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.

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.

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