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

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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

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	
Investigation of Serious Incidents, Incidents, Complaints & Claims Policy	KMPT.CorG.020
Management of Serious Incidents, Incidents, Accidents and Near Misses Policy	KMPT.CorG.017
Welfare Check Protocol	KMPT.CliG.152
Unable to Make Contact Protocol	KMPT.CliG.153

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

CONTENTS

1 INTRODUCTION

It is important to clarify what constitutes a DNA appointment and the difference between cancelled appointments. The following definitions have been agreed:

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

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

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

1.2 This policy relates to appointments within the community (either at a clinical base or the patient's home) for patients across all care groups, unless specified otherwise.

1.3 The Trust's Care Planning Policy and Clinical Risk Assessment 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.

2 PURPOSE

2.1 While DNAs are sometimes unavoidable, the missed appointments are not available for us to provide services to other patients. Our expectation is that patients will attend, especially if the appointment has been arranged at a time of their choice as per full booking within the Choice and Partnership Approach (CAPA) model or a pre-arranged home visit.

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

2.3 Appointments made by telephone will be followed up with a confirmation letter unless, either the patient declines it, or it is a short notice appointment (i.e. 3 days or less) where sending it is futile.

2.4 When initial contact is made with new patients by administrators or clinical staff (either by phone or letter), contact landline and mobile phone numbers need to be confirmed for the patient, relatives and carers as appropriate and updated on RIO if necessary. Consent should be sought to send SMS appointment reminders to the patient (and/or relative or carer if appropriate) if this is available within the locality.

3 DUTIES

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.

4 APPOINTMENT LETTERS

4.1 Patients will be advised about the service policy on DNA and cancellation in all appointment letters with this statement:

'There is a very high demand for this service. To be fair to all we have a strict policy regarding missed appointments and failure to attend appointments will result in your care being transferred back to your GP or the person who referred you. Please contact us as soon as possible if you know you will not be able to attend.'

5 ROLES AND RESPONSIBILITIES

5.1 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.

6 LOW RISK – RAG RATING GREEN

DNAs – Actions taken will depend on risks identified (for further information please refer to flow chart in Appendix F)

6.1 Assessment

6.1.1 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 6.1.3 should be followed

6.1.2 If the patient cannot be contacted and the level or risk type is uncertain then discuss with the GP to confirm symptoms and level of risk. If agreed that patient is presenting with low risk, discharge to care of the GP following discussion with senior team member. If it is agreed that risk is higher follow medium or high risk process below. Note rationale for decision clearly in progress notes on RiO and action it. If it is clear that the risk is low there is no need to contact the GP and the patient should be discharged back to the GP following discussion with senior team member unless any concerns or extenuating circumstances are identified in which case a second appointment letter should be sent.

6.1.3 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.

6.2 **Follow-up appointments**

6.2.1 The clinician who was due to see the patient will review the file and form an opinion about offering another appointment. A patient who DNAs two consecutive appointments will be discharged back to their GP (or other referrer), unless there is a clear reason to offer another appointment. If the decision is not to see again this will be discussed with a senior or the MDT, the rationale for the decision clearly documented in progress notes on RiO, and then actioned.

6.2.2 **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.**

7 MEDIUM OR HIGH RISK – RAG RATINGS AMBER OR RED

THIS INCLUDES ALL PATIENTS UNDER HOME TREATMENT AND/OR ON THE RED BOARD AND IS CONSISTENT WITH THE ACUTE CARE GROUP UNABLE TO CONTACT PROTOCOL (APPENDIX A) **(for further information please refer to flow chart in Appendix F)**

DNAs – Actions taken will depend on risks identified

7.1 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 medium/high risk and actioned as per this section.) It is vital that when determining risk levels, all types of risk including physical health, social health and self-neglect must be considered.

7.1.1 **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.

7.1.2 **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 possible 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 assessment. 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.

7.1.3 **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.

7.1.4 **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.

7.1.5 **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.

7.1.6 **Out of Hours transitions**: If community services have identified a patient as high risk (RAG Red) 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.

