Aims. The aim was for 80% of adults aged over 65 years to be screened for delirium at the point of admission to hospital.
Methods. We implemented multiple interventions including:

- Teaching sessions for doctors, nursing staff and healthcare assistants on delirium.
- Designed a new proforma using a more specific tool for screening delirium (4AT)
- Making the clerking proforma and delirium screening tool more user friendly

Results. Results have shown statistically significant improvement in the detection of delirium with a sample in October 2022 showing 68% of older adults admitted to Hillingdon Hospital having been appropriately screened for delirium.
Conclusion. Current results suggest significant improvements with our interventions, however further progress is still required to reach our aims with regular data collection being paramount.

Improving Physical Health Monitoring on an Inpatient Dementia Assessment Unit – a Quality Improvement Project

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Aims. Meadowview Ward is a dementia assessment unit based at Thurrock Community Hospital as part of Essex Partnership University NHS Foundation Trust. Patients with advanced dementia are routinely admitted with significant physical comorbidities and, as such, robust physical health monitoring is required. Members of the nursing team felt that it would be helpful to formalise the approach to physical health monitoring in order to allow all members of the multidisciplinary team to be aware of the necessary requirements. It was decided to formulate a physical health monitoring prompt sheet to facilitate discussion regarding physical health during ward rounds.
Methods. A multidisciplinary discussion took place to identify the areas of monitoring which should be routinely highlighted in ward rounds. Items labelled as routine monitoring requirements were also listed. A prompt sheet was then devised which divided ward round discussion into nursing and medical feedback, with each section having specific areas for discussion (for example oral intake, recent blood results, any pending investigations). This included prompts for other staff groups including physiotherapists and occupational therapists. A section was also added regarding ongoing monitoring requirements, such as routine outpatient appointments and whether transport had been booked.

In order to assess the impact of the introduction of the prompt sheet a questionnaire was provided to members of the multidisciplinary team who regularly attend ward round. This assessed their perception of the quality of physical health monitoring both before and after the introduction of the prompt sheet, the impact of the sheet on ward rounds and whether they wished the intervention to continue.

Results. There was a significant increase in staff satisfaction with physical health monitoring on the ward (n=7, P = 0.0065). 100% of staff surveyed rated the introduction of the prompt sheet as "strongly helpful" and that they "strongly agree" the use of the prompt sheet should continue. An initial concern from the team had been the potential for the use of the sheet to delay ward rounds, however 57% of respondents reported no impact on ward round duration and 43% felt it strongly expedites assessments.
Conclusion. The introduction of the physical health monitoring prompt sheet has been widely perceived as a success within our multidisciplinary team. It has also demonstrated the effectiveness of a multidisciplinary approach to quality improvement projects, ensuring the wide variety of expertise within teams is utilised.

Trans and Non-Binary Healthcare QIP: Improving GPST Knowledge and Confidence

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Aims. Trans and non-binary people present with condition-specific health needs. General Practitioners (GPs) face increased demand to care for this population. The Royal College of General Practitioners note that "the gaps in education, guidance and training for GPs around treating gender dysphoria… and managing broader trans health issues… needs to be urgently addressed." We are an interdisciplinary team using QI methodology to assess current self-reported knowledge and confidence amongst GP Specialty Trainees in the North-West of England (NWGPSTs) and deliver interventions targeting problem areas.
Methods. Following engagement with Health Education England North-West, a preliminary questionnaire was distributed to all NWGPSTs to assess baseline knowledge and confidence regarding gender-diverse peoples' healthcare.

Results were used to design a teaching session covering basic language and concepts; history and physical exam; gender affirming therapies; psychiatric, medical, and sexual health.

Teaching was delivered in a pilot scheme at four NWGPST training locations. Data were gathered before and after each session, with 3 additional questions to assess the quality of teaching and open-text feedback.
Results. In the preliminary questionnaire (n=150) the most common answer was the lowest amount of knowledge, confidence, or training (1 out of 6) for 11 out of 17 questions. Most reported no training during medical school or GP training programmes. Lack of knowledge in gender affirming therapies, fertility preservation, legal framework and referral pathways were identified.

Using a Likert scale (1 to 5), comparison between pre (n=61) and post-teaching (n=49) questionnaires showed improvement in knowledge in all areas (CI 95%). Overall knowledge improved with a mean of 1.05 (95% CI 0.72–1.38). Teaching quality feedback achieved a total mean score of 4.18. Open-text feedback was overwhelmingly positive about teaching material, enthusiasm of presenters, and contained useful suggestions for improvement.
Conclusion. Baseline knowledge of trans and non-binary healthcare is generally very low. A brief educational intervention made a

statistically significant improvement to self-reported knowledge and confidence.

