and October 2023–August 2024. A total of 298 cases were analysed (102 in the first year, 196 in the second). Patients aged 18 years and above who presented with intentional self-harm and were referred for an emergency mental health assessment were included. Under 18s, inpatients in mental health units and those not requiring ED care were excluded. Process measures assessed included time to triage, observation of at-risk patients, time to ED clinician review, and risk assessment quality. Outcome measures included indicators of compassionate and practical care, such as provision of food, drink, pain relief and discussions regarding treatment.
Results: Monthly meetings with the Psychiatry Liaison Team increased parallel assessments (from 39% to 56%). The appointment of an ED safeguarding lead contributed to reduced times for triage (45 to 40 minutes), and time to physical health assessment (170 to 125 minutes), with dedicated mental health triage compliance increasing (64% to 98%). The proportion of patients receiving well-documented physical health assessments improved from 86% to 92%. While risk assessment quality improved (11% to 17%), particularly regarding drug and alcohol concerns and safeguarding, further work is needed. The presence of alcohol liaison nurses twice weekly supported these improvements. Challenges remain, including a decline in documented observations of at-risk patients (30% to 20%) and only modest improvement in compassionate care provision (13% to 21%).
Conclusion: This audit demonstrates progress in assessing and managing patients presenting with self-harm. Planned improvements include a standardised mental health proforma to enhance triage and risk assessment. Further multidisciplinary team discussions will focus on optimising compassionate care, safeguarding, and substance misuse pathways, with ongoing ED staff education. The audit will continue into 2025 to assess the impact of these interventions.

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Streamlining ADHD Annual Reviews: Implementation of a Form-Based System to Replace Face-to-Face Consultations

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Aims: Patients prescribed medication for ADHD require an annual review, generally conducted by specialist services, which accounts for a significant proportion of the workload. Delays in annual reviews can lead to GPs withdrawing Shared Care and discontinuing medication. Optimising this process could release much-needed resources for already struggling ADHD services.

This project evaluated the impact of replacing routine face-to-face annual reviews (ARs) with a streamlined, form-based system, with key objectives of assessing improvements in service efficiency, patient outcomes, and resource allocation while maintaining adherence to NICE guidelines.
Methods: A single-page Adult ADHD-friendly form consistent with NICE Guidelines on annual reviews was developed to assess medication adherence, symptom stability, and the appropriateness of continued ADHD medication. Created with a service user panel, the form was designed to allow patients to complete it by phone or email in less than 3 minutes.

Following a review of the responses on the AR form, patients requiring a further review or intervention were offered clinic appointments. Data from January to June 2023 were analysed to determine the proportion of patients requiring follow-up, and care records for this group were reviewed.
Results: Of 288 patients contacted, 262 responded, with only 60 (20%) requiring a follow-up review, mainly for medication effectiveness issues (37.1%), dose adjustments (22.6%), or side effects (17.7%), indicating that 80% of cases were manageable via the form alone.

Only 2 forms were redone due to incompletion. 25 patients (8.7%) did not respond, and were discharged after further attempts, including GP contact.

Extrapolated data: Approximately 700 patients were on the AR list. Replacing routine 1-hour face-to-face reviews with 5-minute paper reviews for 80% of patients saved an estimated 560 patient hours annually. This enabled an additional 112 assessments for new or complex cases (assuming each assessment takes 5 hours).

Consultant workload analysis:

Each Programmed Activity (PA) equates to 4 hours. 560 hours = 140 PAs saved annually, or 23 weeks of full-time consultant time (based on 6 clinical PAs per week). At an average consultant salary of £118,000/year, this system achieved a cost saving of approximately £60,000 annually.
Conclusion: This innovative approach demonstrates that replacing routine face-to-face ADHD reviews with a form-based system

significantly enhances service efficiency, reduces waiting times, and optimises resources. Positive feedback from patients suggests high acceptability, with many valuing the convenience of avoiding unnecessary clinic visits. This system aligns with NICE guidelines by ensuring timely reviews while preventing service bottlenecks.

