ongoing PDSA cycles to keep Culture of Care at the centre of patient care.

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Body Mass Index (BMI) and Waist Circumference Monitoring in Psychiatric Inpatient Setting and Staff Knowledge on Monitoring and Management of These Parameters

Dr Rajasee Sharma[1], Dr James Sutton[2] and Dr Praveen Kumar[2]

[1]Birmingham and Solihull Mental Health Foundation Trust, Birmingham, United Kingdom and [2]Blackcountry Healthcare NHS Foundation Trust, Dudley, United Kingdom

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Aims: BMI and waist circumference should be measured on admission and then regularly for inpatients. We aimed to determine whether this was being met, and to explore staff knowledge of such monitoring.
Methods: Retrospective data was collected from Rio, the electronic records system at Bushey Fields Hospital. The fifteen most recently discharged patients from each of five wards as of April 2025 were extracted, after which six patients from each set of fifteen were selected at random. Monitoring data was then extracted by two reviewers.

A questionnaire was separately distributed amongst ward staff to assess staff knowledge of BMI and waist circumference monitoring.
Results: 30 patients were included, with ages ranging from 20 to 81, comprising 18 male and 12 female patients. 26 patients were taking an antipsychotic. Patients had a range of physical comorbidities and were taking a range of additional medications.

BMI was recorded at admission for 22 patients, at one week for 20 patients, at two weeks for 23 patients, and at three weeks for 20 patients. Waist circumference was recorded at admission for 9 patients, and at one week for 29 patients.

13 patients had an above normal BMI, but action was only taken for 4. This included lifestyle advice, provision of relevant leaflets and a referral to appropriate services.

15 staff members received the questionnaire, of which 12 responded. 100% of responders were aware of the normal BMI range, but only half knew the normal range for waist to height ratio. 92% were aware of the need for weekly monitoring for patients on antipsychotics, but only 33% were confident in recording relevant parameters on Rio.

Only 25% of responders felt confident referring patients to relevant services, and 75% felt that educational resources on the ward were inadequate.
Conclusion: Not all inpatients on psychiatry ward receive necessary BMI and waist circumference monitoring, and appropriate management is only initiated for a small number of patients.

Most survey responders were not confident recording relevant information on RiO or making referrals to appropriate services and felt that available educational resources were inadequate.

We have made several suggestions in light of this data, including updating electronic record, introducing posters to the ward, staff refresher workshops and the introduction of a streamlined referral pathway for dietician reviews.

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General Practitioner Hubs and Community Mental Health Team Clinics in Primary Care; Moving Towards Integrated Neighbourhood Care – What Do GPs Want?

Dr Adarsh Shetty and Dr Andreena Aloysius

Cornwall Partnership NHS Foundation Trust, Liskeard, United Kingdom

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Aims: The aim of this quality improvement project was to optimise existing General Practitioner (GP) mental health hub meeting structures for better efficiency, implementing new hub meetings in non-participating surgeries within the primary care network and establishing a framework for satellite psychiatry clinics in GP surgeries.
Methods: The target population consisted of general practitioners in 6 GP surgeries within the North and East Cornwall Primary Care Network (PCN). Between October to November 2024, a structured 12-point electronic survey was distributed to 34 general practitioners to capture both quantitative trends and qualitative feedback. The survey focused on five domains of Community Mental Health Team (CMHT) input into primary care including feasibility, demand, barriers to engagement, logistical preferences (face to face vs virtual) and clinical scope. A reminder email was sent after 4 weeks.
Results: A response rate of 35% was achieved. Out of 6 GP surgeries, 5 had pre-existing GP hub meetings. Two GPs (out of a total of 12 respondents) reported that they did not need a GPHub meeting. 33% of respondents preferred a combination of virtual and face to face meetings, 25% preferred these meetings to be held at the GP surgery and 17% preferred alternating between the GP surgery and CMHT base. Of GP surgeries that had existing hub meetings, 58% preferred the meetings to be monthly for 1 hour each time. Common mental health issues encountered by general practitioners in their settings were mood disorders (24%), anxiety disorder (22%), substance and alcohol misuse (20%), trauma-related experiences/post-traumatic stress disorder PTSD (17%), and psychosis (2%). When offered the option, 67% expressed a wish to have a satellite clinic with a psychiatrist at the GP surgery.
Conclusion: This QI project successfully standardized and expanded the collaboration between the CMHT and GPs in this patch of East Cornwall. By aligning meeting frequency and content with GP preferences, all 6 GP surgeries now participate in either monthly or 3-monthly GP hub meetings. Face to face GP hub meetings are now established in all but one of the surgeries. The demand for closer integration has resulted in the successful establishment of psychiatric satellite clinics in two surgeries, with plans to establish these in all six surgeries.

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Shared Care and GP Records: Implications for Patient Safety

Dr Aneal Sidhu, Dr Soham De and Dr Abhinav Rastogi

Midlands Partnership University NHS Foundation Trust, Telford, United Kingdom

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Aims: GP connect is an NHS digital service that allows approved professionals to access patient GP records and provides essential information such as their current medication. Information relating

to current medication is vital for clinical decisions and patient safety, particularly when patients present to a new service such as A&E. The clinical risks associated with a lack of information can be even more significant when medications such as clozapine, lithiumand other antipsychotics are being prescribed.