We have adapted the teaching based on participant feedback and with involvement from Experts by Experience and Experts by Training. We have enriched teaching with video submissions from Experts by Experience. We have continued to engage with stakeholders, including partners at The LGBT Foundation and Indigo (GP-based Manchester gender service). To grow further, we have trained a faculty of 10 GPSTs to provide teaching, with 11 sessions now delivered to over 300 GPSTs and 5 sessions upcoming. We are planning a nationwide virtual training day.

A Picture of Health? *A Review of the Quality of Physical Healthcare Provided to Adult Patients Admitted to a Mental Health Inpatient Setting*

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Aims. To identify and explore remediable factors in the clinical and organisation of the physical healthcare provided to adult patients admitted to a mental health inpatient setting.
Methods. Data from 291 clinical, 56 Trust-level and 224 Hospital-level organisational questionnaires were completed; 285 sets of case notes were peer reviewed; 168 service user and 79 carer surveys were reviewed to assess the care provided to patients aged 18 years and older who were admitted to a mental health inpatient setting in the UK for at least one week during 01/11/2018 to 31/10/2019, and who:

- Had existing chronic obstructive pulmonary disease/ asthma/ cardiovascular disease/ diabetes
- Had experienced a transfer to a physical health hospital
- Died in the mental health inpatient setting or within 30 days of discharge
- Specialist commissioned mental health services and suicides, homicides and self-harm related deaths were excluded from this study.

Results. The report highlighted 5 key messages:

1. Assess patients for acute physical health conditions on arrival at a mental health inpatient setting and then undertake a detailed physical health assessment once the patient is admitted A detailed physical health assessment was not undertaken appropriately for 28/126 (22.2%) patients.
2. Develop a physical healthcare plan for patients admitted to a mental health inpatient setting A plan for physical health observations was not documented for 48/217 (22.1%) patients.
3. Formalise clinical networks/pathways between mental healthcare and physical healthcare Local care pathways or pre-existing arrangements with physical healthcare providers were used as part of the care plan for 71/291 (24.4%) patients.
4. Involve patients and their carers/friends/family in their physical healthcare and use the admission as an opportunity to assess, and involve patients in their general health In 100/188 (53.2%) sets of notes reviewed, there was no record that the physical health review had been discussed with the patient's family/ carers.
5. Include mental health and physical health conditions on electronic patient records and allow sharing across healthcare providers
6. 20/56 (35.7%) organisations reported that all elements of the clinical record were available in the electronic patient record

Conclusion. The NCEPOD report provided an in-depth review of the quality of physical healthcare in mental health inpatient settings and found that there is room for improvement in physical healthcare of patients. Key aspects of care requiring improvement were treatment of long-term physical health conditions (62/119; 52.1%), documentation of physical health observations (61/119; 51.3%) and delays in identifying acute deterioration (19/119; 16.0%) patients.

The report makes twelve recommendations for clinicians and management to implement in practice.

Introducing an Equality, Diversity and Inclusion (EDI) Champion to Address Unconscious Bias Within the Clinical Intake Meeting Selection Process in a Community Psychotherapy Adolescent Department

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Aims. It is widely recognised that the performance of the health care system falls far short of its potential on a wide range of quality indicators, particularly for racial and ethnic minorities and other disadvantaged groups. Within the Adolescent and Young Adult Service, data from the clinical intake meeting have been previously collected and stratified, identifying disparity conditions and populations based on gender (accepted females to males ratio = 7:1); ethnicity (low proportion of Black/Asian/Mixed background represented within the service); age (vast majority of accepted being in their 17s); disability (low proportion of disabled seen). Primary aim for this project was to evaluate whether the introduction of an EDI champion plus an EDI discussion within the intake clinical meeting could improve our department performance in terms of Equality, Diversity and Inclusion (EDI) quality indicators comparing to historical data.
Methods. A comprehensive Excel spreadsheet has been designed. All new referrals from November 22 till January 23 were included (N=29). Data collection included: non identifiable patients details, gender, date of birth, occupation, ethnicity, language, disability, outcome of the meeting, details of outcome, reason if outcome being negative. A further column on EDI comments.
Results. Following the introduction of the EDI champion for this cohort of patients, a decreased percentage of females (73.9% vs 69.2%) and increased percentage of transgender males (4.3% vs 15.4%) were offered an assessment. In terms of ethnicity, the number of Black/Asians/Mixed rejected for an assessment decreased. Respectively, 36.4% vs 11.1% (chi-square = 4.14, p-value = 0.47); 18.2% vs 11.1% (chi-square = 0.08, p-value $\approx$ 0 being statistically significant); 18.2% vs 0% (chi-square = 2.47, p-value = 0.26). An increased number of White people were

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