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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doi: 10.1192/bjo.2023.318

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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doi: 10.1192/bjo.2023.319

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