Kent and Medway
NHS and Social Care Partnership Trust

POLICY AND PROCEDURE FOR MANAGING PATIENTS WHO DID NOT ATTEND (DNA) AND/OR ARE UNABLE TO BE CONTACTED

Document Reference No.	KMPT.CliG.014.06
Replacing document	KMPT.CliG.014.05
Target audience	Clinical Staff
Author	Service Manager
Group responsible for developing document	Trustwide Patient Safety and Mortality Review Group
Status	Authorised
Authorised/Ratified By	Trustwide Patient Safety and Mortality Review Group
Authorised/Ratified On	March 2025
Date of Implementation	March 2025
Review Date	June 2025
Review	This document will be reviewed prior to review date if a legislative change or other event otherwise dictates.
Distribution date	April 2025
Number of Pages	27
Contact Point for Queries	kmpt.policies@nhs.net
Copyright	Kent and Medway NHS and Social Care Partnership Trust 2025

DOCUMENT TRACKING SHEET

POLICY AND PROCEDURE FOR MANAGING PATIENTS WHO DID NOT ATTEND (DNA) AND/OR ARE UNABLE TO BE CONTACTED

Version	Status	Date	Issued to/approved by	Comments
1.1	Draft	11/08/11	Consultation	
1.2	Draft	27/09/11	Clinical Governance Group	Ratified – Subject to changes being made
2.0	Approved	10/11/11	Policy Manager	Section 7 – Removed word psychiatric Section 13 – Completed
2.1	review	Feb 15	Consultation	
2.2	review	Mar 15	Patient Safety Group	Changes requested
2.3	review	Mar 15		Additions made as requested by patient safety group
3.0	Approved	April 15	Patient Safety Group	Ratified
3.1	Approved	27 February 2017	Trust Wide Patient Safety & Mortality Group	Addendum to KMPT Policy for Managing and Reducing Did Not Attend (DNA) re Specialist Personality Disorders Service added by John Rea, Personality Disorder Service Lead. Addendum was virtually ratified by Trust Wide Patient Safety & Mortality Group.
3.2	Review	February 2018	Trustwide Patient Safety and Mortality Review Group	Re-write of policy
4.0	Approved	27 February 2018	Trustwide Patient Safety and Mortality Review Group	Virtually ratified.
4.1		24 September 2019	Trustwide Patient Safety and Mortality Review Group	Addendum on Section 1- definition of DNA and cancellation
4.2	Approved	10 December 2019	Trust Wide Patient Safety and Mortality Review Group Assistant Medical Director Community Recovery Care Group/ Deputy Chief Operating Officer	Addendum to policy re Criminal Justice Liaison and Diversion Service – Support, Time and Recovery Function added by Service Manager - virtually ratified. Minor amendments to Sections 7, 8 and appendix A to add clarity.

4.3	Approved	July 2020	Appendices approved by Clinical Effectiveness and Outcomes Group	
5.0		February 2021	Clinical Effectiveness and Outcomes Group (CEOG)	Ratified
6.0	Final	March 2025	Clinical Effectiveness and Outcomes Group	Approved

REFERENCES

RELATED POLICIES/PROCEDURES/protocols/forms/leaflets

CPA Policy	KMPT.CliG.001
Clinical Risk Assessment Policy	KMPT.CliG.009
Lone Working Policy	KMPT.CorG.024
Safeguarding Vulnerable Adults	KMPT.CliG.006
Transfer & Discharge of Care of Service Users within the Care Planning Process	KMPT.CliG.146
The 10 Golden Rules for Record Keeping	

SUMMARY OF CHANGES

Date	Author	Page	Changes (brief summary)
24/09/19	Victoria Stevens	Section 1	Addendum on Section 1- definition of DNA and cancellation Addendum on Section 1- definition of DNA and cancellation
04/12/19	Dr Kirsten Lawson, Assistant Medical Director CRCG		Addendum on Section 7- Red Board meeting and CRHT contact. Addition of 7.1.6 Section 8- CRHT contact. Addition of 8.1.1. c Appendix A- updated procotol Amendments add clarity.
10/12/19	CJLDS Manager	Appendix D (now E)	Addendum to policy re Criminal Justice Liaison and Diversion Service – Support, Time and Recovery Function added by Service Manager.
07/09/20			Appendix A updated protocol and Appendix B – Welfare Check Protocol added.
15/12/20	DNA Working Group	2	Need to consider MHA and MCA when discharging Need to make contact within 2 working days Clarified need to contact GP only if risk is uncertain
		3	All risk types should be considered when assessing level of risk On actions to be taken if the patient is of NFA
		4	On actions to be taken when despite being of medium risk, it is deemed not necessary to follow the process in its entirety All medium/high risk DNAs added to RED Board On the MDT making the final decision when unable to locate a person of NFA who DNAs an appointment
		5-6	Delete actions for DNAs occurring in OPAs – not necessary as process is described between sections 6 and 7 (DNAs which occur at assessment or follow up appointment)
		7	Daily and monthly monitoring of compliance to DNA policy added Bi-annual audit removed (due to above inclusion)
		23	CBIT DNA process added via appendix E
		25	CJLADS – small change 14.1.1 re. clients making a self-referral 14 days post discharge
		27-29	Flow charts added
03/12/2024	DNA review group	All pages	Policy reviewed to include overarching Trustwide policy with addendums for specific services detailing service specific processes Removed Talking Therapies For Survivors Of Sexual Assault Service as no longer provided

CONTENTS

1 INTRODUCTION

1.1 This policy relates to all appointments within the community, either at a clinical base or the patient's home for patients across all directorates, where the patient did not attend (DNA). An appointment could be virtual, face to face or via telephone.

1.2 Community services provide bespoke care for their patient cohort which may include people in crisis and those with differing complexities of risk. This policy will provide standardised guidance for all staff and patient cohorts. The policy contains addendums which provide guidance for the DNA response to presentations and individual situations within specialist or bespoke services.

1.3 It is recognised for some patients there could be an increased risk if they do not attend (DNA) for scheduled appointments or cannot be contacted for home visits. Within this policy both groups will be identified as 'DNA' for ease.

1.4 The Trust's Care Planning Policy and Service User's Clinical Risk Assessment, Formulation, and Management Policy sets out the core framework for ensuring that care is managed both safely and effectively, and is responsive to the individual needs of Patients. This policy should be read in conjunction with those documents.

1.5 **Definitions:**

DNA - when the service user does not attend the appointment and does not contact to say they won't be attending.

CANCELLATION- when the service user informs the service that they will not be attending the appointment, **anytime up to the commencement of the appointment**

2 PURPOSE

2.1 This policy sets out how we will manage DNAs across all services in order to maximise resources without compromising patient safety and access to services and care.

3 ROLES AND RESPONSIBILITIES

3.1 Each clinician/practitioner who is due to see a patient is accountable for that patient's care at that time. As such they are responsible for adhering to this policy.

3.2

3.3 When any team member wishes to discharge a patient under this policy, the case will be discussed with a senior team member and a team decision taken based on the premise that care delivery should not be compromised. It is expected that patients' vulnerabilities, symptoms, risks, the Mental Health Act (1983) and Mental Capacity Act (2005) will be considered in the implementation of this policy.

4 APPOINTMENT LETTERS –

4.1 Patients will be advised about the service policy on DNA and cancellation in all appointment letters using the relevant statement for the service/Rio template.

