colleagues. After discussing the findings with our stakeholders, we developed a new discharge summary template with the subheadings of 'Reason for Liaison Psychiatry Involvement', 'Summary', 'Diagnosis (if applicable)', 'Risk Formulation', and 'Treatment or Plan of Action'.

We held a team meeting and distributed a guidance document with scoring criteria for each subheading for our clinical colleagues to practise for two weeks. Subsequently, 75 discharge summaries were randomly selected and independently scored across seven weeks by an internal team member and an external QI data analyst to improve inter-rater reliability. 98 discharge summaries written six weeks before the new letter template was introduced were retrospectively scored for baseline measurement.

Results. At baseline, the discharge summary scores ranged between 6 and 20 (out of a maximum of 20), depending on the individual completing them. The mean score was 12.3.

The implementation of the new discharge summary template improved the mean score to 19.0, irrespective of the author. The mean score was consistent across seven weeks.

Most of our colleagues did not face significant challenges in learning a new style of writing and for some, a standardised template reduced administrative time. The same GPs reviewed the new set of anonymised discharge summaries and were satisfied with the new summary format.

Conclusion. Formulating a standardised discharge summary template which adhered to professional guidelines was pivotal in improving the quality of GP discharge summaries. GP involvement throughout the project convinced stakeholders and colleagues to commit to a new writing template and tremendously helped achieve our project aim.

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.

Eating Disorders Intensive Treatment (EDIT) Subteam: Shoring Up MDT Working to Turn the Tide for Patients at Risk of Hospitalisation

Dr Alyssa Tan Jingren[1]*, Dr Katherine Morton[1], Dr Kelly Nugent[1,2] and Ms Nyree Weir[1]

[1]Tertiary Eating Disorders Specialist Service, Lanarkshire, United Kingdom and [2]Burnbank Medical Practice, Hamilton, United Kingdom

*Presenting author.

doi: 10.1192/bjo.2024.444

Aims. Presentations of severe Eating Disorders (ED) to the Tertiary Eating Disorders Specialist Service (TESS) in Lanarkshire have increased in recent years. Our criteria has also expanded to include severe Avoidant-Restrictive Food Intake Disorder (ARFID), increasing demand for a multidisciplinary team (MDT) approach for patients at high physical risk with less typical ED presentations. Medical Emergencies in Eating Disorders (MEED) recommends MDT working and development of pathways to support these patients.

The "EDIT subteam" was thus developed in March 2023, comprising: TESS psychiatrist, TESS GP, dietician, assistant practitioner, and TESS psychologist.

For TESS patients at high physical risk, high risk of hospitalisation, and who would benefit from a trial of "stepping up" treatment, we aimed to employ coordinated MDT intervention to 1. optimise community treatment, 2. regularly review risk and 3. reduce need for hospital admission.

Methods. Each patient was discussed at a weekly MDT meeting attended by EDIT subteam, where risk assessment and management plan was agreed.

6-month review was conducted using meeting minutes, staff survey and group discussion, with consideration given to: number of patients prevented from requiring hospital, number of patients admitted to hospital and consideration if different levels of intervention could have prevented this, staff satisfaction and review of the MDT complement.

Results. 22 patients – 17 female, 5 male – were included on EDIT for the first 6 months. At point of step-down from EDIT, 13 had ongoing TESS community input, 5 were admitted to hospital, 3 were discharged from TESS and 1 transferred to Community Mental Health Team.

Most EDIT patients received input from multiple domains of the MDT. Given baseline low admission rates and complexity of patient presentation, we were unable to determine how many hospital admissions were prevented, but consensus was that overall, a higher level of care was provided. It was not felt that different levels of intervention could have prevented any of the 5 admissions. Staff feedback was positive: EDIT improved communication, provided job role diversification, contained and shared risk, improved awareness of care plans and resulted in better-considered onward referrals.

Areas for improvement included a lack of Occupational Therapy and nursing, and concern about EDIT patients skipping waiting lists.

Conclusion. The EDIT subteam provides an avenue for high risk patients to be regularly discussed in an MDT setting – although impossible to empirically quantify if admissions were reduced, consensus within TESS was that the introduction of EDIT has improved community treatment for this group of patients.

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.

VTE Prophylaxis Quality Improvement of Service Users Data in Older Adult Mental Health Inpatient Wards in St Charles Hospital, CNWL NHS Trust

Dr Shreena Thakaria*

St Charles Hospital, London, United Kingdom

*Presenting author.

doi: 10.1192/bjo.2024.445

Aims. To reach the target of 100% for VTE (venous thromboembolism) prophylaxis data submitted for all St Charles Older Adult inpatients.

