

Cohort prevalence of self-harm in pregnancy was 15.3% (95% CI 14.3–16.3); self-harm in the postnatal year was 19.7% (95% CI 18.6–20.8). Only a very small proportion of women self-harmed in both pregnancy and the postnatal year (3.9%, 95% CI 3.3–4.4). **Conclusion.** NLP can be used to identify perinatal self-harm within EHRs. The hardest attribute to classify was temporality. This is in line with the wider literature indicating temporality as a notoriously difficult problem in NLP. As a result, the application probably over-estimates prevalence, to a degree. However, overall performance, given the difficulty of the task, is good.

Bearing in mind the limitations, our findings suggest that self-harm is likely to be relatively common in women accessing secondary mental healthcare during the perinatal period.

Funding: KA is funded by a National Institute for Health Research Doctoral Research Fellowship (NIHR-DRF-2016-09-042). The views expressed are those of the authors and not necessarily those of the NHS, the NIHR or the Department of Health and Social Care. RD is funded by a Clinician Scientist Fellowship (research project e-HOST-IT) from the Health Foundation in partnership with the Academy of Medical Sciences which also partly funds AB. AB's work was also part supported by Health Data Research UK, an initiative funded by UK Research and Innovation, Department of Health and Social Care (England) and the devolved administrations, and leading medical research charities, as well as the Maudsley Charity.

Acknowledgements: Professor Louise M Howard, who originally suggested using NLP to identify perinatal self-harm in EHRs. Professor Howard is the primary supervisor of KA's Fellowship.

Junior doctors rate online simulation as 'good enough' but not as good as face to face sessions

Josh Bachra*, Anna Ludvigsen and Kehinde Junaid
Nottinghamshire Healthcare NHS Foundation Trust
*Corresponding author.

doi: 10.1192/bjo.2021.75

Aims. To compare the feasibility and acceptability of delivering a simulation-based learning (SBL) programme for Junior Doctors virtually versus face to face.

Method. The Nottinghamshire Healthcare Simulation Centre has been delivering a SBL programme for Foundation Year 2 doctors on behalf of Health Education East Midlands for the past three years. Since face to face teaching was not possible during the COVID-19 pandemic the programme was delivered online using the same content and format as for prior cohorts. Feedback questionnaires from 128 face to face participants (F2F) and 133 virtual participants (V) were compared.

Result. There was a decrease in Likert scale ratings across all domains in the virtual group. This was most apparent when examining the 'strongly agreed' responses: the venue/remote format was suitable for the session 34% decrease, the course length was appropriate 24% decrease, the pace of the course was appropriate 20% decrease, the simulation was helpful and relevant 15% decrease, the content of the course was organised and easy to follow 13% decrease, the learning objectives were met 10% decrease, the presenters were engaging 6% decrease, the trainers were well prepared 3% decrease. The virtual group included responses in the 'strongly disagree' and 'disagree' categories relating to the virtual format, length and pace, which did not occur in any domain for the F2F group.

Combining the 'strongly agree' and 'agree' statements also showed a decrease in satisfaction with 72.5% of responses falling into this category for the V group and 88.3% for the F2F group.

Fewer participants in the V group would recommend the course to a colleague (98% V vs 99% F2F).

Conclusion. Providing the SBL programme using an online format was feasible while also being acceptable to most participants. However, participants did not rate this experience as highly as face to face teaching. The largest decreases in satisfaction were in areas related to the virtual format. An interesting finding is that participants rated the pace and length of the online course as less agreeable, despite the content and scheduling being the same as for the face to face group.

Based on these findings face to face teaching should resume when practicable. In the meantime, the virtual delivery may be improved if the course length was reduced. Analysis of qualitative feedback may provide insights into why participants did not rate the virtual simulation as highly as the face to face equivalent.

Physical health audit of gwent specialist substance misuse services (North Team)

Mohamed Bader^{1*} and Hayder Al-Hassani²

¹Royal Gwent Hospital and ²Hiraith House, Maindiff Court Hospital
*Corresponding author.

doi: 10.1192/bjo.2021.76

Aims. The scope of this audit is to look at the:

1. Completion rates of standard 12 lead electrocardiograms (ECGs)
2. Completion rates of physical examinations
3. Analysis of the reported findings elicited from physical examinations
4. Completion rates of Blood borne virus (BBV) screens; for hepatitis B, hepatitis C, and human immunodeficiency virus (HIV)

Method. Physical Examination: All patients' physical GSSMS notes were checked for a Medical Assessment sheet. If no physical examination documentation was found, the generic clinical notes were examined for evidence of a physical examination. All findings were recorded in Microsoft Excel for descriptive analysis. Findings were then grouped into generic categories such as infectious, cardiac, etc. (see Figure 7).

ECG: All patient notes were examined in the 'Investigations' section to determine if an ECG was included. Print outs of ECGs done by other agencies/teams were accepted as long as they were within date. If a patient had an ECG on Clinical Workstation (CWS) within date it was not included in the audit unless the ECG was printed and filed in the 'Investigations' section.

BBV Screen: All patient notes were investigated to find evidence of the BBV consent sheet or print out of the results. If no evidence was found, CWS was checked for evidence of a blood borne virus screen. 5 Analysis of BBV screen results and completion of consent sheets were beyond the scope of this audit. If a patient had a BBV screen that was different to the standard GSSMS screen, such as a screen with HIV only or a BBV screen as part of an ante-natal screen, it was still included as a completed BBV screen.

Result. Total patients initially included (n = 125). Patients included in analysis (n = 121). Patient notes not on site (n = 2). Patients assessed on ward but did not engage with service afterwards (n = 2)

Physical Examinations

Received a physical examination by GSSMS (n = 60)