7.2 If the patient's risk is assessed as being of a medium rating but the clinician's knowledge of the patient, their risks, patterns and history of behaviour suggests that the DNA itself is not something of medium risk, then the clinician should discuss the situation with a senior member of staff to determine whether the full process of responding to a DNA for someone who is assessed as being of a medium risk should apply. The decision and the process for reaching it must be clearly recorded in the RiO progress notes.

7.3 All patients of medium/high risk must be added to the RED Board and remain there until a follow up appointment has been completed

8 SINGLE POINT OF ACCESS (SPOA)

8.1 Once accepted for a tele-triage screening, if the SPoA clinician cannot successfully manage to speak to the patient then the following process should be followed:

8.1.1 SPoA clinician should attempt to contact patient at least twice, with 4 hours between attempted contacts and/or over 2 consecutive shifts. If still no contact, additional information will attempt to be sought from the referrer, GP and if appropriate carer. If the referral is routine the referrer will be notified of the attempted contacts and the referral will be closed. The referrer, the person's GP and the person will be notified of the closed referral within 24 hours.

a. If an urgent referral cannot be contacted as outlined above and they may require a same day assessment then email to the duty team or team leader of the patient's CMHT/CMHSOP to follow the medium/high risk process.

b. If emergency referral then call the duty team or team leaders to follow the high risk process.

c. If out of hours SPoA clinician to discuss risk with the shift coordinator and if deemed high risk of self harm or harm to others, to directly refer to CRHT for follow up.

9 RECORD KEEPING

9.1 A patient's record is a basic clinical tool used to give a clear and accurate picture of their care and treatment, and competent use is essential in ensuring that an individual's assessed needs are met comprehensively and in good 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).

9.2 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.**

10 IMPLEMENTATION INCLUDING TRAINING AND AWARENESS

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

11 EQUALITY IMPACT ASSESSMENT SUMMARY

11.1 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. 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. The Equality Impact Assessment for this document can be found on the Equality and Diversity pages on the trust intranet.

12 HUMAN RIGHTS

12.1 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.

13 DNA MONITORING PROCESS FOR COMMUNITY MENTAL HEALTH SERVICES

14.1 On a daily basis community mental health teams will review each DNA which occurred on the preceding day. Each case will be reviewed to determine whether the correct process for managing DNAs took place. The outcome of this review will allow for a timely resolution of any cases where the correct process was not followed through accurately.

14.2 The results of this daily review will be reflected on a local spreadsheet. The daily results will be transferred to a monthly oversight spreadsheet and shared for oversight at an appropriate monthly Care Group meeting.

14.3 The purpose of this monthly oversight is to determine whether there are any trends in cases where the DNA process is not followed correctly and to share good practice and so learn and develop as teams and as a service in better managing DNAs. A flowchart of this monitoring process can be found in appendix H.

14 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 RCAs	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.

15 EXCEPTIONS

15.1 There are no exceptions to this policy

APPENDIX A UNABLE TO MAKE CONTACT PROTOCOL

Unable to make Contact Protocol

KMPT.CliG.153.02

This protocol immediately supersedes and replaces any other unable to make contact or DNA protocol that you had previously been following.

1 CONTEXT:

Service users under the care of the CRHT are acutely unwell and are being home treated as an alternative to inpatient admission, as such their level of supervision and risk management should not be dissimilar to inpatients - in a situation where the service user is not contactable when it had been arranged with them that contact (either in person or on the telephone) would be made, this needs to be treated as a serious event (e.g. when an inpatient's whereabouts cannot be accounted for on a ward).

This protocol guides clinicians on the steps to take when unable to make contact with a service user under the care of CRHT. This protocol should be read in conjunction with the Police Welfare check guidance and KMPTs Guide to Information Sharing KMPT.InfG.SBN-007.01 found by clicking the link or on the intranet.

It is expected that qualified nursing staff would be able to use clinical discretion in the use of this protocol, and that deviations from its cause would be justifiable and fully documented.

