Enhancing Lifestyle Counselling Targeted at Weight Management for Patients on Antipsychotics in a Community Mental Health Team: A Quality Improvement Project

Miss Madhulika Joglekar[1], Miss Keya Patel[1], Mr Sungjun Park[1], Dr Peeyush Roy[2,3] and Dr Olubunmi Olure[2]

[1]GKT School of Medical Education, King's College London, London, United Kingdom; [2]Kent and Medway NHS and Social Care Partnership Trust, Kent, United Kingdom. and [3]Royal College of Psychiatrists, London, United Kingdom

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Aims: The association between antipsychotic medication and weight gain is widely recognised. The Royal College of Psychiatrists' Positive Cardiometabolic Health Resource recommends lifestyle counselling as per the National Health Service Eat Well and Live Well guides, and the United Kingdom Chief Medical Officers' Guidance on physical activity, to promote positive lifestyle behaviours and a healthy BMI in patients with psychosis. Owing to a lack of educational resources for healthcare professionals, patients at a Community Mental Health Team in Kent were not exposed to thorough lifestyle counselling. This project aimed to improve staff awareness and confidence with respect to the recommended dietary and physical activity counselling guidelines by 80% within a four-month period.

Methods: This project was structured using two Plan, Do, Study, Act (PDSA) cycles. Baseline data, sought through an initial survey (S1) consisting of Likert scale and multiple-choice questions (MCQs) assessed staff perceptions of their awareness and confidence with respect to guidelines. PDSA1 involved the display of informational posters with key lifestyle recommendations in all consultation rooms and shared areas. Upon data analysis and participant feedback, PDSA2 involved an educational session delivered to staff, covering the recommended lifestyle guidance. Two identical surveys (S2 and S3) were distributed after each intervention to assess any changes.

Results: S1 revealed considerable variation around the average staff awareness and confidence level (M=5.32, SD=3.461). Although this dropped in S2 (M=4.7, SD=3.303), an increase was observed in S3 (M=4.96, SD=2.166). The initial decrease could be explained by staff overestimation of their awareness and confidence at baseline, which may have been realised once poster resources were introduced. The following increase in mean awareness and confidence suggests a positive impact of the teaching session delivered within PDSA2.

A similar trend was observed in the MCQs. The mean percentage of correct MCQ answers in S1 was 36.0%. Despite an initial decrease to 26.0% in S2, this value increased to 38.9% in S3. This shows an improvement in the knowledge of staff and ability to recall specific lifestyle guidance.

Conclusion: Despite not achieving our initial aim, active teaching was more effective in improving staff awareness and confidence levels regarding patient lifestyle counselling, compared with passive methods such as posters. The delivery of educational sessions, coupled with the provision of supplemental informational resources for patient-facing staff, could further improve awareness and confidence by allowing healthcare professionals to apply the recommended guidance in consultations, and ensure sustainability of their knowledge.

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.

What Works? Improving Cardiometabolic Health in Our Patients – A Full Audit Cycle

Dr Claire Jones[1], Dr Jade Evans[2], Dr Emily Sergeant[2] and Dr Maura Killoughery[1]

[1]South West London and St George's Mental Health NHS Trust, London, United Kingdom and [2]Kingston and Richmond NHS Foundation Trust, London, United Kingdom

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Aims: People under 75 years in contact with secondary mental health services have a significantly higher mortality and morbidity. Psychiatric medications increase the risk of cardiometabolic syndrome, psychiatric patients present less for attention of their physical health needs and are more likely to be overweight/smoke.

The aim of the Cardiometabolic Assessment (CMA) Clinic in our community mental health team is to reduce health inequality – identifying physical health problems, escalate any issues for medical treatment/review (usually to GP) and ensure patients receive treatment or get signposted for health promotion services.

We reviewed our clinic, identifying if it was fulfilling this purpose and looked at did not attend (DNA) rates.

Audit standards were that all patients invited to the CMA clinic should attend and that the CMA clinic should appropriately escalate all patients with concerning physical observations or requiring signposting to additional services.

Methods: Retrospective audit review of 247 appointments, January–December 2023.

We assessed: DNA rates; Physical health issues identified; Appropriate escalation and/or signposting e.g. for stop smoking services or obesity.

Change was implemented:

Educating staff with group and 1:1 teaching (colleagues from primary care were invited).

Written information leaflet sent with each appointment describing importance/purpose of CMA clinic.

Developed a simple proforma based on the modified early warning scoring system for CMA staff to send to the GP.

Staff granted the ability to directly contact GP practices.

Re-audited 36 appointments in the clinic from May–July 2024.

Results: Initial audit cycle: DNA rate of 52%. 53% of physical health issues managed correctly.

Re-audit: DNA rate 42%. 90% of physical health issues managed correctly.

Re-audit showed improvements in both standards.

Conclusion: A small intervention has enabled a direct improvement in patient care.

The DNA rate remains high – potentially a more focused approach to patients attendance may be beneficial. After ongoing multidisciplinary discussions we recommend that CMA clinic staff should consider domiciliary visits for patients at high risk of cardiometabolic conditions who repeatedly fail to attend CMA.

Clinicians to use all opportunities for CMA monitoring and make every contact count for physical health including occurring during care-coordinator reviews, in depot or other clinics. This will reduce the number of times a patient needs to visit the department hopefully improving satisfaction and increasing attendance.

Continued joint working with colleagues in primary care so workload is not duplicated and all opportunities for patient contact is maximised with the aim of reducing morbidity and mortality.

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