Teams available to all junior doctors joining the Trust. Key quality improvement tools, including driver diagrams, questionnaires, measures checklist and Plan-Do-Study-Act (PDSA) cycles, were employed to evaluate and refine the implemented changes.
Results: Survey responses demonstrated significant improvements in preparedness for psychiatry rotations and comprehension of roles and responsibilities post-intervention. Specifically, there was a two-fold increase in the proportion of trainees reporting preparedness for their rotation, from 33% pre-change to 66% post-change. Similarly, those who reported understanding their roles and responsibilities increased from 35% to 65%. Notwithstanding these improvements, persistent challenges include the inability to fundamentally alter the overarching three-day trust-wide induction and difficulties in assessing the sustained impact of changes due to high turnover among trainees.
Conclusion: This project addressed key deficiencies in the induction programme for junior doctors in the Trust, demonstrating that targeted, trainee-led changes can significantly improve preparedness for their psychiatry rotation. Future efforts would focus on embedding sustainable improvements and exploring further restructuring of the broader trust-wide induction programme to address systemic issues.

Cross-Cover Chaos to Calm: A Smarter Protocol for Efficient Patient Care

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Aims: To ensure fair workload distribution and faster patient care, SWLSTG follows a cross-cover policy, grouping wards into clusters based on proximity. Each ward has designated cross-cover doctors responsible for daytime medical advice and patient reviews in absence of the ward doctors.

A duty-doctor covers all the wards, handling emergencies, urgent reviews, and mandatory tasks if no cross-cover doctor is available. Duty-doctors carry the duty phone which is a dedicated mobile phone for urgent but non-life-threatening situations. However, in practice, ward staff often bypass the protocol and contact the duty-doctor directly, leading to:

Increased workload for a single doctor.

Delays in patient care due to unnecessary escalations.

Interruptions in emergency response.

This project aims to reinforce adherence to the cross-cover protocol, ensuring appropriate ward doctors are contacted first before escalating to the duty-doctor, reducing unnecessary workload and improving efficiency of patient care.
Methods: Pre-Intervention Data Collection: Distribute feedback forms to trainees to assess the frequency and impact of unnecessary duty-doctor calls.

New System Implementation: Set up an automatic voicemail on the duty phone using the Teams, reminding callers to contact their cross-cover doctor first (operating 9 am–5 pm on weekdays, except bank holidays). The Teams system also allows call tracking by displaying missed call numbers, unlike the previous system, which only showed "unknown number".

Educational Intervention: Develop a leaflet and ward posters outlining the correct protocol, emphasising contacting cross-covering doctors first unless in a medical emergency.

Implementation: Circulate materials to nursing staff and ward teams, reinforcing adherence through staff meetings.

Collaboration with Ward Managers: Engage ward managers to reinforce adherence and ensure staff compliance.

Post-Intervention Evaluation: Conduct a follow-up survey to measure changes in behaviour and impact on patient care.
Results: The expected **Results:**

Faster response times for non-emergency reviews as cross-cover doctors are located closer to wards and responsible for fewer patients.

Improve efficiency of patient care by providing continuity.

Increase awareness among ward staff regarding the importance of cross-covering doctors.

Greater clarity and adherence to the protocol among staff.

Reduction in unnecessary escalation to duty-doctors.
Conclusion: Implementing a structured approach to protocol adherence improves workload distribution, reduces unnecessary escalations, and enhances efficiency of patient care. An automated voice message serves as a constant reminder, reinforcing the correct escalation process. However, Teams system carries potential downtime risk, so the old duty phone number will remain as a backup. Future steps include ongoing reinforcement, monitoring reliability, and periodic re-evaluation to sustain improvements.

A Practical Alternative? KardiaMobile to Improve Uptake of ECGs on Psychiatric Wards

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Aims: ECGs on psychiatric wards are crucial for detecting cardiac side effects of psychotropics and identifying patients with underlying cardiac conditions. However, there can be variable patient uptake of standard 12-lead ECGs, which can lead to delays in initiating treatment and poor quality of physical health monitoring. KardiaMobile is a portable ECG device which can offer an alternative when 12-lead ECGs have been declined by patients, and was therefore explored as a way to improve ECG uptake. The aim was to reduce delays in ECG completion for patients admitted to inpatient settings and to explore the views of patients and staff around their experience of the device.
Methods: From September to October 2023, baseline data was collected retrospectively from one general adult psychiatric ward (A) and one psychiatric intensive care unit (B). This included the dates of patients' admissions and the dates admission ECGs were completed. KardiaMobile devices were then introduced to wards as an alternative and in-person training sessions were delivered. Data was collected post-implementation of the devices from September 2024 to January 2025, recording use of KardiaMobile ECGs and dates of completion. Questionnaires were also used to collect patient and staff feedback.