2 ACTION:

This action must be taken regardless of if the service user is considered to be at imminent or immediate risk. – Please also be aware of the Trust lone Working Policy in adherence to this protocol

1. **WITHIN THE INITIAL HOUR** try to establish contact by telephone by making repeated attempts; in deciding the frequency of the attempts the service users individual risk assessment should be referred and updated. Report to Shift Co-Ordinator; Agree a plan with Shift Co-Ordinator/Senior Staff 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 etc., care co-ordinator, GP or Local A & E departments with the Team's concerns. ACCESS AND REVIEW MOST RECENT RISK ASSESSMENT AND ENSURE A HARD COPY IS PRINTED AT THIS POINT.

2. **ON REVIEW OF 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 or friends; continue attempts to make phone contact. **If no contact** then staff must attend the home address, as soon as clinically indicated, staff should prioritise workloads accordingly based on risk assessment and taking with them a hard copy of the most recent risk assessment. 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.

3. **ON ATTENDING THE HOME ADDRESS:** if when staff members arrive at the home address of the service user there are escalating concerns for safety, staff should defer to the **welfare check protocol**. If staff are unable to access the service users address with support of a next of kin or a carer, have the option of asking the Police for support. Staff will need to do that via a 999 call where the risk indicates the need for this, and wait for police at the scene with the risk assessment hard copy to share with them. **NB: Staff should employ common sense in this, and negotiate where possible the closest team to attend as admissions often cross localities**

4. **DOCUMENT:** Document in the notes the details of this discussion, and with whom, the rationale for decision made and record the time the discussion took place. Remember to document times as the action occurred, so that the service users' clinical notes reflect a "live" record.

5. **ESCALATE:** In the event of a serious incident being suspected, then staff need to defer to the serious incident reporting policy.

3 OBTAINING AND SHARING INFORMATION:

Relatives/Carers/Friends are often significant sources of information about a service user and can also be part of the service user's care team. It is of extreme importance that a variety of avenues are explored in attempting to identify the service user's whereabouts, including making contact with relatives/carers/friends. In the absence of signed consent to share information, the risk of not contacting relatives/carers/friends should be considered and balanced against a risk to service user and public safety.

Under common law, staff are permitted to disclose personal information in order to prevent and support detection, investigation and punishment of serious crime and/or to prevent abuse or serious harm to others where they judge, on a case by case basis, that the public good that would be achieved by the disclosure outweighs both the obligation of confidentiality to the individual patient concerned and the broader public interest in the provision of a confidential service.

Consent to share information/breach of confidentiality is superseded by perceived and actual risk to patient.

4 EQUALITY IMPACT ASSESSMENT

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. 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.

5 HUMAN RIGHTS

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.

APPENDIX B WELFARE CHECK PROTOCOL

Welfare Check Protocol

KMPT.CliG.152.02

Note: This protocol exists with the exception of Service Users referred to Psychiatric Liaison services still within the care of the General Hospitals. These Service Users remain the responsibility of the Acute Trust and as such will be dealt with if the need arises via the Acute Trust welfare check process.

In addition this protocol does not replace the need for emergency intervention where for example someone leaves the ward stating absolutely that they pose risk to them selves or others where the police may need to have immediate input.

1 BACKGROUND

In January 2015 Kent Police commissioned a piece of work to research calls in Nov & Dec 2014 and concluded that of the 253 calls they sampled 20% of those that officers attended were deemed not to be a police matter.

This briefing note is written to clarify the role of the police in attending and carrying out ‘welfare checks’ or 'safe and well checks', and to provide clarity on the escalation process to be used if and when disagreement occurs between agencies as to police involvement or deployment.

Demands from partner agencies for police to conduct welfare checks have been steadily increasing, and in the majority of cases the responsibility for these checks should NOT fall to police. The term itself is one which appears to have become common parlance in Kent Police and across the Country, applied when an external agency requests that police visit someone who is believed to be vulnerable, for a range of reasons.

To this end Kent Police have now stated that they will no longer perform welfare checks on request, unless very specific requirements are met, and information shared. This has given rise to the need to create a protocol in order to guide staff, and ensure that we use our Police colleagues effectively. This work has been undertaken jointly between Clinical Quality & Compliance Lead, Trust Security Management Specialist, and the Mental Health Liaison Inspector for Kent Police.

