Aims. An evaluation of the service and care provided to eating disordered patients referred to Tier 3 CAMHS within NHS Lanarkshire. Eating disorders are recognised as a relatively common disease with preventable mortality. The primary aim was to determine if patients with eating disorders adhere to the assessment and management as outlined in MEED and SIGN 164. The secondary aim was to scope the number of eating disordered cases to plan recruitment and training of specialist staff.
Methods. The pilot study was carried out in November 2022 and repeated in January 2024. The Electronic Patient Record and paper notes of eating disordered cases assessed in 2023 were used to audit against MEED and SIGN 164. Additional patient demographics including patient's age, sex, median BMI at initial appointment, working diagnosis and suspected co-morbidity were also collected. The service was further evaluated on its processes from source of referral, time taken to be seen, therapies offered and duration within service.
Results. A total of 46 cases were identified in the audit compared to 57 in the pilot study. Most of the cases seen in 2023 were girls in their early teens (89% between the ages 13–16). 10% have a median % BMI <80%. 15 were given a diagnosis of AN (33%), 4 with BN (9%), 4 with ARFID (9%), 2 with OSFED (4%) and 19 with no formal diagnosis (42%). There was a high level of suspected comorbidity (80%).

Referrals were mostly made by GPs (87%), followed by school (11%) and other professionals (2%). The average time taken for the initial assessment was 63 days (40% were seen within 4 weeks). 14 (30%) of cases were offered FBT only whereas 3 (7%) had CBT-E. 7 (15%) did not receive any intervention and 19 (41%) were given other therapies.

With respect to the MEED risk markers, there had been improved recording of weight changes (40% to 80%), hydration status (40% to 70%), temperature (5% to 30%), bloods, over exercising (85% to 90%), purging (75% to 85%) and self-harm behaviours (85% to 90%). However there had been reduction in the recording of BP/HR (80% to 50%), ECG (75% to 40%) and engagement with services (75% to 60%).
Conclusion. Overall, there's some improvement in assessment and management of ED cases but the standard remains inadequate. This project has helped understand the gaps in services and provisions available. Ongoing evaluation is required to help steer service development and optimise patient care.

Improving Quality and Satisfaction With Handover at the Riverside Centre, Hillingdon

Dr Gabriella Bernstein, Dr Avani Puri* and Dr Mellisha Padayatchi

Central and Northwest London NHS Foundation Trust, London, United Kingdom
*Presenting author.

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Aims. This project was launched in January 2022 to improve handover between on-call teams and wards, following GMC concerns in 2020 with the out-of-hours handover process. In 2021, a 'Hospital At Night' Microsoft Teams evening meeting was successfully introduced. However there remained low satisfaction with other areas of the handover process, including use of paper forms to handover between shifts. The aims of the project were to review the current handover process and improve quality and satisfaction of handover. The target was to improve baseline satisfaction with the handover process by 20% (6 months after change implementation).
Methods. A driver diagram was built to identify factors contributing to quality and satisfaction with handover and develop change ideas.

Qualitative surveys using Likert rating scales were sent to all doctors to explore satisfaction with handover format and quality of information received. Opinions of doctors and the wider MDT were used to develop ideas and evaluate support for change. Surveys were repeated following each cycle.

From July 2022, interventions were introduced and monitored over four QIP cycles. This included an electronic handover in the form of a twice-daily email handover list, which was updated following feedback. Microsoft Teams morning weekend meetings were then introduced and modelled on the existing 'Hospital At Night' protocol.
Results. Following interventions, the percentage satisfaction with handover format improved from a baseline of 14% and was maintained at an average of 81% across 15 months.

The satisfaction with the quality of handover improved from 36% and was maintained at an average of 97%.

The weekend virtual handover has also been well received with 71% satisfaction. This maintains the satisfaction levels achieved with the 'Hospital At Night' virtual handover. The involvement of the MDT has been high with 71% of doctors satisfied that the necessary team members are attending.
Conclusion. Introducing a standardised electronic twice-daily handover has improved satisfaction with and quality of handover. It has also improved communication between on-call teams and wards.

The introduction of additional virtual handover meetings at the weekend has also been well received. It allows another opportunity to strengthen clinical leadership and the MDT to work more effectively out-of-hours. Future intervention will be targeted at standardising the content of these meetings and attendance in line with the 'Hospital At Night' protocol.

We aim to monitor local benefit from these changes, and expand this project to other hospital sites which are not yet using an electronic handover system.

Thematic Review of Serious Incidents in a Liaison Psychiatry Service

Dr Imrana Puttaroo*, Ms Natasha Bunton, Dr Michael Yousif and Dr Aideen O'Halloran

West London NHS Trust, London, United Kingdom
*Presenting author.