Results: The metrics used were average delay to ECG completion (days) following inpatient admission and percentage of patients delayed by 3 or more days. On Ward A, baseline average delay to ECG completion was measured at 6.93 days and percentage of patients delayed by 3 or more days was 24.14%. Ward B recorded 12.77 days for average delay and 69.23% for delay by 3 or more days. Post-implementation data was collected until similar numbers of KardiaMobile ECGs were completed compared with baseline ECG data. There was insufficient uptake of KardiaMobile identified on Ward A for comparison, with patients reported to decline use. Ward B post-implementation recorded 0.5 days for average delay to KardiaMobile ECG completion and 7.14% of patients delayed by 3 or more days. Their feedback was overwhelmingly positive with respect to the use of the device and gave insight into why 12-lead ECGs had been declined.
Conclusion: There were identified reductions in delays on Ward B following introduction of KardiaMobile devices. Patients and staff expressed preference for the device due to its ease of use and convenience. Comparing data across the two separate wards has given insight into the possible challenges with use of KardiaMobile, as well as the significant benefits, suggesting potential applicability outside of inpatient settings.

Quality of Antipsychotics Prescribing in Dementia Patients in Wakefield (WF9 Area)

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Aims: This Quality Improvement Project evaluated antipsychotic prescribing for dementia patients in Wakefield (WF9), comparing local practice with NICE guidelines. NICE recommends antipsychotics for severe agitation/distress, initiated and monitored under specialist supervision for ≥12 months. NHS England data (Jan 2024) shows similar dementia diagnosis rates in Wakefield compared with the national average, but antipsychotic prescribing is ~33% higher regionally. This project investigated this.

Aims were to:

1) Compare antipsychotic prescribing in two WF9 care homes with NICE guidelines (initiation, monitoring, follow-up).

2) Compare local data with NHS England data for Wakefield.

Methods: Data from 95 care home residents (Apr 1–Jun 1, 2024) were collected with staff support. Medication charts were reviewed, and data on physical health monitoring and care plans were extracted from System 1. Of 95 residents, 65 were open to community older people's services, and 30 were not (data from care home records/register). Data were compiled in Excel.
Results: Of 95 residents, 66.3% (n=63) had dementia. Among these, 66.4% (n=40) were open to community services. Antipsychotic prescriptions were initiated by local psychiatrists in 58% (n=14/24) of dementia patients; by out-of-area services (unknown) in 21% (n=5/24); and by GPs/hospitals in 21% (n=5/24). Blood monitoring was documented in 56% (n=13/24) and ECG monitoring in 50% (n=12/24). A clear follow-up plan existed for 81% (n=51/63) of dementia patients, but 19% (n=12/63) lacked documented follow-up >1 year. Only 8% (n=2/24) had a documented plan to reduce antipsychotics.

Comparison with NHS England Data: This audit confirmed higher antipsychotic prescribing in Wakefield than the national average. Local data suggested a 4-fold higher rate. ~60% of prescriptions were initiated >1 year prior, and 92% (n=22/24) lacked a clear reduction plan, possibly due to anxiety around reduction (especially by trainees) and limited multidisciplinary input. Regional variations (e.g., Barnsley's lower rate) raise questions about prescribing thresholds, service differences, and MDT caseload management.
Conclusion: Of 95 residents, 66.3% (n=63) had dementia, and 38% (n=24) of those with dementia were on antipsychotics. 8% (n=5/95) were on antipsychotics without a dementia diagnosis. While 81% had follow-up plans and all were monitored for side effects, adherence to NICE guidance for blood/ECG monitoring was suboptimal (56%/50%). Documentation of follow-up and antipsychotic reduction plans requires improvement. A maintained antipsychotic register may improve documentation and ensure appropriate monitoring/review.

Length of Stay in ED for Patients Awaiting Inpatient Psychiatric Beds

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Aims: The King's Fund have noted that the number of people waiting more than 12 hours after decision to admit to admission has increased significantly over the last ten years. With increasing demand for psychiatric inpatient beds, waiting times for mental health patient admissions are projected to similarly increase. This study aimed to investigate the length of stay for patients within a large inner city emergency department (ED) awaiting a mental health inpatient admission.
Methods: Time of decision to admit (DTA) and time of discharge were recorded and reviewed for all patients awaiting a psychiatric inpatient admission in August 2024.
Results: In total 101 patients were assessed for a psychiatric admission during this period. The average length of stay from arrival to discharge from the ED was 1 day and 7 hours, with the longest length of stay being 5 days and 5 hours. The average time from DTA to discharge from ED was 1 day and 16 minutes with 73.3% of all patients spending more than 12 hours waiting for their bed from DTA. It is noted, that out of the 101 patients initially assessed for admission, 14 were discharged to the community.
Conclusion: Emergency departments are less likely to be equipped with the resources, physical infrastructure and trained staff required for caring for patients with high acuity of mental illness for prolonged periods of time. This study provides information demonstrating the strain that services have in providing the right care in the right place. With the reduction in available inpatient psychiatric beds by 24% since 2010, ongoing consideration needs to be given on how appropriate care can be delivered to this cohort of vulnerable and unwell patients.