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Datix for Deaths Due to Physical Health Causes Outside Mental Health Inpatient Settings: Staff Perspective

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Aims: Datix is a web-based incident reporting and risk management system used across hospitals in United Kingdom to report incidents. DATIX is used primarily for risk management. Therefore the purpose of reporting an incident is to alert the healthcare system to risks and to provide guidance on preventing potential incidents that may lead to avoidable harm or death. Datix can be used to report patient safety incidents or adverse incidents of varying categories such as unexpected effects, medication errors, etc. and these help to provide learning both at individual and organisational level.

The aim is to gather staff perspectives on the current Datix system for deaths secondary to physical health in patients known to mental health settings.

Methods: Online Microsoft Form qualitative questionnaire was created to gather staff perspectives on recording of Datix incidents involving deaths due to physical health causes but outside mental health settings. The preliminary questionnaire was shared with Corporate Risk and Compliance Manager, Interim Deputy Director of Nursing in Trust and as advised one of the clinicians attended the Clinical Risk Management Group prior to rolling out to the local Older People's Community Mental Health Team and Humber Academic programme attendants list. Data was extracted onto Excel for the time March–May 2023 from Microsoft forms. Thematic Data analysis and summary was done collectively by three clinicians in Older Adult.

Results: Total: 28 respondents.

Respondent Demographics: approximately 57% nurses; 22% doctors, 7% social workers, 14% team leaders/managers; age 64% below 50 (29% 35–40); 29% 55–65.

7% of respondents have never filled in Datix for death, 36% filled within the last three months.

Source of information: Electronic notes 36%, discussion with colleagues 28%, during review 11%, relatives 14%, never found out 11%.

48% respondents needed to spend a week before finding the cause of death.

Thematic analysis Scale (1 least intensity, 10 highest intensity): Ease of access 14%, In emotionality 43%; Exhausting 61%.

61% respondents did not feel that Datix of deaths caused by physical health needs to be completed by mental health staff. 89% think the process could be made easier.

Conclusion: The study shows clearly that most of the respondents did not feel that Datix forms needed to be filled in for older adult psychiatric patients in the community, whose death occurred due to physical health causes but outside mental health setting.

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Quality Improvement Project on Split-Post Placement in Core Psychiatry Training

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Aims: Split-post placements are part of Psychiatry training, being a combination of inpatient and outpatient settings. The outpatient post could be set within the community mental health teams outpatient clinics, Crisis teams, Gender Identity and CAMHS clinics.

Trainees in such split-posts typically spend 2–3 days per week doing outpatient work, with the remainder in inpatient settings. The allocation is primarily a factor of training needs, to ensure safe delivery of clinical services, patient safety and provision of appropriate experience. Post allocation ensures trainees have the opportunity to achieve training competencies. This means that while individual preferences cannot always be met, the posts allocated will meet the trainee's needs.

Our survey consisted of measuring the level of satisfaction with clinical experiences and supervision whilst working in split-posts, and factors pertaining to Trainees' perception of patient safety, continuity of care and workloads.

Methods: Taking into consideration HEE guidelines regarding training placements, we collaborated with trainee programme director and created a qualitative survey including East Midlands Psychiatric Core trainees at Northamptonshire Healthcare Foundation NHS Trust working in split-posts. Of 15 trainees, 9 responded and completed the survey.

Results: While our survey respondents were able to identify that split-posts allow for more variety in clinical experience, they also noted several difficulties in transitioning between outpatient and inpatient settings, including:

Inability to keep up with pending work.

Difficulty establishing strong professional relationships with both staff and patients in both settings, as they are only present for 1–2 days.

Interruption in continuity of care, with work from both posts frequently overlapping.

Compromise in the level of supervision available to them, as they were only assigned a clinical supervisor in one setting.

62.5% of trainees found the workload across both placements manageable. However, half of the trainees faced challenges transitioning between clinic and inpatient roles. 37.5% of trainees did not feel adequately supervised in split-posts.

Conclusion: Our survey shows room for improvement within split-post placements. Based on our findings, we can advise the following

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