4.2 Opt-in letters are not to be used for patients.

5 RISK MANAGEMENT

5.1 As per the NICE guidelines, and changes being made on a national level, in line with NCiSH data, we will no longer be categorising risk as High, medium and low, or utilising the RAG (Red, Amber, Green) rating. As risk is dynamic, unpredictable, and can be dependent on, or influenced by changing factors in a person's life, our assessment will focus not on the level of risk, but rather answer the question, "Does risk exist?" If we identify that risk of harm to self, or to or from others, or general risks, exist, then a Risk Management Safety Plan will need to be developed, in collaboration with the patient, and members of their network, if possible

5.2 The Risk Management Safety Plan includes the opportunity to discuss with the patient, and their network, what actions could or should be taken if a patient does not arrive for an appointment, or is unable to cancel an appointment. How a DNA is then dealt with by staff will have been proactively discussed, and a plan determined, and written into the patient's safety plan. The management of a DNA will then be unique to every patient, considering the requests made by the patient, and their network, and written as an action, into their safety plan.

5.3 Empowering the patient, and their network, to have a say as to how the patient's behaviour or decisions, are managed, fits with the systemic change towards the inclusion and involvement of the patient, and their network, in their own treatment planning. They are not just agreeing to a standard organisational plan but rather determining a unique and bespoke plan to manage DNAs, that takes their own needs, circumstances, and reasonable adjustments, into account. If the patient, and their network, has been instrumental in determining their own personal plan to action should they DNA, then the thought is that this will encourage a sense of accountability to following their plan. Thus, emphasising the shift to person-centred engagement.

DNAs – Actions taken will depend on risks identified and in accordance with the narrative above. (For further information please refer to flow chart in Appendix C)

5.4 **Assessment**

5.4.1 If the patient has not agreed the assessment appointment date then the patient should be contacted to ascertain if another appointment is needed within two working days. If so, then it should be booked collaboratively. If that appointment is subsequently not attended (DNA) then the process as described in point 5.1.3 should be followed

5.4.2 If the patient cannot be contacted and the risk type is uncertain then discuss with the GP to confirm symptoms and risk. If no or few concerns around risk and these are well managed, discharge to care of the GP following discussion with senior team member. If risk is complex (consider severity, frequency immanency) clinician needs to describe their clinical decision making in terms of an action/ management plan. Note rationale for decision clearly in progress notes on RiO and action it. A second appointment letter should be sent.

5.4.3 Where a new patient has agreed (by means of phoning/emailing to confirm attendance) an assessment appointment date with reasonable notice and this has been clearly communicated to them, but then subsequently DNAs they will be referred back to the GP/referrer and discharged unless extenuating circumstances are present (e.g. transport didn't attend). This is to be discussed with a senior team member; note rationale for decision clearly in progress notes on RiO and action it. The GP will be informed of this outcome within 7 days of the missed appointment. The letter will be copied to the patient.

5.5 **Follow-up appointments**

5.5.1 The clinician who was due to see the patient will review the file and form an opinion about offering another appointment. If the decision is not to see again this will be discussed with a

senior clinician/team leader, the rationale for the decision should be clearly documented in progress notes on RiO and then actioned.

5.5.2 Managing DNAs in this fashion acts as a safeguard by ensuring GPs/referrers are informed of the DNA and allows them to take other actions as necessary. It also facilitates best use of resources. Re- referrals are accepted, however, there is an expectation that the GP/referrer would seek the patient's assurance they will attend any offered appointments.

DNAs – Actions taken will depend on risks identified

5.6 The same process will be followed whether the DNA is for an **assessment or a follow up appointment.** (For purposes of caring for patients on clozapine, depot medication or on a Community Treatment Order, patients who DNA should be considered as complex risk and actioned as per this section.) It is vital that when determining risk, all types of risk including physical health, social health and self-neglect must be considered.

5.6.1 **Within the initial hour** try to establish contact by telephone to patient by making repeated attempts; in deciding the frequency of the attempts the service user's individual risk assessment should be referred to and updated. Discuss with a senior; agree a plan as to who and when a further contact must be attempted, considering the need to telephone again, contact their carer or other contacts i.e. neighbour, GP or local A&E departments with the teams concerns. All decisions, rationale and actions must be fully documented.

5.6.2 **On review of the risk assessment** if no contact has been established and no collateral information can be confirmed pertaining to the service user's welfare from carers and family and friends; continue attempts to make phone contact. If no contact then staff must attend the home address if an assessment of risk allows this, as soon as clinically indicated and agreed with senior staff. In cases where the home address is unknown or the person is of no fixed abode, attempts should be made to ascertain likely whereabouts by contacting any known friends or family, or by making contact with local homeless or rough sleeper services. If likely whereabouts are identified then attempts should be made to attend. If it is not possible to identify the potential whereabouts then the home address cannot be attended. In these cases, the situation should be discussed by the multidisciplinary team to determine the more appropriate course of action. This may be to continue efforts to locate the person for an agreed period of time, involve other services to support or to discharge. Staff should prioritise workloads accordingly based on risk complexity . Staff may want to try and arrange to meet a carer or next of kin at the address that may have prior agreed means of accessing the address. At each stage, discuss with a senior, note rationale for decision in progress notes on RiO and action it.

5.6.3 **The home address should be visited as soon as is clinically indicated.** On attending the home address if there are escalating concerns for the patient's or others' safety, staff should refer to the welfare check protocol. If staff are unable to access the service user's address with support of a next of kin or a carer, they have the option of asking the Police to support.

5.6.4 **Document:** document in progress notes on RiO the details of this discussion, with whom and the rationale for decision made, recording the time the discussion took place. Remember to document times as the action occurred, so that the service user's clinical notes reflect a 'live' record. For reference, this is further described in the 10 Golden Rules for Record Keeping.

5.6.5 **Escalate:** in the event of a serious incident being suspected, then staff need to defer to the Investigation of Serious Incidents, Incidents, Complaints and Claims Policy and the Management of Serious Incidents, Incidents, Accidents and Near Misses Policy. Partner organisations will refer to the sharing of incidents process.

5.6.6 **Out of Hours transitions**: If community services have identified a patient as elevated risk but the team have been unable to make contact to assess and review the person, then referral to the CRHTT should be undertaken to continue attempts at contact. If the CRHTT are unable to contact within the team's prescribed time frames for contact the above policy is applied.

5.7 All patients of elevated risk (consider immanency, frequency and severity) must be added to the RED Board and remain there until a follow up appointment has been completed.

6 RECORD KEEPING

6.1 A patient's record is a basic clinical tool used to give a clear and accurate picture of their care and treatment. Comompetent use is essential in ensuring that an individual's assessed needs are met comprehensively and are documented in real time (General Medical Council 2006; the Royal College of Psychiatrists 2009; Health Professions Council 2008 Standards of Conduct Performance & Ethics; Nursing and Midwifery Council 2009 Standards, amended 2010; NHS Record Keeping - NHS Code of Practice for Record Keeping 2006 and NHS England Document and Records Management Policy 2014).

6.2 All NHS Trusts are required to keep full, accurate and secure records (Data Protection Act 1998) demonstrate public value for money and manage risks (NHS Litigation Authority, Information Governance Toolkit, Essential Standards). **Compliance with this Policy and these legal and best practice requirements will be evidenced through information input into the electronic record, RiO.**

6.3 Partner organisations will adhere to this policy when delivering Mental Health Together and Mental Health Together plus services.

6.4 Record keeping for partner organisations will be determined by this policy and the policies of each organisation and adherence will be monitored through the contract**.**

7 IMPLEMENTATION INCLUDING TRAINING AND AWARENESS

7.1 The policy will be implemented via each team through their local team governance meetings and the meetings minuted for evidence of awareness.

8 EQUALITY IMPACT ASSESSMENT SUMMARY

8.1 The Equality Act 2010 places a statutory duty on public bodies to have due regard in the exercise of their functions. The duty also requires public bodies to consider how the decisions they make, and the services they deliver, affect people who share equality protected characteristics and those who do not.

