Result. Key findings included:

High rates of physical comorbidities among psychiatric inpatients of all ages
Novel illnesses occurring during admissions
Evidence that patients are not receiving adequate physical healthcare from wider NHS
Junior doctors receiving inadequate support from Seniors and acute Hospital services when managing physical illnesses

Poor recording of cardiometabolic monitoring with few interventions delivered (even when indicated) and challenges finding relevant data in records.

During the MPLS pilot, a Consultant Physician provided virtual ward rounds and advisory sessions. 100% of staff involved reported the service was beneficial for their clinical practice and patient outcomes.

Conclusion. Taking these findings and input from colleagues within AWP and nationally, we created a comprehensive strategic overview on how AWP can deliver high quality physical health care, detailing improvements to make across 5 key domains: Inpatient, Community, Workforce, Education and Information Technology (IT).

Presently, we are working with Clinical Commissioning Groups developing protocols clarifying roles and responsibilities across primary and secondary providers. We are standardising communication between AWP and primary care and expanding links with specialist secondary services (e.g. endocrinology and cardiology). We formed the BRIGHT (Better Recording of Information for Governance and Healthcare in the Trust) project workgroup alongside IT to build safer and more effective records systems.

Medium term recommendations include employing a full-time MPLS Consultant Physician, in addition to 'Physical Health and Wellbeing Workers' in all localities, Advanced Nurse Practitioners (working within structured physical care systems) and more allied health professionals (dieticians, speech therapists and physiotherapists).

In the long term, the new Physical Health, IT and QI working groups will maintain development of these proposals, improve training and supervision for clinicians, and achieve healthcare parity for patients across localities.

The impact of COVID-19 on an inpatient mother and baby unit: a service evaluation

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Aims. Unique challenges have been faced by women in the perinatal period during the COVID-19 pandemic and the impact of this is compounded for women suffering from mental illness. This service evaluation looked at different aspects of the treatment pathway on a specialist inpatient psychiatric Mother and Baby Unit during the pandemic to identify what changes occurred.

Method. Data were collected for all admissions to the unit between January 2019 and October 2020, with the beginning of the pandemic being defined as on or after 1st March 2020. Information was collected retrospectively from electronic clinical notes on ethnicity, length of stay, diagnosis, mental health act use and restrictive practice, medication, psychology, occupational therapy and social services involvement.

Result. There were 114 admissions to the MBU during the study period. 4 were parenting assessments rather than acute psychiatric admissions and were excluded from the analysis, giving a sample of 110 women. 58% (62/110) were classed as "pre-pandemic" and 43.6% (48/110) were "during pandemic". 95.45% (105/110) of women were postpartum 4.55% (5/110) were pregnant. Mean length of stay was shorter during the pandemic at 44 days, compared to 61 pre-pandemic. There was greater use of the mental health act during the pandemic: only 43.75% of patients were informal throughout admission, compared to 70.97% pre-pandemic. Mean duration of detention was shorter at 25 days (32 pre-pandemic). Psychotic illness made up a greater proportion of diagnoses during the pandemic: 56% (27/48) compared to 44% (27/62) pre-pandemic. The next most common diagnostic group was mood and anxiety disorders, which made up 29% (14/48) of diagnoses during the pandemic, but 43% (27/62) pre-pandemic. Outcomes as measured using the Health of the Nation Outcome Scale showed a mean improvement between admission and discharge of 6.65, compared to 5.15 pre-pandemic. HONOS scores were higher on admission during the pandemic (12.83, vs 10.88), suggesting a higher level of acuity.

Conclusion. During the COVID-19 pandemic on this Mother and Baby Unit, length of stay was shorter, a greater proportion of patients were detained under the mental health act (although length of detention was shorter) and psychotic illness was more prevalent. This study demonstrates that there were differences in this perinatal inpatient population during the pandemic and this may be a reflection on the wider impact of COVID-19 on perinatal mental health.

Audit of shared-care lithium monitoring in a large rural GP practice

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Aims. To compare monitoring of lithium treatment with shared care lithium monitoring agreements in a large rural GP practice.

Background. A 'near miss' event with a patient with drug induced long QT syndrome highlighted a need for an audit of lithium monitoring at a large rural GP practice.

The practice had entered into shared-care monitoring agreements with the local mental health care trust. Under these agreements, responsibility for physical monitoring of lithium treatment was assumed by the practice.

Method. Using audit functions built into the IT system, all patients at the practice who were currently prescribed lithium-containing medications were identified (n = 28). Individual monitoring standards were determined for each patient based on the shared care agreement. These varied depending on age and comorbidity. Monitoring data obtained from medical records was compared against the individualised monitoring requirement.

Result. The key finding was that 26% of patients for whom annual ECGs were indicated according to the shared care agreement had received an ECG in the past year. 78% of patients had a lithium level recorded in the previous 3 months. 81% of patients had a renal function test within their monitoring requirements. 52% of patients had lipid measurement in the previous year.

Conclusion. There is a great degree of heterogeneity in the extent to which shared care monitoring agreements are achieved. It is noted that those standards to which a Quality Outcome Framework incentive applied had a greater chance of being met.