and extrapyramidal side effects, requiring regular monitoring. However, adherence remains inconsistent due to challenges in patient attendance, staff awareness, and varying monitoring intervals. This quality improvement project aimed to determine the prevalence of HDAT use in an assertive outreach team, assess adherence to the local trust HDAT monitoring guidelines, and implement a clinician-built HDAT Calculator and Tracker to improve monitoring efficiency.

Methods: In the absence of an electronic prescribing system, monitoring was routinely done manually. Therefore, clinicians created an HDAT Calculator and Tracker using Microsoft Excel, based on local trust HDAT monitoring guidelines and the Prescribing Observatory for Mental Health (POMH) Ready Reckoner Version 11, to automatically calculate and identify patients on HDAT, flag upcoming and overdue assessments, and facilitate monitoring. Data collected included the dates and results of the most recent electrocardiogram (ECG), blood tests, quantitative antipsychotic side effect assessments, and weight.

Results: Of 105 patients reviewed, 11 (10%) were identified as receiving HDAT at the time of data collection. 5 of the 11 patients on HDAT were in an inpatient setting. ECG and blood test compliance were both 91%, with reasons for missing parameters documented in all but one instance. 2 of 11 patients were due for their annual weight assessment. Notably, gaps were identified in the documentation of quantitative antipsychotic side effect assessments, with 3 of 11 patients lacking a recorded assessment and 4 of 8 overdue for their annual review.

Clinicians identified a significant challenge in monitoring patients after HDAT initiation due to varying intervals between required assessments (e.g. 3–4 days, 1 month and 3 months post HDAT initiation) and the complexity of ensuring timely follow-up. The HDAT Calculator and Tracker offered a systematic, sustainable solution, enabling clinicians to recognise upcoming assessments and plan timely interventions. Overall, feedback highlighted reduced administrative workload and increased confidence in ensuring continuity of care and safe prescribing.

Conclusion: This project highlights the importance of structured, ongoing monitoring in psychiatric practice and presents a model for improving safe prescribing in high-risk populations. Future steps include iterative updates to the tool as new knowledge emerges, increasing HDAT monitoring awareness within the multi-disciplinary team (particularly around the adverse effects of HDAT), joining up care with local physical health clinics, embedding the tool into routine clinical practice and integrating it with electronic patient records and prescribing systems currently under development.

Working Diagnoses: A Pilot Study

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Aims: Mental Health and Neurodevelopment Resource Group (MHNRG) are planned to replace Mental Health Clustering. However, they are broad diagnostic groupings which will potentially have limited benefit in relation to evaluating outcomes, health inequalities, pathways, and interventions. In addition to mandatory completion of MHNRG, local services have the option to collect additional categorical data which led to the introduction of Working Diagnoses.

This is a pilot study to trial Working Diagnoses to test its functionality and feasibility.

Methods: The aim of the Working Diagnoses is to create an accessible form on the electronic patient record allowing assessors to select a list of up to four working diagnoses via a drop-down menu. Following consultation with clinicians from differing psychiatric specialities, a list of 53 separate working diagnoses were agreed upon which were individually mapped to their respective ICD–11 diagnostic codes and Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT) to make it future proof.

The pilot was conducted within the local Crisis Resolution and Home Treatment and Primary Care Mental Health teams. A live and secure Microsoft Excel document with a list of the working diagnoses through a drop-down menu was created. Assessors consisting of both doctors of various grades and psychiatric nurses within the teams were briefed on the aims and objectives of the pilot study.

At this stage, it is not intended for the diagnostic data to flow into the Mental Health Services Data Set (MHSDS).

Results: 127 patients referred to the teams between November to December 2023 were included in the pilot study and allocated their working diagnosis; 66 received one diagnosis, 52 received two and 9 received three diagnoses and none received four.

All presentations were able to be satisfactorily described by the Working Diagnoses options. The general feedback from assessors who participated in the study reported that it was simple and easy to use despite having limited formal training.

Conclusion: We believe that mental health services require granular details of a person's presentation if we are to effectively commission, transform and manage our services. Though other options could be utilised, implementing a limited categorical diagnostic list appears to be an acceptable, effective, and efficient method of gathering the information that has been missing in mental health services locally.

The next steps will be to trial this to other services within the wider trust.

Re-Introducing the Maintenance Slot in the Maidstone KMPT ECT Suite and Enhancing the ECT Clinic's Capacity by 20%

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Aims: Kent and Medway NHS and Social Care Partnership Trust (KMPT) had been providing fewer Electroconvulsive Therapy (ECT) treatments per capita compared with the national average. Following a reduction in patient numbers after the COVID-19 pandemic, the KMPT ECT Suite aimed to offer both initial and maintenance therapy. This required increasing the number of sessions per day to enhance clinic capacity by 20% to accommodate the reintroduction of a maintenance slot.

The project aimed to enhance the ECT clinic's capacity by 20%, from 6 to 7 patients per session, in order to reintroduce the maintenance slot. The goal was to provide continuity of care, especially for patients who relapse during specific periods, such as the winter or festive seasons.