8.2 In KMPT the culture of Equality Impact Assessment will be pursued in order to provide assurance that the Trust has carefully considered any potential negative outcomes that can occur before implementation. The Trust will monitor the implementation of the various functions/policies and refresh them in a timely manner in order to incorporate any positive changes.

9 HUMAN RIGHTS

9.1 The Human Rights Act 1998 sets out fundamental provisions with respect to the protection of individual human rights. These include maintaining dignity, ensuring confidentiality and protecting

individuals from abuse of various kinds. Employees and volunteers of the Trust must ensure that the trust does not breach the human rights of any individual the trust comes into contact with.

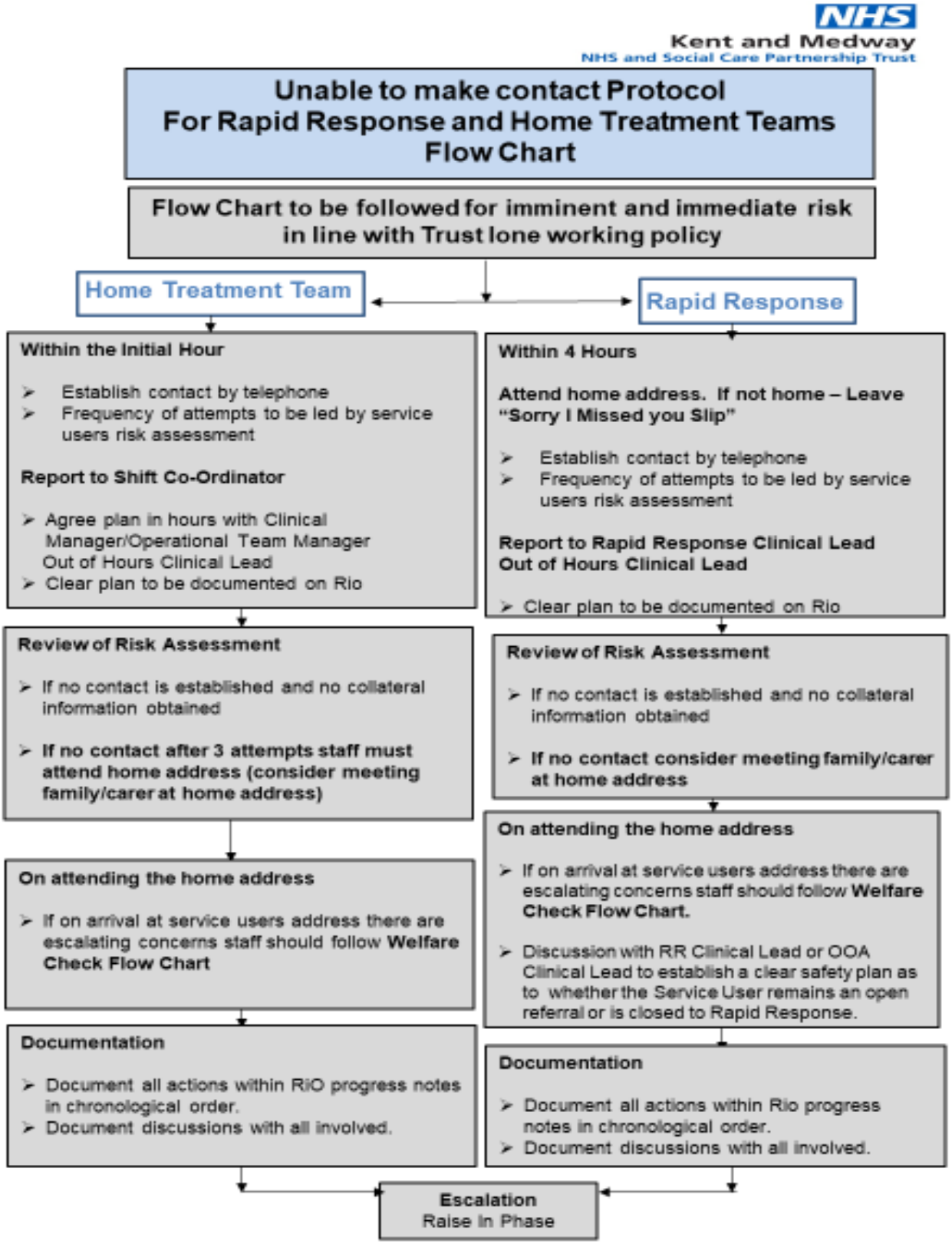
10 MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THIS DOCUMENT

What will be monitored	***How will it be monitored***	***Who will monitor***	***Frequency***	***Evidence to demonstrate monitoring***	***Action to be taken in the event of non compliance***
Compliance with DNA policy	Local team oversight Monthly Care Group Patient Safety and Risk Meeting	Local Team Managers Senior Management Team	Daily Monthly	Daily / Monthly reports	Individual and team feedback and additional training if required. Required change to practice to be actioned within a specific time.
Themes within SIs	Monitoring of themes from PSIRF	Patient safety team	Six monthly	Patient safety bulletin	Individual team feedback and additional training if required. Required change to practice to be actioned within a specific time.