2 CONTEXT

Kent Police, KMPT, and a number of other partners have now publically committed to a local Mental Health Crisis Care Concordat Declaration. The Concordat itself redefines the core responsibilities of health, police and other agencies in providing care for people experiencing a mental health crisis. A Concordat objective is to review multi-agency protocols regarding Police assistance to mental health partners, at this time there is no such protocol. Although the Concordat is clearly focussed on mental health this protocol can also be implemented to cover physical health and social provision requests that are made upon Kent Police.

3 POLICE LEGAL POWERS:

Police have a large number of powers deriving from statute that enable them to carry out their duties. Where there is no specific legislative power, courts will often imply a power that corresponds to the core duties, to enable police officers to lawfully fulfil that duty. However, powers do not extend simply to facilitate officers acting in excess of those core duties.

Police have a positive duty to protect life under article 2 of the European Convention of Human Rights, incorporated into UK law by the Human Rights Act 1998. This obligation arises where police know, or ought to know, about a real risk to life. In the situation of a 'welfare check' being carried out by police, any article 2 duty can usually be satisfied by reliance on section 17 PACE, which provides that:

"1) Subject to the following provisions of this section….a constable may enter and search any premises for the purpose-
(e) of saving life or limb or preventing serious damage to property."

In this particular scenario, S17(1)(e) enables an officer to carry out their core duty to protect life and property.

In recent years, forces across the country have had numerous cases where exactly this type of post event examination has been carried out during inquest proceedings. Some cases have led to rule 43 recommendations by coroners.
Essentially, welfare checks should not encroach on an individual's right to privacy.

4 CASE LAW:

In the case of Syed v DPP [2010] the High Court ruled that this provision did not justify entry where there was a general concern for the welfare of someone within the premises and therefore officers were not in the execution of their duty when purporting to rely on s17 to force entry against the wishes of the person who answered the door.

Mr Justice Collins said:

"It is plain that Parliament intended that the right of entry without any warrant should be limited to cases where there was an apprehension that something serious was otherwise likely to occur, or perhaps had occurred, within the house….Concern for welfare is not sufficient to justify an entry within the terms of section 17(1) (e). It is altogether too low a test.

I appreciate and have some sympathy with the problems that face officers in a situation such as was faced by these officers. In a sense they are damned if they do and damned if they do not, because if in fact something serious had happened, or was about to happen, and they did not do anything about it because they took the view that they had no right of entry, no doubt there would have been a degree of ex post facto criticism. But it is important to bear in mind that Parliament set the threshold at the height indicated by section 17(1)(e) because it is a serious matter for a citizen to have his house entered against his will and by force by police officers."

5 RECOMMENDATIONS

It is recommended that the following instruction is adopted by Kent Police;

It is not part of the core duties of police to carry out general welfare checks on behalf of other non-police agencies.

Police will carry out a 'welfare check' when a request is made to police about an individual, if it is an emergency and there is a real concern that something serious is about to, or has already, occurred to the relevant individual on those premises. The police will respond because it enables a professional intervention if an individual is in need of immediate assistance due to a health condition, injury or some other life threatening situation. Unless this threshold is reached, police have no duty, and therefore no power, to take any action once outside those premises.

Note:- Officers considering their power under S17 PACE must ensure that they gather as much information as possible in support of their grounds. This might include speaking with occupants, neighbours or collating any other information/intelligence to support an honestly held belief that entry without warrant is necessary.

Non-emergency welfare checks:

In the event that police have no special power there is no more reason for police to attend the premises than the relevant agency which has raised the concern in the first place. Police will not attend. The concern, and the resolution of that concern, will remain that of the requesting agency.

It may occasionally be considered appropriate for police to accompany another agency to conduct such a check, but this will need to be assessed on a case by case basis and it is for the requesting agency to provide the relevant information/intelligence to support the need for the presence of the police. If the requesting agency cannot provide this, police will not attend. The matter will remain that of the requesting agency.

In the event of a disagreement between the requesting agency and police, the requesting agency in the first instance can ask to speak to the Force Duty Officer in the Control Room or use the multi-agency escalation process that Kent Police has in place with partners.

