Audit of Appointment Non-Attendance in Leeds Child and Young Person Learning Disability Psychiatry Clinic

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Aims: Appointment non-attendance has significant impacts on care and resource allocation across the NHS. This audit investigates appointment non-attendance within the Leeds Child and Young Person Mental Health Service (CYPMHS) Learning Disability (LD) Psychiatry Clinic, aiming to identify contributing factors and propose strategies to improve attendance in the context of the unique challenges and complexities associated with LD.
Methods: This retrospective clinical audit analyses data on 237 scheduled appointments at the Leeds CYPMHS LD Psychiatry Clinic between September 2023 and August 2024. Data collection involved reviewing electronic medical records to identify trends within anonymised patient information, handled securely in compliance with NHS and University of Leeds data protection policies.

MS and AG investigated multiple strata to identify trends explaining DNAs, including: attendance status (parent and child) by month and overall, age, gender, ethnicity, location, appointment time, day of the week, and format (virtual vs in-person). More detailed analyses explored potential patterns by clinician, school, postcode-linked deprivation indices, diagnosis, medication, and recorded reasons for non-attendance.
Results: 83% of overall appointments were attended.

Afternoon appointments had a higher attendance rate (94%) compared with morning slots (81%). Older teenagers were more likely to attend, with a trend of increasing attendance by year of age: 91% in 17-year-olds vs. 67% in 9-year-olds. Home visits had the highest attendance (100%), followed by school visits (85%), virtual consultations (81%) and clinic-based appointments (80%).

Attendance patterns differed between children and parents. While home visits had the highest attendance for both (100%), school visits were preferable for children (86%) whereas parents attended best virtually (83%).
Conclusion: This audit highlights predictors of appointment attendance. Findings suggest that targeted adjustments may enhance engagement and reduce DNAs, such as: prioritising home and school-based visits, afternoon appointment timing, and developing strategies to improve access amongst younger children. These findings align with existing literature, showing higher non-attendance rates among younger children and for morning appointments in paediatric and learning disability (LD) services.

The inverse attendance patterns between parents and children by location raises questions about whether services should prioritise child or parental attendance in decision-making. Joint attendance is often important for LD assessments, so this may require further discussion amongst the clinical team.

Further research is needed to identify barriers to attendance for younger children, and to explore whether alternative scheduling/alternative interventions could improve engagement and reduce DNAs. These insights can inform broader service delivery strategies to improve care access and efficiency.

Prophylactic Vitamin D Prescribing for Adult Inpatients on Psychiatric Wards at Warneford Hospital – an Audit

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Aims: Vitamin D deficiency is a common and preventable problem seen in the UK, which can contribute to physical and mental health illness. The Department of Health and Social Care states that adults in restricted settings, such as inpatient psychiatric units, are at increased risk of vitamin D deficiency due to limited exposure to sunlight. Local Trust guidelines specify that all adult inpatients should be offered vitamin D prophylaxis year-round, unless there are symptoms of osteomalacia, in which case vitamin D serum levels should be tested and a treatment dose regime prescribed. Despite this, we noted that many patients did not receive prophylactic treatment. The primary aim of this audit was to increase the number of prophylactic vitamin D prescriptions for psychiatric inpatients at Warneford Hospital, in line with local Trust guidelines and national guidance.
Methods: We firstly collected data on current prescribing of prophylactic vitamin D for adult inpatients across 3 wards. We then re-formatted local Trust guidelines on vitamin D prescribing and testing into a simplified poster and flow chart. Copies were distributed to doctor's offices in three adult inpatient wards, 2 female and 1 male, at the Warneford Hospital. We then compared the number of patients who were prescribed prophylactic vitamin D pre- and post-intervention.
Results: There were 51 patients across all 3 wards, 33 female and 18 male. In a two-week timeframe, the total number of patients who were prescribed prophylactic vitamin D doubled, from 8 (16%) to 16 (31%) patients. The biggest increase was seen in patients on the male ward, with a 5-fold increase from 1 (6%) to 5 (28%) patients. The patients on the ward changed in this timeframe, due to the normal flow of discharges and admissions on acute wards.
Conclusion: There was an increase in the numbers of patients who had prophylactic vitamin D supplementation prescribed in all included inpatient wards, showing that presenting guidelines in a simplified manner is a useful intervention to improve prescribing practices. Our intervention could be further improved by using additional channels of communication, such as e-mails or presentations for prescribers. A qualitative approach may be useful to explore existing barriers for patients to accept vitamin D prescriptions. In future, reducing the number of serum vitamin D level tests due to prophylactic prescribing of vitamin D in the absence of osteomalacia could have significant financial and environmental benefits for the Trust and the NHS.