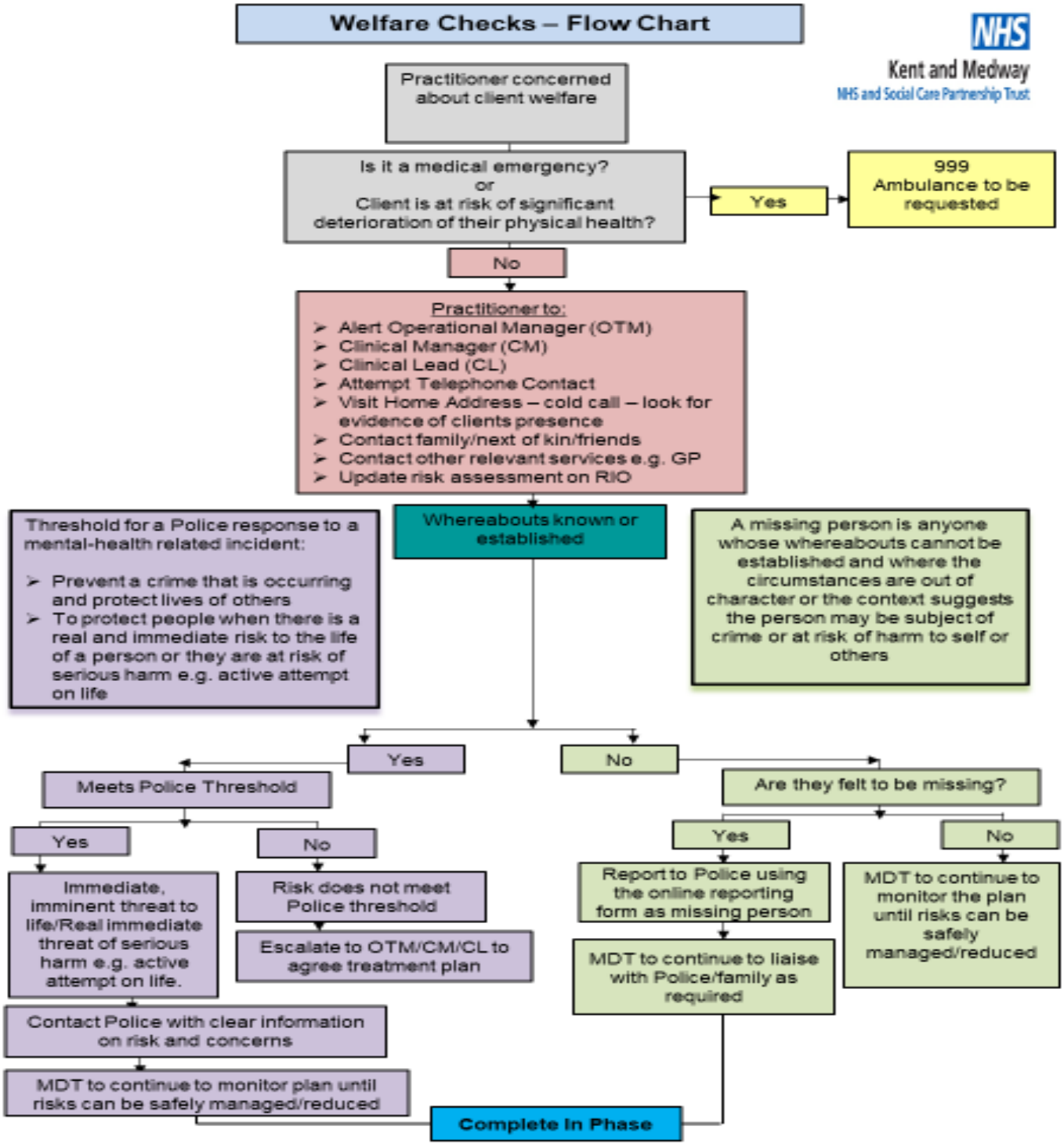
11 EXCEPTIONS

4.1 There are no exceptions to this policy

APPENDIX A UNABLE TO MAKE CONTACT PROTOCOL



APPENDIX B WELFARE CHECK PROTOCOL



APPENDIX C RISK ASSESS

The move away from rating risk means that a patient can no longer be placed in a specific compartmentalised space or be categorised as a consistently high or consistently low risk patient. As risk is fluid, dynamic, unpredictable, and can change from moment to moment, there is a need to be constantly reviewing and assessing risk, as well as constantly reviewing and updating the patient's safety planning. We want to be able to determine how the patient is doing, right now, in real time. The action then to be made if a patient DNA will then be determined from recent evidence i.e. their latest risk formulation, which was collaboratively produced with the patient, and their network, and talks to their current risk, at the time the formulation was written, their recent safety plan, as well as the plan put in place in this safety plan should the patient DNA. Contact with the patient, or with their network, and the information they provide, at the time of the DNA. All this evidence, as well as where the patient was last seen, or whether they cannot be presently located, will then determine the necessary actions to be taken, and by whom.

PRIMARY ACTIONS

Tick as completed and record on action log

ELEVATED RISK – COMPLETE ACTIONS IMMEDIATELY AND CONCURRENTLY

- Search Immediate area – coordinated by Nurse in charge of department
- Establish where when and by whom the individual was last seen
- Complete Missing Person details form
- Inform the below person of the incident passing them description of the individual
  - Manager on Call
  - Security
  - Porter staff
- Contact NOK(if appropriate) to enquire as to whether they are aware of the MPs whereabouts or have any information that may assist in locating them.
- Complete necessary internal incident forms

Clinical site manager to be consulted to assess whether individual should be treated as a Missing Person and reported to Police, having regarding to the rights of the individual.

SECONDARY ACTIONS

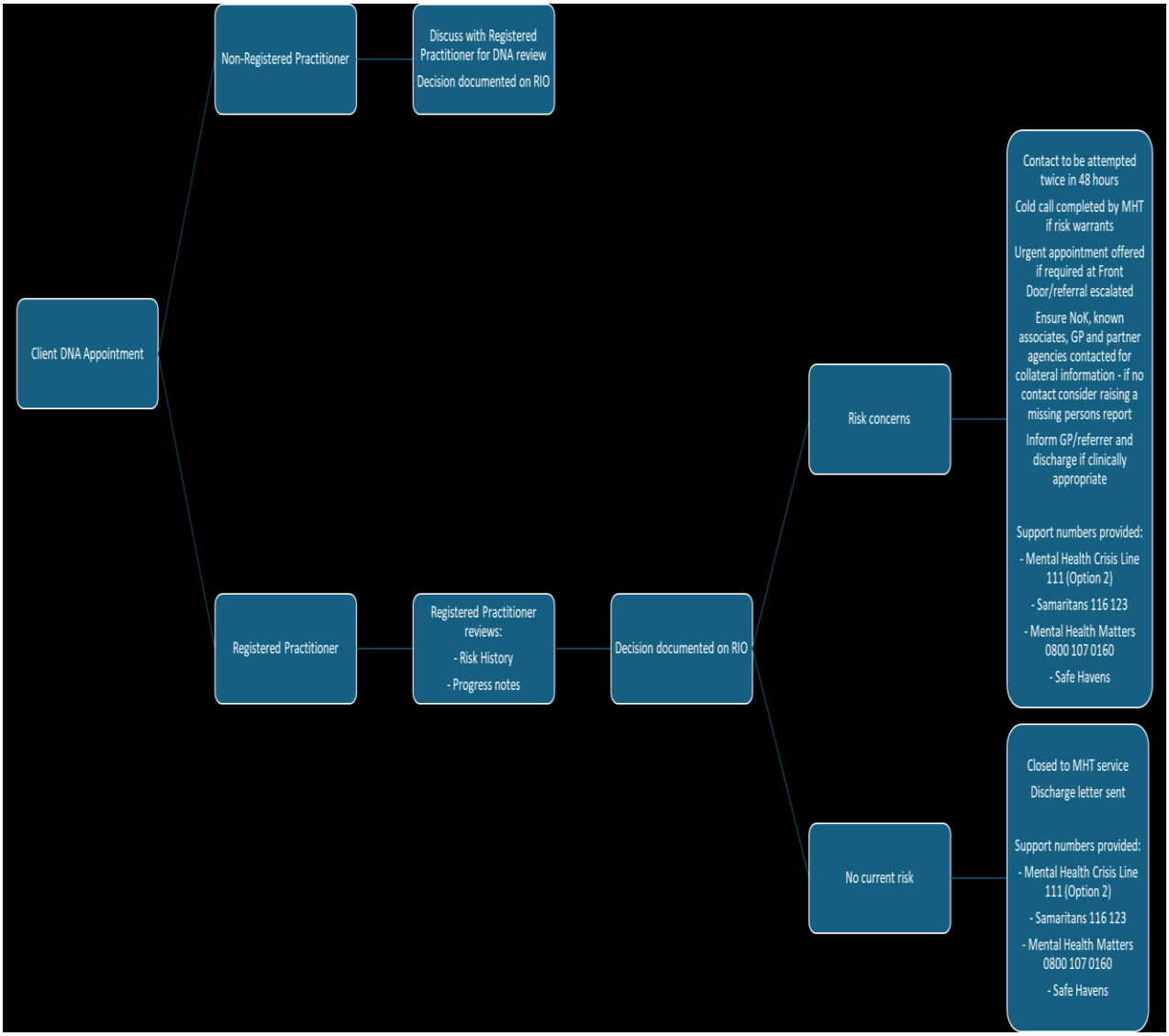
- Identify single point of contact of multi agency liaison, pass their details to Police and record on the action log. Act immediately if complexity of risk is elevated – immanency, frequency, severity.
- Where possible obtain a photograph of the Missing Person
- Coordinate search of all hospital grounds utilise all available staff
- Ensure CCTV is monitored and reviewed
- Ensure all actions are appropriately recorded on the action log
- Ensure that the missing persons belongings remain in place for the Police

Review Risk Assessment and Actions continually assuring they are correctly undertaken regarding the circumstance, taking into account Risk to the individual and staff

IF THE PATIENT IS FOUND ENSURE THEIR MEDICAL AND WELFARE NEEDS ARE MET AND CONTACT POLICE IMMEDIATELY.