It is therefore recommended by the acute service line for KMPT that:

In the event of consideration being given to the need for a Police welfare check the following **must** be fulfilled:

- Staff **must** make every effort to contact the service user, their next of kin, or carer to establish their welfare.
- Staff unable to make phone contact are expected to make a domiciliary visit to the last known address stated within clinical records. It may be that the teams know that the Service User is residing at an alternate address from the progress notes, and therefore may choose to attend that address as well or instead of the primary residence listed.
- In the event this is an inpatient not known to CRHT, every effort **must** be made to ensure that there is a member of ward staff known to the person present at the

visit, both to identify the person, and to provide accurate information on risk to other agencies that may need to attend

- Staff **must** have with them, on attendance at the address for a welfare visit, a hard copy of relevant risk information
- On arrival should staff be unable to raise an answer from the service user of concern, and have a genuinely held belief that there is a significant risk, and the risk documentation present supports this, staff will need to make an emergency call to police, and wait at the address to support officers.
- If police attending do not agree that there is a significant risk, and their core powers would not extend to the situation; staff will have to document this attempt fully. At this point staff can then revert to the section 135 process under the mental health act
- All incidents of this nature **must** be reported via DATIX web as per incident reporting policy

6 STAFF SAFETY:

It is in no way intended that acute staff should put themselves at risk in the performance of this protocol, nor is that the intention of Kent Police. There are some safety precautions that staff should therefore be aware of and observe when conducting these welfare visits:

- Staff must adhere to Trust Lone Working procedures, and even if attending an address for a welfare check as a 'double-up' similar procedures are to be adopted
- Ensure a risk assessment is carried out prior to conducting a welfare check and if required, a 'doorstep' assessment on arrival at an address which will help determine whether other agencies, particularly the Police and/or Ambulance, need to attend before entering
- Staff must conduct not only a clinical risk assessment but also an environmental and personal safety assessment; if the area staff are going to is not safe which also puts personal safety at risk then further assistance may be required
- In the event that Police are also requested to attend, staff must share as much relevant information as possible with the attending officers, including risk assessment information, but only information that is relevant to the situation that will assist the Police in conducting their own risk assessment with the aim of achieving a positive outcome
- If the Police are called to assist due to any significant risk present then staff are to follow the attending officers lead and instruction and in some cases it may be required that Police officers enter an address/property first to contain any potential dangers within

7 ESCALATION PROCESS:

In addition to this protocol there is now in place a Kent missing persons protocol that will link to this – brief details below, but please review full document available via intranet. .

Risk Assess

LOW ⟷ **HIGH**

Phone Patient | **Call 999**

PRIMARY ACTIONS

Tick as completed and record on action log

LOW RISK – Complete within 1 hour of becoming aware of the incident
HIGH 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

LOW RISK - 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

LOW RISK – Complete within 2 hour of becoming aware of the incident
HIGH RISK – COMPLETE ACTIONS IMMEDIATELY AFTER PRIMARY ACTIONS

- Identify single point of contact of multi agency liaison, pass their details to Police and record on the action log
- Where possible obtain a photograph of the Missing Person
- Coordinate search of all hospital grounds utilise all available staff
- Ensue 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

8 EQUALITY IMPACT ASSESSMENT

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. 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

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. If you think your policy/strategy could potentially breach the right of an individual contact the legal team.

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

Policy Statement

While 'did-not-attends' (DNAs) are sometimes unavoidable the short/no notice missed appointments are not available to others. Our expectation is that patients will attend, especially if the appointment has been arranged at a time of their choice.

This policy sets out how we will manage DNAs 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).

Appointment Letters
Patients will be advised about the service policy on DNA and cancellation in all appointment letters with this statement:

'There is a very high demand for this Service. Late cancellations or not attending agreed appointments means longer waiting times for all. Therefore, to be fair, we have a strict policy regarding missed appointments. Failure to attend appointments may result in you being discharged back to the care of your GP'

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.

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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.