A Review of Communication Practices Between a Psychiatric Inpatient Unit and an Emergency Department to Improve Patient Safety and Clinical Outcomes During Transition of Care

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Aims: Individuals with psychiatric disorders face a significantly higher risk of cardiovascular disease and other medical conditions, leading to increased morbidity and premature mortality compared with the general population. This disparity may also be partly due to diagnostic overshadowing. Effective communication between clinical settings is essential for patient safety and continuity of care whilst delays or inaccuracies in information sharing can have serious consequences.

This study aimed to evaluate the quality and timeliness of communication between an acute inpatient psychiatric unit, Hallam Street Hospital (HSH), Sandwell, Black Country Healthcare NHS Foundation Trust, and an emergency department, Midlands Metropolitan University Hospital (MMUH), West Midlands, to identify gaps and improve transitions of care.

Methods: A retrospective study was conducted between November 2024 and January 2025 reviewing inpatients transferred from HSH to MMUH. Patient records from the corresponding electronic systems were analysed (Rio (HSH) and Unity (MMUH)) to determine whether:

A handover document containing relevant clinical information was provided upon transfer to MMUH.

A discharge summary including a management plan was available upon patient's discharge to HSH.

Results: Twelve patients were referred from HSH to MMUH during the study period with three (25%) requiring re-attendance. A limitation of this study was its small sample size due to the recent transition of the handover system.

Ten patients (83%) were accompanied by staff, while one (8%) attended alone, one (8%) accompanied by family.

Four patients (33%) were sent to MMUH with a handover document. Only one (8%) had been scanned onto Rio. None were available for viewing on Unity.

Nine patients (75%) returned to HSH with discharge summaries, however only five (42%) had been uploaded onto Rio.

The discharge summaries generally contained adequate details on the patient's hospital course and management plan, aligned with NICE guidelines.

Conclusion: The audit highlighted a lack of a standardised protocol for written handover during patient transfers. While discharge summaries were electronically sent to GPs, a dedicated copy for HSH records was not consistently generated. Clinicians relied heavily on verbal handovers provided by accompanying staff or the patients themselves, increasing the risk of miscommunication and errors.

To enhance patient safety and continuity of care, we propose developing a standardised transition-of-care protocol, ensuring systematic documentation, and conducting a re-audit to assess improvements in practice.

Audit on Drug Screening Practice on Inpatient Psychiatric Wards

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Aims: The relationship between mental illness and substance misuse is well established. Early identification through drug testing can inform more holistic management plans. This audit aims to check the compliance of the current practice on acute psychiatric wards with the Trust policy for drug screening, it also aims to draw conclusions, and recommend changes to increase the compliance and benefits from implementing the policy.

Methods: Data was collected retrospectively from two adult acute psychiatric wards, including a sample of 20 male and 20 female patients admitted in 2024.

The parameters assessed were:

The presence of any documentation regarding drug testing on admission.

If the drug test was offered, accepted or refused, and if the results were documented.

If the positive results were acted on, such as referrals to substance misuse services.

Results: Any documentation related to drug screening was present in 23 out of 40 patient records (57.5%).

This indicates that nearly half of the patients admitted lacked proper documentation of whether a drug test was indicated, considered, offered, or completed.

21 out of 40 patients (52.5%) were offered a drug test.

In 4 cases, drug screening was recommended as part of the plan but was not offered or followed through. Reasons for this were not recorded.

Among the 21 tests offered, 15 patients (71.4%) completed the test. 8 (53.3%) were positive and 7 (46.7%) were negative.

6 patients (28.6%) refused UDS, but the reasons for refusal were not documented.

5 out of 8 patients with positive drug test results were referred to the substance misuse service.

Conclusion: This audit highlights inconsistencies in drug testing practices on inpatient wards, particularly regarding documentation, offering of tests, and follow-up on the results.

Recommended changes are as follows:

Drug screening should be offered to all inpatient groups, results should be acted on appropriately.

Improving documentation: The inpatient teams to ensure documenting if drug testing has been or should be offered, if it was accepted or refused, its results, and if positive, the follow-up plans.

By implementing those changes, drug testing can become a more effective tool for identifying and managing substance misuse, ultimately improving patient outcomes.

Findings and recommendations for change are being circulated in the Trust, and a re-audit following the implementation of recommendations will be undertaken after 3 months to evaluate the effectiveness of changes and ensure continuous improvement.

Comprehensive Evaluation of Referral Practices From General Practitioners to Balbriggan CMHT, Dublin: Audit Cycle Overview

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