Background. Antipsychotics are the most frequently prescribed psychotropic medication for PwID. Treatment with antipsychotic agent is associated with cardio-metabolic risks such as obesity, diabetes, and dyslipidemia. A strong association is well documented between antipsychotic use and the risk of stroke in schizophrenia although the magnitude of this association has yet to be studied in PwID.

PwID have an increased risk of premature death. Cardio-metabolic monitoring and appropriate intervention to this vulnerable cohort will improve the preventable cardio-metabolic multimorbidity. The NICE guideline (CG11) recommends antipsychotic medication should only be initially prescribed and monitored by the secondary care professionals for at least 12 months. They also should work together with primary care to ensure appropriate interventions are arranged where necessary.

Method. A retrospective audit was performed for 40 service users, taking antipsychotic medication. Quota sampling was used to identify 10 cases each from the caseload of 4 consultant psychiatrists, within the Intellectual Disability community setting, between September 2019 and October 2019.

An audit tool was designed, in accordance with cardio-metabolic measures (smoking status, height, weight, Blood Pressure, HbA1c, Lipid profile), based on physical health CQUIN targets and the Lester adaptation tool. Collection of data was performed from electronic case records and electronic blood results service. The work was performed with the approval of local clinical audit team and analysed by using Microsoft Excel.

Result. Baseline cardio-metabolic assessment was observed in over a half of the sample population (50–65%) whilst only less than 15% was noted at 3–6 months. Documentation Evaluation of physical health assessments for new admissions to the Oleaster during the first wave of COVID-19 on body weight and blood pressure was seen only in 15% and 2.5% of population respectively at 3–6 months. Collaboration with GP for annual health check was observed in 78–100% of population.

Intriguingly, our finding indicates a significant improvement in all required compliance when nursing team is involved.

Conclusion. Improving physical healthcare is essential to reduce the cardio metabolic outcome in PwID taking antipsychotic medication. Better involvement of community nurses as well as availability of Sphygmomanometers at every outpatient clinic will determine the successful implementation of cardio metabolic monitoring and effective collaboration with primary care clinicians.

Once the action plan is disseminated to the teams, the impact of change will be reassessed by a re-audit in one year's time.

Evaluation of physical health assessments for new admissions to the Oleaster during the first wave of COVID-19

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Aims. Physical health of psychiatric inpatients is worse than the general population. Physical health monitoring of these patients can have positive effects on outcomes. Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) states that a physical health assessment (PHA) should be completed within 72 hours of admission. This comprises a physical health form (PHF) and minimum data set (MDS): BP, BMI, TB and BBV status, alcohol and drug screen, smoking status, Hba1c and lipids. In a 2017 audit, compliance was shown to need improvement, with 28.3% of admissions not having a PHF documented.

Objectives. To assess whether PHAs for new admissions to the Oleaster, Birmingham during the first wave of COVID-19 were completed in line with trust policy

To compare findings with a previous audit

To make recommendations to improve inpatient physical health and compliance with trust policy

Method. A retrospective audit was conducted, with PHA details accessed via the electronic medical records system RiO. Admissions from 16/03/2020-30/06/2020 were accessed and 158 admissions (155 patients) were included. 21 admissions were excluded as they were internal transfers; only data from the initial admission were included. Data were collected by 2 medical students and a psychiatry trainee using a data collection tool. Data were recorded and analysed on Excel.

Result. Of 158 admissions, 81 had PHFs (51.3%). 59 were completed within 72 hours of admission (34.3%); 39 were completed fully (24.7%). Of incomplete PHFs, 2 explicitly stated incompletion due to COVID-19. 22 PHFs were created but not completed within 72 hours. 15 gave a deferral reason e.g., refusal to consent or agitation. For 77 admissions (47.3%), no assessment was documented, with no reason given.

2 admissions (1.3%) recorded the full MDS within 72 hours of admission.

2 admissions (1.3%) had fully complete PHAs (PHF and MDS) within 72 hours of admission, fulfilling trust policy.

Conclusion. 51.3% of admissions had a PHF, with 34.3% documented within 72 hours of admission. However, only 1.3% of admissions fulfilled trust policy of both a completed PHF and MDS within 72 hours of admission. There were more admissions without a PHF than in the previous 2017 audit; 47.33% compared to 28.3% previously. Given trust targets that a PHA should be fully completed for 100% of admissions, it was found that the Oleaster did not meet these guidelines during this period and improvements must be made to maintain integrity of patient care.

Impact of COVID-19 on referrals for physical and mental health care

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Aims. To determine the effect of the COVID-19 pandemic on referrals to mental health and physical health services.

Method. We analysed referral data from three psychiatric services in the boroughs of Camden and Islington across 2018-2020: Early Intervention Services (for patients with a 1st episode of psychosis), Crisis Resolution Teams and inpatient admissions. We also analysed GP referral data to Cancer Services (two-week wait referrals) to Whittington Hospital, Royal Free Hospital and University College Hospital (all of North Central London). We examined the impact of the COVID-19 pandemic on these referrals and compared the findings between physical and mental health. We chose to use EIS and Cancer services as comparable services since they both operate with the two-week target of achieving diagnosis of psychosis and cancer respectively.