Methods. It was found at the start of the QI project, the service was at 63% (August 2023). I reviewed this data and discussed it with the ward managers of the older adult inpatient wards and implemented two PDSA cycles. I went through the ward list of service users and noted on the database who had an outstanding VTE prophylaxis check. From this, I then created a section for the nursing handovers to include whether each service user had their VTE prophylaxis forms filled in and whether VTE prophylaxis was appropriately prescribed. The wards have a weekly MDT meeting where this could be discussed and all staff could be reminded to document the VTE data on the trust data system. I rechecked the data two months later to see if the data had improved. Following this, I created a VTE poster to be distributed via email to ward staff and hung up in the ward doctors' offices to

https://doi.org/10.1192/bjo.2024.445 Published online by Cambridge University Press

help educate staff on the importance of VTE prophylaxis. The statistics were rechecked two months later for further improvement.
Results. At the start of the QI, it was found that the service was underperforming in reaching its target of 100% of the VTE prophylaxis data entry for all service users in older adult inpatient wards. After implementing the first PDSA cycle, the data increased to 84% compliance (October 2023 data). After implementing the second PDSA cycle, the data increased to 100% compliance (December 2023 data). The data showed both implementations had a significant impact on the data input and the target being reached. The new strategy has now been firmly placed into the team working pattern as a routine measurement and continues to be actively utilised.
Conclusion. In an older adult inpatient ward setting with service users who have co-morbidities, reduced mobility and risk of dehydration from self neglect, it is vital they are assessed appropriately for VTE risk factors and prescribed the appropriate prophylaxis. Once this was highlighted to the ward staff and an easy system of the PDSAs were implemented, the team are now able to actively input the data and provide optimal care for the service users.

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.

Improving Women's Sexual and Reproductive Health in Acute Inpatient Psychiatric Services – A Quality Improvement Project

Dr Sally Tulip[1]*, Dr Sarah Godsell[1], Dr Sophie Roche[1], Dr Alara Acunas Okay[1] and Dr Kirsty Hartshorn[1,2]

[1]Barnet, Enfield and Haringey Mental Health Trust, London, United Kingdom and [2]North Middlesex University Hospital NHS Trust, London, United Kingdom
*Presenting author.

doi: 10.1192/bjo.2024.446

Aims. Women with severe mental illness are at higher risk of sexually transmitted infections (STIs), unplanned pregnancies and poor engagement with cervical and breast screening. Despite current national guidance, these issues are poorly addressed during psychiatric admissions.

We aimed to improve the provision of women's sexual and reproductive healthcare on psychiatric wards using a quality improvement framework.
Methods. Female psychiatric inpatients aged over 18 were included. A baseline audit was performed in October 2022 on a female psychiatric ward, followed by six PDSA cycles from August 2022–January 2024 (n = 108).

We introduced women's health assessments (WHAs), offering counselling on: (1) contraception, (2) cervical and breast screening, and (3) STI screening. We arranged treatment and follow-up.

Changes were made at each PDSA cycle: ensuring provision of emergency contraception and STI swabs; establishing a protocol for referring to the sexual health clinic; creating dedicated clinic time to offer counselling; developing a poster and educational leaflet; and creating a proforma to record outcomes. The interventions were then extended to a neighbouring ward.

We reviewed electronic notes and recorded the percentage of patients offered counselling at baseline and after each cycle, later also recording the percentage of patients accepting interventions.
Results. At baseline, 12.5% of inpatients had been offered at least one of: contraceptive counselling, cervical and breast screening or STI screening. This improved to 87.7% offered a leaflet and 63.1% offered counselling by the final cycle. Of these patients, 48.8% accepted at least one intervention. On the neighbouring ward, offers of counselling increased from 28.6% to 63.6%.

Introduction of dedicated clinic time increased offers of interventions the most, to 94.1% (cycle 3). Compliance was lowest in cycle 4 (54.2% offered any intervention) which coincided with junior doctor changeover. Provision of an educational leaflet did not increase acceptance of interventions (cycle 5).

Introduction of WHAs led to detection and treatment of STIs in seven patients. Absent contraception was identified and started for a patient taking sodium valproate. Five patients were administered emergency contraception and two commenced long-term contraceptives. A case of female genital mutilation was identified, and a case of cervical neoplasia (CIN 3) was detected.
Conclusion. Provision of WHAs improved women's healthcare in inpatient psychiatric settings, with clinician contact being the most valuable resource in achieving this. There were several barriers, importantly clinician availability and awareness during junior doctor changeover. We will establish our interventions trust-wide, protocolising WHAs in the junior doctors' handbook, and collect patient feedback.

Additional authors: Dr Terteel Elawad, Dr Judith Stellman.

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.

Developing and Delivering a Regional Teaching Programme in Liaison Psychiatry: A Quality Improvement Project

Dr Sally Tulip* and Dr Cara Katona

Camden and Islington NHS Foundation Trust, London, United Kingdom
*Presenting author.

doi: 10.1192/bjo.2024.447

Aims. Several sites across the North London Mental Health Partnership (NLMHP) do not have a liaison-specific rolling teaching programme. Best practice standards set by the RCPsych Psychiatric Liaison Accreditation Network (PLAN) are therefore not being met.

The aims of this quality improvement project (QIP) were to: (1) ascertain the perceived need for liaison-specific teaching across NLMHP sites; (2) develop and deliver a teaching programme; and (3) assess attendance, clinician satisfaction and confidence before and after teaching sessions.
Methods. A pre-programme questionnaire on Microsoft Forms was sent to team members across NLMHP sites to assess whether respondents were receiving liaison-specific teaching, the perceived utility of the programme, and suggestions for development.

A cross-site monthly teaching programme was developed. Sessions were presented by liaison clinicians from a list of liaison-specific topics via Microsoft Teams.

A post-session questionnaire was sent to establish session satisfaction, confidence pre- and post-session, and further comments. Mean satisfaction scores were calculated. Percentage change in confidence score was calculated for each session and overall.

Themes were identified from the qualitative data and suggestions implemented.

https://doi.org/10.1192/bjo.2024.445 Published online by Cambridge University Press