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Aims. NHS England defines serious incidents as events in health care where the consequences are so significant that they warrant a comprehensive response. Serious incidents are individually reviewed, as per national standard practice, in our liaison psychiatry service line at West London NHS Trust. The aims of these individual reviews include system wide learning, organizational accountability and to make changes to the system to prevent a repetition.

There is currently no mandated requirement for thematic review of incidents. Therefore, there is a risk that long-term learning may be limited and overarching themes spanning the incidents may be missed. To improve this process, we have undertaken a thematic review of all serious incidents over a 2-year period, across the three teams in the liaison psychiatry service line.

The aims of this quality improvement project therefore were:
To understand persistent or recurrent systemic factors that contribute to serious incidents.

To identify priority areas for system changes in order to improve the safety of liaison psychiatry services.

To ensure lessons learnt from incidents are embedded within the liaison psychiatry service.

Methods. This was a joint project undertaken by liaison psychiatry clinicians and the clinical governance team. Initially an inductive analysis of ten serious incidents took place. Over six months, we combed through the serious incident reports and collated the data. We then identified and stratified the key themes.

Results. The 5 headline themes identified were:

1. Risk assessment and risk management.
2. Human factors.
3. Issues with referrals.
4. Triangle of care.
5. Organisational factors.

Conclusion. The dominant theme which occurred across all cases was risk assessment and risk management. A narrow focus when considering risk and underestimation of risk led to the creation of suboptimal safety plans for patients. Our thematic analysis found a range of organisational factors, including the excessive demand on staff and resource limitations. Human factors are usually a reflection of organisational culture or system wide approaches. The issues we found with the implementation of the Triangle of Care reflect the need for a greater focus on involving families and carers.

The learning was shared with all staff in our annual development day, and this is planned to be an annual review of serious incidents across the liaison service. This approach should improve the depth of our learning and enable the service line to have an overview of the key themes which need to be addressed to deliver safer services.

Evaluating Improvement Collaboratives in Quality Improvement Projects: Design Variations and Their Impact

Ms Geetika Singh, Dr Mehtab Ghazi Rahman*, Mr Isaac Obeng, Ms Lucy Palmer and Ms Janet Seale

Central and North West London NHS Foundation Trust, London, United Kingdom
*Presenting author.

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Aims.

Aim: To compare and evaluate three improvement collaboratives designs in terms of tangible and non-tangible benefits.

Background: Leading health systems have invested in substantial quality improvement capacity building, but little is known about the aggregate effect of these investments at the health system level.

Collaborative learning is one of the educational approaches of using groups to enhance learning through working together. Research shows that collaborative experiences that are active, social, contextual, engaging and student-owned leads to deeper learning.

Methods. CNWL organised three collaborative programmes with varying duration and distinct approaches to team selection, wrap-around support mechanisms, training design and post-collaborative QI support.

These three virtual collaborative programmes were co-designed with service users and carers to support 24 teams each in planning, delivering and sustaining improvements aligned with the Trust's Strategic Priorities.

All programmes provided knowledge on the Model for Improvement and co-production, enabling frontline ownership of safety solutions while building organisational QI capacity and capability.

Each collaborative was divided into Planning and Delivery phases. The evaluation, which covers a 3-year period, compares programme metrics to assess effectiveness, impact and identify areas for improvement.

Results. Incorporating cognitive diversity is crucial in improving the learning process. Collaboratives play a vital role in achieving this, as they bring together different services, staff, and SU&C to drive improvement.

The benefits of collaborative work in quality improvement extend beyond the project data, as it can lead to positive unintended consequences such as a shift in team culture and the adoption of an improvement mindset. These outcomes gained on the journey should be evaluated and celebrated. Moreover, collaboration fosters a culture and platform for sharing and spreading learning beyond the team/service.

However, it is important to take the time to consider and compare different designs of collaboratives during the scoping phase. Factors such as the duration of the collaborative programme, the need for additional wrap-around support and the selection of measures to evaluate the programme should be carefully considered before proceeding.

Effects of changes

1. Comparing different collaborative designs identified the key enablers to a successful project. They were application process brought teams together that were ready and willing to improve; targeted wrap-around support to Sponsors, SU&Cs, Coaches and having decision gateways in design enabled focused and candid conversations about team progression.
2. Collaborative with longer time frame were more resource intensive but had a greater positive impact on safety culture, successful projects and sustained gains than the shorter duration.
3. CNWL Added Value framework evaluated tangible and non-tangible benefits, i.e. staff experience, safety and learning culture, patient experience, streamlined processes and efficiencies gained.

Conclusion. It is important to look at the local context when designing a collaborative with their clinical setting.

A consideration should be based on resources available to support the entire duration of collaborative and what are the desired outcomes of the collaborative.