Where appropriate ensure all other parties notified of the missing incident are aware that the patient has been located

APPENDIX D – MENTAL HEALTH TOGETHER DID NOT ATTEND PROCESS



APPENDIX E - MENTAL HEALTH TOGETHER + (MHT+) DID NOT ATTEND PROCESS

Introduction

People under the care of MHT+ who have multiple care needs as such are considered to have increased complexities and risk. MHT+ takes an assertive approach to engagement with individuals in order to reduce the risk of their being lost to services and potentially becoming increasingly unwell. MHT+ team members will be flexible and creative in situations where individuals miss appointments or are resistant to working with the team. The information input into the patient electronic record on Rio evidences that assessed needs are met in good time and comply with good practice and legislation.

This addendum is to reinforce that SMI patients under MHT+ will not be discharged based on lack of engagement alone and that there will be senior and team discussions to consider how to more assertively engage the patient. Examples could include more frequent attempts at telephone contact, cold call home visits, visits to regularly frequented places, contact with family, friends and carers as agreed with the patient, contact and discussions with other services involved including GP/third sector

Do Not Attend and Disengagement

In the event that people DNA, then the risks need to be reviewed and the following action taken.

It should be noted that clients referred to and accepted for assessment into MHT+ should be deemed as an increased risk and their risk profile should be carefully reviewed. Consideration of increased risk includes all those under care of HTT, on clozapine, on depot medication or on a CTO.

Within the initial hour of the DNA try to establish contact by telephone to person by making repeated attempts; in deciding the frequency of the attempts, the individual's referral information and risk assessment/ history should be reviewed. If risk has been identified at the time of their latest risk formulation, or a number of risk events have been logged, and a recent report of experiencing a difficulty in identifying the current triggers of risk, and/or putting alternative coping strategies in place, then consider other services (e.g. rapid response/ home treatment team, AHMPS, police). The clinician should contact the referrer, review the risks, obtain any other contact information and discuss how to engage the client. Escalate any risks to team leader/clinical lead and agree a plan as to who and when a further contact must be attempted, considering the need to telephone again and contact their family, carers or friends. If, however, no contact can be established and no collateral information can be confirmed from significant others, then continue attempts to make contact by phone, prioritise diary and attempt home visit - based on risk assessment. Consider also professionals meeting to share information.

Consent to share information/breach of confidentiality is superseded by perceived and actual risk to patient. At each stage, discuss with team leader/clinical lead, note rationale for decision in progress notes on Rio and action it.

If unable to make contact by home visit with significant other and there are escalating concerns for safety, then the right care, right person guidance should be followed.

Attempts to engage the client can be up to 3 months using an assertive approach. This needs to be reviewed by the MDT and in discussion with the referrer and family. During attempts to assess a person with no previous history and no evidence deterioration has occurred, the person will be discharged back to the referrer with a contingency plan and offer of re-referral.

However, a person who has disengaged from MHT+ will require a professionals' meeting/ MDT review meeting with team leader/ clinical lead attendance to agree next steps to be taken to engage,

manage risks or agree transfer of care. There needs to be prior discussion with the family/carer before transfer takes place. Information will be provided to enable rapid reassessment by MHT+ if necessary.

APPENDIX F NEUROPSYCHIATRY AND NEUROPSYCHOLOGY SERVICES DID NOT ATTEND (DNA) AND PATIENT CANCELLATION GUIDELINES

This Appendix sets out how DNAs will be managed in order to maximise resources without compromising patient access to services and care. Appointments made by telephone will be followed with a confirmation letter unless, either they decline it, or it is a short notice appointment (i.e. 3 days or less) where sending it is futile .·

When initial contact is made with new patients by admin staff either by phone or letter, contact landline and mobile phone numbers need to be confirmed and consent should be sought to send SMS appointment reminders to the patient (and/or relative or carer if appropriate).

1. Roles and Responsibilities:

When any team member wishes to discharge a patient under this policy the case will be discussed at the weekly team meeting (or with supervisor if appropriate, where the clinician does not work in a team) and a team decision taken based on the premise that care delivery should not be compromised. It is expected that patients' vulnerabilities and risks will be considered in the implementation of this policy.

2.0 DID NOT ATTENDS (DNAS)

2.1 New Patients

Where a new patient has agreed (by means of phoning/emailing to confirm attendance) an appointment date with reasonable notice and this has been clearly communicated to them, then subsequently DNA's they will be referred back to the GP/referrer and discharged. The GP will be informed of this within 7 days of the missed appointment. The letter will be copied to the patient.

2.2 FOLLOW-UP

The clinician who was due to see the patient will review the file and form an opinion about offering another appointment. If the decision is not to see again then this will be discussed in the weekly clinical meeting as detailed about point 1 (or discussion with supervisor if appropriate, when not in a team).

Any patients who DNA's two consecutive appointments will be liable to be discharged back to their GP (or other referrer).

Managing DNA's in this fashion acts as a safeguard by ensuring GP's/referrers are informed of the DNA and allows them to take other actions as necessary. It also facilitates best use of resources. Re-referrals are accepted, however, there is an expectation that the GP/referrer would seek the patient's assurance they will attend any offered appointments.

3.0 PATIENTS WHO CANCEL AN OUTPATIENT APPOINTMENT

Patients (new or follow up) who cancel their appointment will be offered an alternative at the time of cancellation. They will as far as is practical be offered a choice of days and times.

3.1 NEW APPOINTMENTS

New patients cancelling appointments on **more than two occasions** will be discharged back to their GP/referrer. The GP/referrer will be informed by letter (copied to the patient) indicating the need for a re-referral.

3.2 FOLLOW UP APPOINTMENTS

Follow up patients cancelling their appointment on **two consecutive occasions** will not be offered a follow up until after the team has met to review the case (or supervisor if

appropriate, where clinicians do not work in team). At this review a decision on the further management will be made. If this is discharge then the GP/referrer will be informed of this in writing indicating the need for a new referral if still deemed necessary.

.

3.3 PATIENT CANCELLATIONS

Patients cancelling their appointment and failing to re-book within four weeks will be discharged back to their GP/referrer. GP/referrer to be informed in writing indicating the need for a re-referral.

.

4.0 HOSPITAL/THERAPIST CANCELLATIONS

Patients having their appointment cancelled by the service will be contacted and offered another appointment.

APPENDIX G ADDENDUM TO POLICY RE: SPECIALIST PERSONALITY DISORDER SERVICES

Introduction

This addendum governs the management of DNAs within the specialist Personality Disorders Services which only offers group therapy interventions. DNAs in the specialist PD service should be responded to slightly differently as compared to other services in order to reduce reinforcement of unhelpful behaviours and to optimise attachment to the therapy group. Predictably responding to DNAs with individual contact from the group therapist as directed within the Trust-wide policy, is likely to encourage some service users to DNA even more in order to elicit that individual response from the therapist. This can also hinder the group therapy process if they fail to attach to the group because they imagine they have a special relationship with the therapist compared to other group members. Some people with personality disorder are more likely to engage in risk taking behaviours if they believe that the response that behaviour elicits from others is desirable, and the service aims to discourage this type of relationship. This addendum therefore places greater emphasis on individualised responses based on an assessment of risk and utilising the expert clinical judgement within the specialist Personality Disorders Service.

Personality disorder is an attachment disorder and by its very nature, service users find forming and sustaining relationships difficult. Engagement and remaining engaged in treatment is often a challenge for service users whose life experiences mean that they can have difficulty trusting others, anticipate rejection or being let down, avoid personal or social contacts and often find it hard to take personal responsibility. For some, DNAs will be predictable and will initially need to be tolerated in order achieve therapeutic engagement.