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4.0 Hospital/Therapist Cancellations

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

APPENDIX D 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 CMHT 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 (High risk patients) The PD service is a specialist, tertiary service accepting referrals only from secondary care mental health teams. 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 CPA Care coordinator when the patient is under CPA 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 (including all service users with a current risk rating of high risk).
If there are no concerns or where servicers have a risk rating of low, 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

DNAs. 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 care co-ordinator.
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 care coordinator (when there is one) will agree appropriate next steps. If the service user is no longer open to a CMHT, the MDT should consider whether a referral to CMHT 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 E ADDENDUM TO DID NOT ATTEND POLICY: COMMUNITY BRAIN INJURY TEAM DNA AND CANCELLATION POLICY

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 CPA 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.

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 F: ADDENDUM TO DID NOT ATTEND POLICY: CRIMINAL JUSTICE LIAISON AND DIVERSION SERVICE – SUPPORT, TIME, AND RECOVERY FUNCTION.

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

CJLDS 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:

6 LOW RISK – RAG RATING GREEN

CJLDS STR is a voluntary support service aimed at assisting individuals to engage with health and social care systems and does not operate a RAG rating system.

7 MEDIUM OR HIGH RISK – RAG RATING AMBER OR RED

CJLDS STR is a voluntary support service aimed at assisting individuals to engage with health and social care systems and does not operate a RAG rating system.

9 PATIENTS WHO CANCEL AN OUTPATIENT (STR) APPOINTMENT

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

9.2 Initial Appointments

9.2.1 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.

9.3 Follow up appointments

9.3.1 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.

14 REFERRALS TO CJLDS STR

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

14.1 Individuals with telephone contact details

14.1.1 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 CJLDS STR function where they have been open to the Criminal Justice System within the last 14 days.

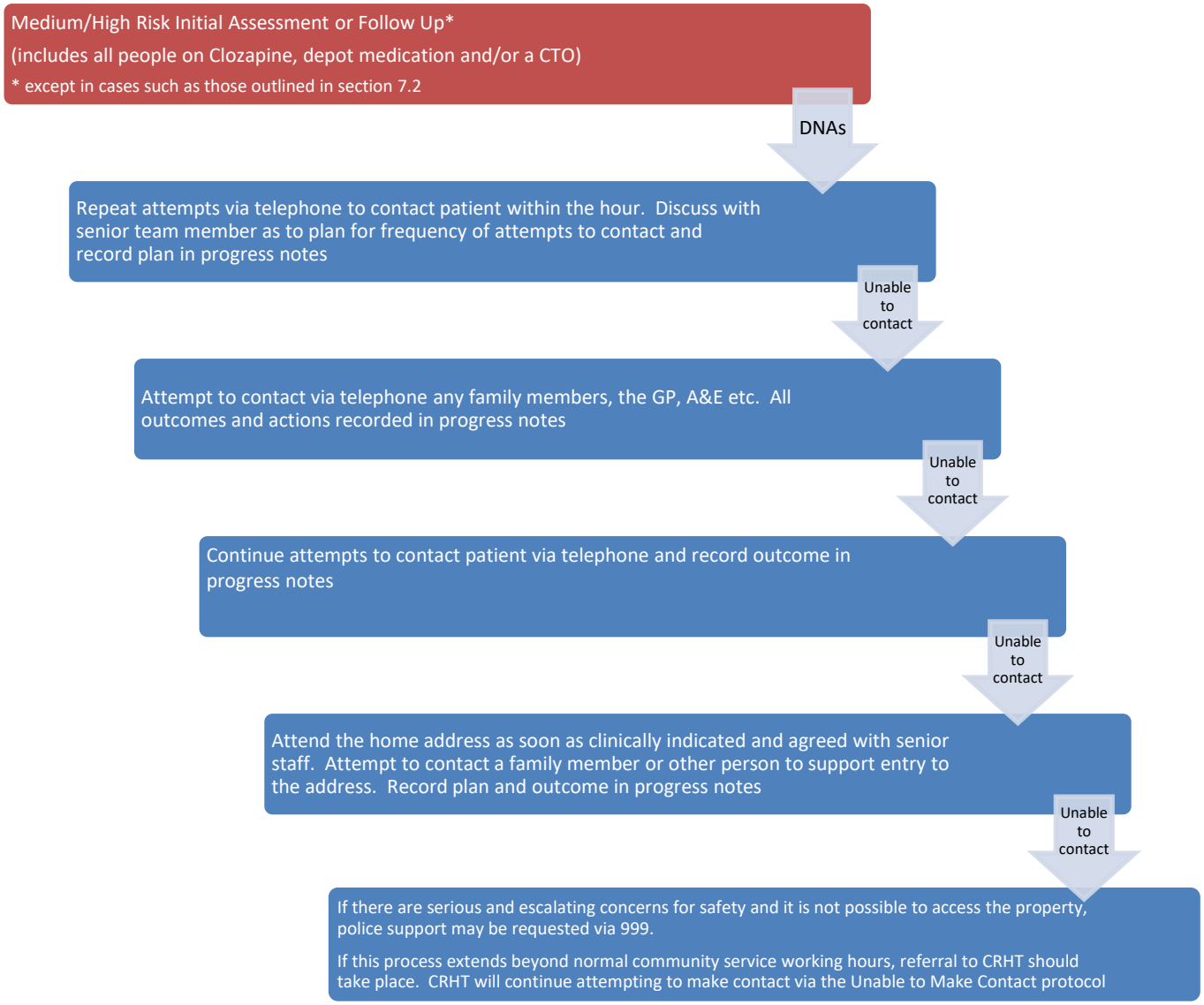
14.2 Individuals with no telephone contact details