Methods: A quality improvement approach was utilized, starting with a process map and Gemba walk to observe the day-to-day operations of the ECT suite. Both assessments revealed smooth clinic operations with no major issues. Data review showed that 25% of clinics ran at full capacity, suggesting there was room to trial the reintroduction of the maintenance slot with current staffing levels.

The project used the Plan-Do-Study-Act (PDSA) methodology to trial the maintenance slot. The plan involved offering 5 inpatient slots, 1 community slot, and 1 maintenance slot per month. The maintenance slot was trialled once a month, with the aim to reduce readmissions for specific patient groups. The trial ran from October 2023 to March 2024. During this time, the team was able to accommodate 7 patients per session, but increasing the number to 8 proved difficult. However, after an agreement from the Senior Leadership Team (SLT), the clinic extended its hours to accommodate up to 8 patients per session.

Results: Results showed that each ECT session, including treatment and recovery, took approximately 39 minutes. Clinics averaged 180 minutes per session, with 5 patients per session, although the clinic capacity was 6. Despite fluctuations in patient numbers, 25% of clinics reached full capacity.

Conclusion: Data analysis from the trial period demonstrated that the team could accommodate the increased workload for a short period. Given that 25% of clinics already operated at full capacity, further efforts to increase ECT uptake may require a review to assess the sustainability of the maintenance slot. Feedback from staff confirmed that 7 patients per session could be managed with current staffing, provided transportation was efficient. The team also began recording safety huddle notes, enhancing data-driven decision-making and tracking attendance strictly.

From Reactive to Proactive: A QIP for Improving Physical Health Monitoring and Management for Children and Young People with Eating Disorders

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Aims: Effective monitoring of children and young people (CYP) with eating disorders (ED) is vital to prevent complications such as malnutrition, electrolyte imbalances, and refeeding syndrome. Assessments at the Northamptonshire Healthcare NHS Foundation Trust Children and Young People Community Eating Disorder Service (NHFT CYPCEDS) & Leicestershire CAMHS Eating Disorder Team (LPT CAMHS EDT) revealed poor coordination between primary care, the clinics, and paediatric hospitals, coupled with limited staff knowledge of physical complications in ED and their management. This contributed to delayed and substandard referrals, high-acuity cases, and increased paediatric admissions. Reliance on GPs, owing to capacity issues, resulted in inconsistent and subpar physical monitoring. Therefore,

we aimed to improve physical health monitoring and management for CYP with known ED in Northamptonshire and Leicestershire.

Methods: CYPCEDS established a dedicated physical health department, introducing regional clinics in Northamptonshire to improve accessibility. SOPs were developed to streamline physical health management, including refeeding protocols and escalation pathways, while a MEED-based physical health template was integrated into the Trust's software. A physical health-focused referral letter and the Early Risk Management (ERM) Guide were provided to primary care, explaining ED, its red flags, and key helplines. Staff training workshops were conducted, and innovations like point-of-care machines were implemented. Collaboration with LPT CAMHS supported shared learning. The QIP's impact was evaluated through audits of paediatric admissions, referrals, and physical health templates, and staff and patient feedback.

Results: Electronic physical health template ensured consistent baseline assessments for all new referrals and monitoring during follow-ups. High-acuity referrals were addressed within 24 hours by the Service, while physical health nurses and structured referral pathways reduced the psychiatrists' workload, improving waitlists and caseload management. Refeeding monitoring improved, with most blood work done in-service using point-of-care technology, reducing reliance on external providers like GPs. Patient feedback highlighted better accessibility and satisfaction, with remote clinics boosting attendance. Staff confidence in managing physical health complications increased, and primary and tertiary teams felt well-supported by joint pathways.

Conclusion: The QIP addressed gaps in physical health care for CYP with ED in the region by establishing physical health departments, improving monitoring, standardizing assessments, training staff, optimizing resources, and enabling timely escalation. These improvements led to better patient outcomes, reduced physical acuity, and fewer hospital admissions. Referrals were streamlined, and collaboration between primary, tertiary services, and LPT ensured high-quality care across the region. Future plans include monitoring patient outcomes, creating an SOP repository, and piloting a GP early warning system.

Improving Accuracy of ACE-III Marking in the Wyre Forest Older Adult Community Mental Health Team

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Aims: Accurate implementation and marking of the ACE-III (Addenbrooke's Cognitive Examination) within memory assessments is vital in informing clinical diagnoses. The 100-mark cognitive test is subject to various nuances in its marking criteria that can easily be overlooked or misinterpreted.

Given noticeable discrepancy in staff completion, we aimed to review the accuracy of scoring of the ACE-IIIs completed by the team. We sought to identify the domains with the greatest variability in scoring, hypothesising that this would be the visuospatial domain, and feed this back as a teaching session with view to improving future accuracy in completion.

Methods: 50 patients were identified from the Wyre Forest Older Adult Community Mental Health Team who had recently (last six