Result. The number of referrals to EIS and CRT both decreased to 61% in April 2020 with respect to their baseline; EIS referrals continued to decrease to 48% in May before starting to recover. Inpatient admissions saw a smaller reduction to 87% in April 2020. The number of cancer two-week wait referrals similarly decreased and reached a trough of 37% in April 2020. The rate of recovery back to the baseline number of referrals and admissions relative to previous years differed between services, with acute care recovering faster. Referrals to CRT and inpatient admissions recovered by 98% and 115% respectively by June 2020; comparatively, referrals to EIS recovered to 102% by December 2020. In contrast, cancer two-week wait referrals returned to 106% by September 2020, a rate faster than EIS, but slower than CRT and inpatient admissions.
Conclusion. The reduction in the number of referrals across all examined services correlated with the first wave of the COVID-19 pandemic. The rate of decrease was similar across all services, coinciding with the peak of COVID-19 infections. However, the ultimate degree of decrease and following rate of recovery in numbers differed across both psychiatric and non-psychiatric services. These differences likely have multifactorial origins. The authors discuss contributing factors, such as changes in health seeking behaviours observed during the pandemic, potential impact of reduction in face to face consultations in primary care, as well as temporary changes in the population demographic of Camden and Islington resulting in absent target groups (i.e. students who make up a large proportion of referrals to EIS opting to return home). It remains important to not neglect mental health and face a hidden epidemic once COVID-19 pandemic settles.

An audit of risk assessments and management for self-harm and suicide in patients with depressive symptoms at a primary care practice in the UK

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Aims. Over 5 million adults in England are living with depression, with the highest prevalence rates recorded in the North West and North East of England, 12.88% and 11.53%, respectively (NHS Digital, 2019). Depression is also associated with the highest rates of self-harm and suicide (SH&S) (Singhal, Ross, Seminog, Hawton, & Goldarce, 2014). The impact of SH&S on a family ranges from shock and horror to, blame, secrecy and shame. Survivors may also be negatively judged or self-stigmatise (Cerel, Jordan, & Duberstein, 2008). Managing self-harm episodes has a significant financial implication for the NHS (Tsiachristas, et al., 2017). If high-risk individuals are identified and intervened early, it would not only save lives but also potentially reduce financial strains. The aim of the audit is to evaluate the performance of risk assessment and management of self-harm and suicide at the Reedyford Healthcare Group, Nelson, England, and to determine whether the primary care practice is meeting the standards of the National Institute for Health and Care Excellence (NICE) guidelines for adults with depression.
Method. A retrospective audit of 62 patients presenting with depressive symptoms over 3 months was performed at the Reedyford Healthcare Group.

Two criteria from the NICE guidelines for adults with depression were included with associated standards of 100%:

All patients with depression should be assessed for suicidal ideation and intent by asking direct questions.

A patient presenting with significant risk to self/others should be referred to specialist mental health services the same day, as soon as possible.
Result. 42 patients were asked direct questions about SH&S. 2 patients presenting with immediate risk were urgently referred to specialist services. Nonetheless, all those patients at increased risk of suicide were given an increased level of support by the practice. The results indicated that the practice could improve, and a quality improvement approach has been planned.
Conclusion. The assessment of risk in patients presenting with depression is vital. This audit shows that it is not always done in practice. The author has not found other published audits on this topic and suggests that this may be appropriate for a national audit. This is particularly prudent with the current concern regarding mental health in the COVID-19 pandemic.

An audit to assess whether patients under the care of a community mental health team who are taking clozapine are having their lipid profile checked annually and are given lifestyle advice and have had a QRISK3 assessment

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Aims. 'All cause' mortality is higher among patients with serious mental illness than the general population and a significant contributor from this is cardiovascular disease. Mean triglyceride levels have been shown to double and cholesterol levels to increase by at least 10% after 5 years' treatment with clozapine. NICE guidelines state all patients should have their lipids measured at baseline, 3 months after starting treatment with a new antipsychotic, and then annually.

The first aim of our audit was to identify whether patients who had been on clozapine for at least 3 months from our community mental health team (CMHT) who were not taking cholesterol lowering medication are having their lipid profile checked annually. The second aim was to see whether these patients have high total cholesterol levels and whether they had had a documented discussion about exercise, diet or lifestyle and a QRISK3 assessment.
Method. We constructed a list of 56 patients who were taking clozapine from the CMHT. We excluded 17 patients who were on cholesterol lowering medication and would have excluded any patients who had been on clozapine for less than 3 months. We then looked at whether the patients had had a lipid profile and identified patients with a cholesterol level >5.0 to indicate a 'high cholesterol level.' We then searched through the last year of each of the patient's case notes to see whether they had had a QRISK assessment or lifestyle advice by searching for the words 'diet, exercise, lifestyle and QRISK'.
Result. 36 of the 39 (92%) patients had lipid levels checked in the last 12 months. 21 of the 39 (54%) patients had a cholesterol over 5.0. 9 of the 39 (23%) patients had a documented discussion regarding lifestyle, diet or exercise in the last year. 0 of the 39 (0%) patients had a documented QRISK3 assessment.
Conclusion. Most (92%) patients from the CMHT had their lipid profile checked in the last year. 54% had total cholesterol level over 5.0. Only a small proportion (23%) had documented lifestyle discussion and none of the patients had a QRISK3 assessment. The results will be presented to the CMHT and we will organise teaching on giving lifestyle advice and QRISK3 assessments.