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.