Whilst it is certainly true that DNAs need to be responded to so that risk is managed effectively and limited NHS resources used efficiently, it is also true that for people with personality disorder it is important to understand what might be communicated by not attending an appointment and that this is thought about with the service user (and others group members) in order that they can gain greater insight into their behaviours and emotions. It is equally important that understanding the motivation/reasons for not attending informs the clinician's response.

The following must not be read in isolation of the Trust-wide policy, the following paragraphs are amendments to the identified sections of the Trust-wide policy. The numbering system for each point corresponds to the relevant numbered paragraph within the Trust-wide policy. Where there are no amendments, all other sections of the Trust- wide policy apply:

2.2 The PD services only offer group therapy. These are not open groups and new members only join in a planned way and with the prior knowledge of existing group members. If a service user DNAs a group, this 'vacant' place cannot be offered to another service user and becomes an unutilised resource. Service users are informed that they are expected to inform the group of any planned absences but that their attendance is expected to be at least 80%.

2.3 It is necessary for groups to run at the same time, on the same day each week so that service users can plan this long term commitment and to foster the consistent structure needed for emotional containment. Therefore service users cannot be offered a choice of treatment appointments within the outreach groups unless there is more than one group being offered within the Mental Health Together+ locality. The therapeutic communities at Ash Eton and The Brenchley run a three day per week programme and service users have to be able to commit to attending all 3 days in order to participate in the treatment.

5.3.3 (Complex patients) The PD service is a specialist, tertiary service accepting internal transfers only. If a service user fails to attend their initial assessment appointment, the clinician or team administrator must attempt to make contact with the service user and confirm the reasons for not attendance. If they are unsuccessful or if there are concerns they will inform the referrer and agree

an appropriate next step which is documented in RiO. This may include the referrer carrying out any of the actions a – d identified in the Trustwide policy.

5.5.4 (Planned/routine referrals) The nature of group psychotherapy prohibits the use of interpreters joining the groups. It is therefore necessary that service users are reasonably fluent in spoken English in order to be eligible for this treatment.

5.5.1 Contact will also be made with the Named Keyworker to inform them of the DNA and agree appropriate next steps. This discussion must be recorded in RiO.

5.5.5 Outreach groups will be delivered from locations that are compliant with legislation governing access for people with disabilities. However if a service user has a specific impairment that means that they cannot access this location, an alternative group in a different location with improved access may be considered. The Therapeutic Communities at Ash Eton and The Brenchley unit will ensure that any reasonable adjustments are made in order to allow service users with impairment to access the service. These needs will be identified in advance at assessment.

5.6.1 The clinician will attempt to make contact with the service user by telephone as it is known that engagement for this group of patients is difficult. If the service user is under CPA, the care Coordinator will be contacted to inform them of the DNA and agree next steps. As a minimum a letter will be sent to the service user, acknowledging their DNA and asking them to make contact with the service within 7 days if they would like to be seen. This letter will be copied to the care coordinator and GP.

6.1. Prior to commencing treatment, service users will be informed of the expectations that they are required to adhere to:

- Contact the service in advance to inform staff of any planned absences
- Contact the service as soon as possible to inform them of any unplanned absences
- Attend at least 80% of the sessions

Outreach groups and therapeutic communities are run on pre-arranged regular schedules, known to service users and therefore they are aware of when their next appointment is scheduled.

6.1.1 Service users who are known members of an outreach group or the therapeutic communities will be contacted on the first day they DNA if there are any concerns about risk or their welfare.

If there are no or well managed risk concerns, clinicians will exercise clinical judgment about whether to contact them, based on their knowledge of the service user and understanding of their inter-personal communications. When the decision not to contact a service user directly has been made, the rationale for this must be documented in RiO. There is potential for setting up an unhelpful dynamic of service users achieving individual contact from staff if they routinely and predictably follow up on all DNA. In the case of outreach group members, a letter will be sent to the service user reminding them of the next group and encouraging their attendance. This letter will be copied to the GP and Named Key Worker.

Therapeutic community members who are not contacted on their first DNA but fail to attend a second consecutive day will be contacted by staff. If attempts to make contact are unsuccessful, an MDT discussion and liaison with the Named Key Worker (when there is one) will agree appropriate next steps. If the service user is no longer open to a MHT+ the MDT should consider whether a referral to MHT+ is recommended.

6.1.2 If a service user has 2 or more consecutive DNAs from an outreach group or the therapeutic community without notification to the service, they will be sent a letter inviting them to re-engage and return to the community within 7 days. If they fail to do this their treatment place will be at risk.

6.1.3 Service users' attendance at the therapeutic community will be considered as part of their review every 3 months and where there is concern about regular DNAs a discussion

will be had with them in the community about the service user's motivation, ability to commit to the programme or any difficulties within the community that they might be avoiding. It is acknowledged that for some service users they need to take time out of the programme in order to achieve long term engagement and that in some circumstances DNAs might need to be tolerated.

Service users who frequently DNA the therapeutic communities or who do not respond to a 7 day re-engagement letter will have their place within the community considered by the community. Community members will vote on whether a service user has jeopardised their place to such an extent that the community think they should be discharged from the service. Staff will always retain a right to veto a decision by the community to discharge a service user when they believe attendance problems can be worked through e.g. regular DNAs might suggest a pattern that communicates something about a service user's attachment style. Any individualised process for managing or responding to DNA's should be reflected in the service user's care plan.

APPENDIX H ADDENDUM TO DID NOT ATTEND POLICY: COMMUNITY BRAIN INJURY TEAM DNA AND CANCELLATION

The community Brain injury Team provides neuro- rehabilitation to its clients who have sustained brain injury. CBIT is not a mental health service and does not follow the standard mental health pathway. CBIT patients who have co-morbid mental health needs will need to be supported by an appropriate mental health service. The KMPT DNA policy does not fully reflect the CBIT service needs or process therefore this Appendix provides the guidance required.

As a result of brain injury, many CBIT patients will have difficulties with memory, organisation or other cognitive skills and this may result in a higher incidence of DNA. CBIT will attempt to provide reasonable support to help patients remember appointments/ engage with therapy. We will consider the impact of cognitive difficulties when implementing the DNA policy, to ensure patients with cognitive difficulties are not disadvantaged. CBIT clinical appointments may be in patient's own home, community setting, staff base or via video / phone consultation.

THIS CBIT DNA AND CANCELLATION POLICY IS SUPPLEMENTARY TO KMPT DNA POLICY.

INITIAL ASSESSMENT DNA / CANCELLATION

Contact with patient will be attempted by phone to establish reason for DNA/ Cancellation. An alternative appointment will be offered. If no phone contact can be made a letter will be sent asking patient to contact service to arrange an appointment. If no contact can be made by phone or letter, or if the patient refuses another appointment, a letter will be sent to patient and GP / refer to inform them and patient will be discharged.

New patients DNA / cancelling agreed initial appointments on **more than two occasions,** without due reason will be discharged back to their GP/referrer. The patient and GP/referrer will be informed by letter

Re-referrals may be accepted, however, there is an expectation that the GP/referrer would seek the patient's consent and assurance they will attend any offered appointments.

THERAPY APPOINTMENT DNA FOR COMMUNITY VISIT

If DNA appointment was at patients home a contact slip may be left, if appropriate. This will be recorded as a failed visit.

Contact with patient will be attempted by phone to establish reason for DNA.
An alternative appointment will be offered. Appointments will be made by phone, in person (when visiting) or by letter, whichever is appropriate.

At clinicians discretion or if risk assessment suggests there may be reason for concern, additional action may be taken. E.g. if at risk of falls, attempts will be made to contact known carer. If at risk of self-harm it will be escalated to welfare check with consideration of involving another contact.

GOAL PLANNING MEETING DNA / CANCELLATION

Contact with patient will be attempted by phone to establish reason for DNA. An alternative GPM appointment will be offered. If no contact can be made by phone or letter, or if the patient refuses another appointment, a letter will be sent to patient and GP/ refer to inform them of discharge.