14.2.1 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 G DNA FLOW CHART

Low Risk

Medium/High Risk



APPENDIX H TALKING THERAPIES FOR SURVIVORS OF SEXUAL ASSUALT SERVICE DID NOT ATTEND (DNA) AND PATIENT CANCELLATION GUIDELINES

Policy Statement

While 'did-not-attends' (DNAs) are sometimes unavoidable the short/no notice missed appointments are not available to others. Our expectation is that clients will attend, especially if the appointment has been arranged at a time of their choice.

This policy sets out how we will manage DNAs 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. Where initial phone contact is not possible, an appointment letter will be sent requesting that the client confirm attendance or re-arrange to a more convenient time.

Appointment Letters
Patients will be advised about the service policy on DNA and cancellation in all appointment letters with this statement:

'There is a high demand for this Service. Late cancellations or not attending agreed appointments means longer waiting times for all. Therefore, to be fair, we have a strict policy regarding missed appointments. Failure to attend appointments may results in you being discharged back to the care of your GP'

1. Roles and Responsibilities:
When any team member wishes to discharge a client under this policy the case will be discussed with the clinical lead and a decision taken based on the premise that care delivery should not be compromised. It is expected that clients' vulnerabilities and risks will be considered in the implementation of this policy.

2. Did Not Attends (DNAs)

2.1 New Clients for assessment
Where a new client has agreed (by means of phoning to confirm attendance) an appointment date with reasonable notice and this has been clearly communicated to them, then subsequently DNA's they will be contacted by letter informing them that if they do not contact the service within 10 days of the dated letter to re-arrange another appointment they will be discharged from the service. The GP will be copied into this correspondence.

2.2 Clients in therapy
The clinician who was due to see the client 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 consultation with the clinical lead.

Any client who DNA's two consecutive therapy appointments will be liable to be discharged back to their GP.

Managing DNA's in this fashion acts as a safeguard by ensuring GP's 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 would seek the patient's assurance they will attend any offered appointments.

3. Client who cancel an Appointment

Clients (new or receiving therapy) 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 clients cancelling appointments on **more than two occasions** will be discharged back to their GP. The GP will be informed by letter (copied to the client) indicating the need for a re-referral.

3.2 Clients in Therapy

Clients receiving therapy cancelling their appointment on **two consecutive occasions** will not be offered another appointment until after the clinician has met to review with the clinical lead to review the case. At this review a decision on the further management will be made. If this is discharge then the GP will be informed of this in writing indicating the need for a new referral if still deemed necessary.

3.3 Client Cancellations

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

4.0 Therapist Cancellations

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

December 2020

APPENDIX I DNA OVERSIGHT PROCESS FOR COMMUNITY MENTAL HEALTH SERVICES