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.

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

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**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)

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**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)

Has not received a physical examination by GSSMS (n = 61)

An abnormality was detected in 77% of patients, charts to be added to display the findings to poster.

Most common findings were Hypertension (n = 9) and Abdominal Tenderness (n = 9).

ECG
Had an ECG (n = 37)
Did not have an ECG (n = 84)

BBV Screen
Had a BBV test in the last 6 months (n = 62)
Did not have a BBV Test in the last 6 months (n = 59)

**Conclusion.** Areas of Good Practice

1. As opposed to previous practice, physical examination rates have risen from 0% to 50%. The 50% rate also likely underestimates true practice as patients were included in these numbers if they: a. Disengaged prior to a medical examination but after a nursing assessment. b. Refused a physical examination

2. The vast majority of physical examinations elicited positive findings, identifying health needs and risks

3. ECG completion rate of 31%, despite being low, represents a significant improvement as the team did not have an ECG machine prior to the audit. Establishing a baseline ECG would also be of clinical value even if normal, as it would allow for future comparisons of QTc intervals compared to pre-treatment baselines. Patients may have had an ECG on mental health wards or in general hospital with the results/ECG being communicated to GSSMS staff, although it would not have been included in the audit as a completed ECG unless a copy was filed in the notes.

4. As previous BBV screen completion rate had not been quantified to obtain a baseline, it is difficult to compare current BBV screen completion rate. 66% of patients had had a BBV screen in the last year. This audit did not account for patients who disengaged prior to their BBV screen or patients who refused a BBV screen. This audit also includes all patients under GSSMS and BBV completion rates included alcohol dependent/neverinjecting patients which would be of lower risk as opposed to Injecting Drug Users. With that context in mind, a completion rate of 66% likely reflects good practice.

Areas for Improvement/Recommendations

1. Development of a checklist which can be placed on the front of a patients notes with dates that can be documented for ECG, Physical Examination, etc. as well as non-physical health documents such as risk assessments and care plans to ensure documents stay in date.

2. Further audits with more data would reveal further information with regards to the needs of patients under GSSMS. If current trends continue with improvements in detection, a larger pool of analysable data would be available. Based on current limitations of this audit a re-audit would benefit from: a. Quantifying BBV screen results to identify percentage of patients who are antibody and PCR positive; this can be done as a standalone project. b. Quantifying actions taken as a result of physical examination findings as that would indicate what additional service requirements (if any) need to be highlighted. The current method of auditing does not comment on severity or chronicity and does not account for the actions taken as a follow-up to the physical examination which may indicate acuity.

3. Further audits may require alterations to data collection may be allow for more specific measurement of health risks and needs. Eg. Highlighting if a patient is injecting substances or on a QTc prolonging medication. This would allow for more specific analysis of patients at risk of adverse outcomes. It is unclear if the improvement in monitoring is targeting GSSMS patients at higher or lower risk of adverse health outcomes.

Lessons Learnt

• Patients under GSSMS commonly were found to have physical examination findings, most commonly abdominal tenderness, potentially highlighting a significant pathology of the abdominal organs. ECG and physical examination completion rates are improving

• BBVs are being done frequently for the majority of patients

• Further recommendations for yearly re-audit would allow for targeting specific questions such as what percentage of patients require hepatology interventions or what percentage of patients are of high risk of cardiac events on Methadone

## Audit of the use of the physical health improvement (PHIT) to document physical health examination on an electronic health record at a mental health trust in Manchester

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**Aims.** The audit aimed to identify: The percentage of patients with Initial Physical Examination (IPE), ECG and bloods on admission being completed; If IPE, bloods and ECG result are documented on PHIT; To identify reasons for these interventions not being completed and review if refusal is being appropriately documented.

**Background.** "The Five Year Forward View for Mental Health NHS" report highlighted the poor physical health of those with mental health problems when compared to those without. In order to improve the identification and treatment of physical health problems within mental health inpatients, blood test results, physical examination and ECG results should be recorded and reviewed regularly. Within Greater Manchester Mental Health trust, the electronic records system PARIS contains a specific care document to record physical health interventions, known as the PHIT tool. The inpatient unit Park House, had recently changed to the PARIS system prior to this audit and the use of PHIT tool to monitor physical health parameters was considered a priority by the management team.

**Method.** All admissions to Park House inpatient unit, Manchester in April 2019 were audited. Patients were identified using a report prepared by Business Intelligence. Electronic notes were reviewed for evidence of physical interventions on admission and input of these data to the PHIT tool. Using a retrospective review of electronic notes, relevant information was anonymised and collected to a spreadsheet for further analysis. Inclusion/exclusion criteria was based on local conditions and practical consideration.

**Result.** An initial sample of 140 was reduced to 89 patients following application of inclusion/exclusion criteria. Of the 89 patients included, 73% had an IPE, 84% of patients had admission blood tests and 74% had an admission ECG. Recording of parameters on the PHIT tool was lower than expected with information recorded in 33–42% of patients. Where patients had refused IPE, ECG or bloods, a valid reason for refusal was documented between 63–91% of patients.