Re-referrals may be accepted, however, there is an expectation that the GP/referrer would seek the patient's consent and assurance they will attend any offered appointments.

REPEAT DNA / CANCELLATION

Repeat cancellation / DNA of agreed follow up therapy appointments on consecutive/ repeat occasions will be discussed with the patient, where possible and in team meeting. If appropriate, clinician will send a letter noting dates of DNA. Any mitigating circumstances will considered e.g. memory problems. Enablement to attend/ engage will be considered.

A decision on further intervention/ discharge/ action plan will be made. If there are no reasonable mitigating circumstances or if contact with the patient fails, discharge will be made.

If discharge is made the patient and GP/referrer will be informed in writing.

Re-referrals may be accepted, however, there is an expectation that the GP/referrer would seek the patient's consent and assurance they will attend any offered appointments.

#

APPENDIX I ADDENDUM TO DID NOT ATTEND POLICY: LIAISON, DIVERSION & RECONNECT (LDR)

The Liaison, Diversion & RECONNECT (LDR) aims to provide improved access to health and social care services for vulnerable individuals who have had contact with the Criminal Justice System.

Liaison, Diversion & RECONNECT (LDR) operates an assessment service within police custody suites and courts, and individuals with identified vulnerabilities will be offered a referral to the teams Support, Time and Recovery (STR) Function. Please note that the STR team does not work with individuals who present with acute mental health issues or pose a significant risk to self. The STR team will support individuals to access and engage with appropriate services in the community to address their vulnerabilities. These services are typically:

- Housing
- Financial
- Substance Misuse
- Alcohol Services
- Primary Care Counselling
- Access to GP services

The following paragraphs are amendments to the identified sections of the Trust-wide policy and must therefore not be read in isolation. The numbering system for each point corresponds to the relevant numbered paragraph within the Trust-wide policy and additional numbers indicate additional sections to be included. Where there are no amendments, all other sections of the Trust-wide policy apply:

PATIENTS WHO CANCEL AN OUTPATIENT (STR) APPOINTMENT

For the purpose of this section, outpatient appointments will be referred to as STR appointments.

INITIAL APPOINTMENTS

New patients cancelling initial STR appointments on **more than two consecutive occasions** will be discussed during the teams' weekly case management meeting. During this discussion, it will be agreed if further management is required. If discharge is agreed, the individual will be sent a discharge letter, with the teams contact details if the individual wishes to self- refer back into the service.

FOLLOW UP APPOINTMENTS

Follow up patients cancelling STR appointments on **more than two consecutive occasions** will be discussed during the teams' weekly case management meeting. During this discussion, it will be agreed if further management is required. If discharge is agreed, the individual will be sent a discharge letter, with the teams contact details if the individual wishes to self- refer back into the service.

REFERRALS TO LDR STR

All individuals referred to LDR STR will be sent a 'Referral Receipt' letter the next working day which identifies the reason for referral and the teams contact details.

INDIVIDUALS WITH TELEPHONE CONTACT DETAILS

Within the first week of receiving the referral, the team will make three attempts to contact individuals. Individuals who have been uncontactable will be discussed during the teams' weekly case management meeting. During this discussion, it will be agreed if further management is required. If discharge is agreed, the individual will be sent a discharge letter, with the teams contact details. All clients are able to complete a self-referral back in to the LDR STR function where they have been open to the Criminal Justice System within the last 14 days.

INDIVIDUALS WITH NO TELEPHONE CONTACT DETAILS

Individuals with no known telephone contact details will be discussed during the teams' weekly case management meeting. During this discussion, it will be agreed if further management is required and unless otherwise agreed, the case will not be accepted on to the STR caseload. The individual will be sent a discharge letter, with the teams contact details if the individual wishes to self-refer back into the service.

APPENDIX J – CRISIS LINE NO CONTACT PROCESS

Kent and Medway Urgent Mental Health Helpline offers a telephone service only; there is no availability of face to face contact within the team.

It operates a specific “no contact” process. In this context, “no contact” means unable to contact the referred person by phone. **The KMPT Did Not Attend (DNA) policy does not apply to the Crisis Line.**

If the first attempt to complete the triage within 72 hours was unsuccessful the patient will remain on the KMUMHH caseload and will be reallocated to a second Clinician by the shift coordinator for a further call attempt within 4 hours. The only exception is if the 1st attempt at contact is made after 21:00hrs, in this scenario the 2nd attempt will not be made within 4 hours and will instead be allocated as part of the morning workload from 7:30hrs.

If no contact is made following two attempts the referral will be closed and the GP will be informed via an EDN. The client will receive a text message advising of our attempts to establish contact and what the next steps have been for their referral. If the client does not have a mobile number to receive text, a letter will be sent to them. If a Clinician is concerned about a person who has not been able to be contacted and considers they require an urgent assessment based on the information provided they will escalate this to the shift co-ordinator or Team Leader to agree an onward approach. In these circumstances the team may request the appropriate MHT/MHT+/Rapid Response attempts a face to face visit. This will be undertaken as per that teams’ usual processes in line with the DNA policy.

If it is clear that there is an imminent risk to the individual or to others, the KMUMHH team may also consider requesting Kent Police or SECAMB assistance to conduct a “Welfare Check” if there are concerns there is a threat to life. The client will remain on the KMUMHH caseload until the client is deemed to be safe and an onward plan can be formulated.

If an individual contacts the team within 12 hours of a referral being closed without contact, and they have not been transferred to MHT/MHT+/Rapid Response they will be reopened to the helpline and allocated for triage without requiring further screening. Beyond 12 hours they will need to be re-referred (this can include self-referral) to ensure the clinical picture is accurate. If they have already been transferred to MHT/MHT+/Rapid Response the caller will be given the contact number for that service and/or warmly transferred directly.

It is only in exceptional circumstances of imminent risk to self or others that a person who has not been contacted will be referred on to the MHT/MHT+/Rapid Response.

APPENDIX K – PROTOCOL TO MANAGE DNA DISENGAGEMENT AND TRANSFER OR DISCHARGE FROM EIPS

Protocol to manage DNA, Disengagement and Transfer from EIPS

Introduction

People under the care of EIPS and have multiple care needs as such are considered to have increased complexities and risk. EIPS takes an assertive approach to engagement with individuals in order to reduce the risk of their being lost to services and potentially experiencing a longer duration of untreated psychosis. EIPS team members therefore will be flexible and creative in situations where individuals miss multiple appointments or are resistant to working with the team. The information input into the patient electronic record on Rio evidences that assessed needs are met in good time and comply with good practice and legislation.

This protocol guides clinicians on the steps to take when unable to make contact with a person under the care of EIPS and should be read in conjunction with the following Trust's policies: Trust's DNA Policy, Clinical Risk Assessment Policy, Transfer and Discharge Policy, Guide to Information Sharing, Record Keeping Policy, and Right Care, Right Person guidance.

The Trust acknowledges that for some people there could be a high clinical risk if they do not attend appointments and sets out the actions to take dependent on level of risk. Appointments in EIPS consist of:

- Assessments at clinic or home
- follow up at clinic or home or other setting,
- OPA or CPA reviews at clinic
- Family meetings at home
- Activity or group programme

Do Not Attend and Disengagement

In the event that people DNA , then the risks need to be reviewed and the following action taken.

DNA & disengagement during the assessment phase

It should be noted that clients referred to and accepted for assessment with EIP should be deemed as an increased risk and their risk profile should be carefully reviewed. Consideration of increased risk includes all those under care of HTT, on clozapine, on depot medication or on a CTO.