Increasingly, secondary care services are prescribing various psychotropics under shared care arrangements. This QI project sets out to assess the accuracy of GP records in noting shared care medications, barriers to recording these and potential solutions. Several primary care services are relying on AI tools to summarise letters and both opportunities and threats relating to this are discussed.

Methods: 120 records were reviewed for patients under a community mental health team in Telford, Shropshire. These patients constituted one consultant's case load.

Each patient's psychotropic medication on their GP connect medication list was reviewed against the most recent correspondence sent to the GP by secondary care.

Results: 55 of 120 patients had an inaccurate medication record on GP Connect, constituting a total of 77 inaccurately recorded psychotropic medications. Secondary care was the prescriber for 75 of these medications. Out of the 77, there were 55 psychotropics which were not recorded at all. The remaining inaccuracies included inaccurate doses or showing a discontinued psychotropic as a current repeat. The clozapinestatus of 7 patients and lithium status of 2 were not recorded on GP Connect, and 16 depot medications were missing.

Liaison with primary care, including the pharmacy team, was done to identify solutions to rectify these inaccuracies in the GP records, and to develop processes to ensure they are aligned to include secondary care prescribing.

Conclusion: This QI project evidences significant challenges with prescribing across services and access to uniform information. This can have serious implications on patient safety particularly in medical emergencies. In the current climate with pressures on both primary and secondary care, closer liaison with primary care that goes beyond sharing correspondence is needed, including development of joint pathways. Several GP practices are utilising AI tools to review incoming correspondence which can be useful, however agreed protocols are required to facilitate this.

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Quality Assuring the 'Triangle of Sleep' Psychoeducational Group Intervention for People Presenting with Neurological Conditions and Sleep Difficulties Using a Co-Production Model

Miss Freya Stephenson, Miss Sarah Allester, Miss Jessica Sidratul, Mr Yahye Mohamud and Mr Jake Smith

King's College London, London, United Kingdom

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Aims: Sleep difficulties affect up to 58% of individuals with Functional Neurological Disorder and other neuropsychiatric presentations. The Triangle of Sleep is a clinician-led pilot psychoeducational intervention combining learning points from Cognitive Behaviouralmodel for Insomnia (CBT-I), with behavioural principles for restructuring of day-routine and mindfulness-based exercises, designed to improve sleep. This quality improvement project worked alongside the intervention team to independently collect staff team and patient feedback using two co-production cycles to implement improvements in design and delivery of the intervention.

Methods: Participants with sleep difficulties were recruited from the East Kent Neuropsychiatry Clinic to attend three one-hour group sessions covering sleep hygiene, day structuring, and mindfulness. The Plan–Do–Study–Act method was used to guide the approach. An initial scoping review identified how existing guided self-help interventions were quality assured. A questionnaire was developed using andragogy, and self-directed learning (SDL) principles to evaluate participant experiences. Verbal feedback was gathered from semi-structured interviews based on the questionnaire. The data was analysed by five reviewers and discussed with clinicians to produce a consensus document identifying feasible improvements, which were implemented over two PDSA cycles.

Results: The first cycle received responses from 2 patients and 3 student observers. Key themes included clarity of learning objectives (LOs), limited discussion opportunities, repetition, optimal SDL material utilisation, and desire for an additional session. Themes were discussed with clinician facilitators resulting in a consensus document of proposed changes. Revisions included promotion of SDL materials and session restructuring to include clear LOs and discussion opportunities. An additional session was not implemented due to resource constraints.

Before the second cycle, the questionnaire was refined for sustainability of continuous improvement. The second pilot retained 8 participants, with 5 patient feedback responses. There was limited consensus between participants unlike the previous cycle. A key improvement was a 20% increase in use of SDL materials compared to the previous cycle.

Conclusion: A co-production model proved effective for quality assuring a psychoeducational intervention. Iterative patient feedback enabled feasible, patient-centred improvements to acceptability and clarity. While immediate reflections on motivation in applying theories taught were mixed, the use of SDL materials suggests improved self-efficacy for long-term implementation of principles and potential for sleep improvement. The 'Triangle of Sleep' pilot provides a foundation for upscaling and the development of digital or AI-supported delivery models to increase reach and sustainability. In areas with less access to formal CBT-i this intervention could provide specialist insomnia treatment with lower clinician burden.

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Improving Critical Appraisal Teaching Experience for Psychiatry Resident Doctors: A Multi-Cycle Quality Improvement Project

Dr Hardeep Singh[1], Dr Mary-Anne Cotton[2], Dr Sidra Shaheed[2], Dr Asuvathan Aravinthan[2] and Dr Aisha Anwar[2]

[1]Dorset Healthcare University NHS Foundation Trust, Poole, United Kingdom and [2]Surrey and Borders NHS Foundation Trust, Surrey, United Kingdom

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Aims: To evaluate and improve the Critical appraisal teaching experience for residents at Surrey and Borders NHS Foundation Trust (Foundation year, GP and Core Psychiatry Trainees) within the SABP East Locality using a structured, iterative quality improvement approach, and to enhance trainee confidence in