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.