Within the initial hour try to establish contact by telephone to person by making repeated attempts; in deciding the frequency of the attempts, the individual's referral information and risk assessment/ history should be reviewed. If the risks are high consider other services (e.g. rapid response/ home treatment team, AHMPS, police). The clinician should contact the referrer, review the risks, obtain any other contact information and discuss how to engage the client. Escalate any risks to team leader and agree a plan as to who and when a further contact must be attempted, considering the need to telephone again and contact their family, carers or friends. If, however no contact can be established and no collateral information can be confirmed from significant others, then continue attempts to make contact by phone, prioritise diary and attempt home visit - based on risk assessment. Consider also professionals meeting to share information.

Consent to share information/breach of confidentiality is superseded by perceived and actual risk to patient. At each stage, discuss with team leader, note rationale for decision in progress notes on Rio and action it.

If unable to make contact by home visit with significant other and there are escalating concerns for safety, then the right care, right person guidance should be followed.

Attempts to engage the client can be up to 3 months using an assertive approach. This needs to be reviewed by the MDT and in discussion with the referrer and family. During attempts to assess a person with no previous history and no evidence deterioration has occurred, the person will be discharged back to the referrer with a contingency plan and offer of re-referral.

For clients who have been accepted for treatment

A similar process to manage DNA's of appointments (as outlined in the assessment phase above) should be followed. This includes based on risk multiple assertive contacts with clients, cold calls, home visit, contact with family/ carers, discussion with team leader, discussion at MDT meeting and right care right person guidance. The length of time out of contact will increase the risk and determine how long the lead health care professional should continue to attempt contact. However, a person who has disengaged from EIPS will require a professionals' meeting/ MDT review meeting with team leader/ clinical lead attendance to agree next steps to be taken to engage, manage risks or agree transfer of care. There needs to be prior discussion with the family/carer before transfer takes place. Information will be provided to enable rapid reassessment by EIPS if necessary.

Transfer Options

EIPS provides treatment for people who are within a three-year period of experiencing a first episode of psychosis. The length of time on an EIPS caseload is up to three years and in the main where there is engagement with the service user, transfer of care has the following options:

People who make a full recovery within the three-year period may not need further input from the team. Following an MDT review, and a collaboratively agreed period of supportive monitoring, such cases will be closed, with fast track referral pathways being clearly identified to the person and their GP/other health professionals.

Some people will need ongoing care following their three-year involvement with EIPS due to the complexity of their needs. Planning should begin 6 months prior to care being transferred to an appropriate community service. An MDT review must be held at the point of transfer.

Transfer of care before 3 years with EIP

Some clients who have capacity to take informed decisions may not wish to continue ongoing care up to the full 3 years involvement. An MDT review will be arranged and the person will have the option of transferring care to their general practitioner. They will, however, retain the option of resuming contact with EIPS providing they still meet criteria for the service. EIP will make an outreach contact at 3 months to review progress.

In the event a person with significant risk or has had one more episode of psychosis disengages from EIP and requests discharge an urgent MDT review should be arranged. If the person refuses to attend then it should be held in the person's absence with the consultant psychiatrist to discuss risks and actions required to ensure individual and public safety. Consideration could be for EIP to take a time limited assertive approach for a minimum of 3 – 6 months. Alternatively, consultation with other services (e.g. complex psychosis service) or transfer to primary care or other community services may be considered. The case could also be discussed at the directorate clinical risk forum.

A decision to transfer care from the service can only occur when the risks have been fully considered by the MDT, team leader and family & carers. Following transfer the EIP services will make an outreach contact in an agreed way (phone or face to face) at a planned date and time after transfer (maximum of three months). At this outreach contact, progress will be reviewed and an agreement made on the frequency (if needed) of any further outreach contacts. There will be clear documentation on Rio progress notes and a letter sent to the GP confirming the agreement made.

The client, their family (with consent) and GP will be provided with a transfer summary, clearly identifying relapse indicators and advice that they can re-access EIP services prior to the outreach contact and at any time within 3 years of the initial referral to EIP if needed. The client is discharged from the caseload.

The EIP locality Team Leader is responsible for ensuring that the client is identified on the EIP Locality Meeting Template. This will include the date that the outreach contact is planned to ensure that all of the team are aware and can follow up in the absence of the lead health care professional.

There will be a team discussion to identify the appropriate staff member to follow up. This will also indicate if contact has been successful and any further risk management plans needed.
If the outreach contact is unsuccessful, a further contact should be attempted. If agreed in the transfer care plan, the family/carer can be contacted. If no contact can be made, EIP need to liaise with the GP to ascertain if there has been any contact with the client and if there are any known concerns. A letter should be sent to the client to arrange an appointment or request contact. A home visit should be attempted if appropriate dependant on risk. If contacts are unsuccessful, EIP will write a letter to the client's GP advising that follow up has not been possible and identifying past risks/relapse indicators as identified on discharge summary.

When the client moves permanently out of area

In the event that a person moves out of the area during the three years of EIP care, then EIP should continue care where practical until the transfer plan has been agreed in their new local area. The individual, their family/carer or significant other should be introduced to the new service, how to contact them and provide the local numbers to call in crisis.

Extended Assessment

Some people may be accepted on to the EIPS extended assessment pathway with diagnostic uncertainty for up to six months. During or at the end of this time, the outcome of the assessment may be to transfer to other services. The individual, their family/carer or significant other should be introduced to the new service, how to contact them and provide the local numbers to call in crisis.
Refer to the CYP to Adult Services transition protocol for children and young people approaching age 17.5 years and EIPS and CYPMHS protocol.

APPENDIX L - PATIENTS WHO DO NOT ATTEND (DNA) MEMORY ASSESSMENT SERVICE (MAS)

DNA process for a MAS requires balancing practical logistics with a compassionate approach, particularly since people with potential memory difficulties might miss appointments for a variety of reasons beyond their control. The goal should be to reduce the potential for further distress while also improving engagement and attendance.

The expectation is that a person will attend and every effort is made to support the person to attend MAS.
It is expected that people referred to the MAS are able to engage and choose an appointment appropriate to them.

Every effort will be made by administrative colleagues to contact an individual to schedule their initial memory assessment. In the event of non-contact, a total of three attempts should be made across a 5 working day period to reach the person referred by telephone, reviewing the contact information with the referrer as necessary. The persons dementia coordinator, if they have one, should also be contacted by telephone during that time, to supporting scheduling the assessment.

In the event of not establishing telephone contact, communication will be sent inviting a person to contact MAS within 7 working days. The persons dementia coordinator will also be informed of this action by telephone. If no contact is made, the referral is transitioned back to primary care/dementia coordinator and communicated with the referrer.

Where a person may express ambivalence about progressing to a memory assessment, staff should emphasise that participation is voluntary and consent will be thoroughly discussed at the initial appointment. It should be made clear that the patient has the right to withdraw consent at any point during the process, ensuring they feel supported and in control of their care decisions. Should someone wish to speak to a clinical staff member, please refer them to the MAS clinical lead or Operational Team Manager.
Points to consider when managing DNA;

1. Clear and Simple Communication: Ensure appointment reminders are simple, consistent, and offered in multiple formats (text, email, phone calls). People with potential memory difficulties might forget, so offering reminders in the days leading up to the appointment can make a significant difference in reducing DNAs. It is therefore expected a telephone reminder is offered 24-48 hours prior the appointment, in addition to SMS reminders.

2. DNA Follow-Up: If a person misses an appointment, the clinician should contact expressing understanding rather than frustration, and offering support in rescheduling.

3. Flexible Rescheduling: People with memory difficulties may need extra time to process information or may struggle with rigid schedules. Offering flexibility in rescheduling and helping them find a time that works for them is crucial, asking if there is a specific barrier to attendance (location, transport, understanding or confusion about the process).