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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doi: 10.1192/bjo.2021.271

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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doi: 10.1192/bjo.2021.272

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.

Audit on clozapine dose and plasma level correlation for patients with chronic treatment-resistant psychosis

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doi: 10.1192/bjo.2021.273

Aims. Clozapine is associated with a risk of severe adverse events for which there are current monitoring systems are in place; however, there are no established regimens for monitoring of clozapine plasma levels. Recent Medicines and Healthcare products Regulatory Agency (MHRA) guidance advises clozapine levels should be monitored in certain clinical situations where toxicity may be suspected. This audit aimed to evaluate current practice of clozapine level monitoring within one Local Mental Health Team (LMHT).
Method. Electronic (RiO) records of 41 patients (33 male, 8 female; aged from 27 to 76 years; mean age 45 years) registered to the ZTAS system within the Nottingham City Central LMHT were reviewed. 46% had been on clozapine for over 16 years. 73.3% of patients were within clusters 12 and 13; 25.4% of patients were in cluster 11, with one patient in cluster 8. Dates of clozapine plasma level tests for each patient between 2006 and 2020 were found on the electronic NoTIS system, along with clozapine, norclozapine and total clozapine levels. Concurrent clozapine dose and regimens were obtained from pharmacy records from 2018 onwards.
Result. 273 clozapine plasma levels were conducted between 2006 and 2020. The average interval between levels taken was 10 months, 2 weeks but had a wide range, the shortest interval being 2 days, the longest being 13 years. 88 levels taken were >600 ug/L, suggesting increased toxicity risk. 108 levels were <350 ug/L, suggesting possible sub-optimal dosing or non-compliance. Statistical tests on correlation coefficient, although statistically non-significant (R = 0.37), showed a positive trend between total clozapine dose and the plasma level between all 3 parameters (i.e. clozapine, norclozapine and total clozapine).
Conclusion. There does not appear to be any routine plasma clozapine level monitoring throughout the LMHT with an average interval between tests of 10 months. There was a non-significant but positive trend between total daily dose of clozapine and clozapine level. 32% of clozapine levels returned were higher than the recommended level. We would recommend as suggested in the guidelines from MHRA, clozapine plasma levels should be monitored in certain clinical situations with increased toxicity risk. Trough levels should be taken with records of time of previous dose taken. Limitations of this study included a small sample size (41 patients) with data collection reliant on electronic systems. It was unclear if these results represent trough levels, making values difficult to interpret. Multifactorial impact on clozapine metabolism causes wide patient variability in plasma levels.

The diagnosis and management of adult ADHD in HMP Elmley, a Category B remand prison

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doi: 10.1192/bjo.2021.274

Aims. Attention deficit hyperactivity disorder (ADHD) is a highly prevalent disorder in young adult prisoners. This audit aimed to identify how many residents are prescribed medication treatment for ADHD in HMP Elmley and whether those seen by the prison psychiatrists have been managed in line with NICE guidelines. We also audited waiting times and time to follow-up appointments. This was done with the overall aim to identify potential areas for development.
Method. We performed a spot audit of all residents in HMP Elmley who were prescribed ADHD medication on 4th November 2019, using their electronic patient records. Appointments with the psychiatrists were then subdivided into initial assessments and follow-up appointments for the purpose of analysis. Performance was measured against NICE Guideline [NG87]: Attention deficit hyperactivity disorder: diagnosis and management. We also calculated the waiting times for initial appointment and follow-up appointment.
Result. We found that 33 of residents were on ADHD medication at the time of the audit, approximately 3% of the prison population. 64% of those had a pre-existing diagnosis and 36% had been given a new diagnosis at HMP Elmley. Of those newly diagnosed 100% had undergone a Diagnostic Interview for Adults in ADHD (DIVA) assessment for diagnosis.

Baseline physical health checks had been performed in 68% of patients prior to starting medication and a cardiovascular examination had occurred in 9%. At follow-up 100% of patients had their physical observations and weight checked and their symptoms reviewed.

91% of patients were started on methylphenidate or lisdexamfetamine as first line treatment, with the rest started on atomoxetine and the reason for this documented.

100% patients were offered general psychological support.

There was a mean 22 day wait for an initial appointment (range 0-65) and a mean 20 day wait from starting medication to a psychiatric follow-up appointment (range 8-37)
Conclusion. The number of residents treated for ADHD in HMP Elmley is relatively low (3%) compared to the estimated prevalence in prison population.

The key areas for improvement are in baseline cardiovascular examinations and physical health evaluations. The waiting time between initial psychiatric appointment and follow-up is another area where improvement is needed and this will form the basis of a quality improvement project.

Future steps include setting up a specific ADHD clinic with an allocated nurse practitioner to support, producing a template for ADHD assessments and follow-ups, producing a local policy on ADHD and developing specific resources for ADHD psychoeducation.

Escalation of care planning on an older adult inpatient unit during the COVID-19 pandemic

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doi: 10.1192/bjo.2021.275

Aims. Initial planning during the first wave of the COVID-19 pandemic involved difficult decision making for many clinicians. The Older Adult Mental Health Wards in Bridgend were relocated from the district general hospital (Princess of Wales) and merged at Angelton Clinic, an off site separate unit. It was therefore essential that patients had clear escalation of care plans as access to medical input was limited and transfer to hospital potentially not appropriate in the later stages of chronic illness such as dementia.

The initial aim of the PDSA cycle was to assess the level of compliance with Do Not Attempt Resuscitation (DNAR) discussions and if appropriate, DNAR documentation. The other aim was to assess the utilisation of Escalation of Care plans.