

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

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

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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.
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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.

REFERENCES

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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

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 protocol Amendments add clarity.
10/12/19	CJLDS Manager	Appendix D	Addendum to policy re Criminal Justice Liaison and Diversion Service – Support, Time and Recovery Function added by Service Manager.

CONTENTS

1	INTRODUCTION.....	1
2	PURPOSE.....	1
3	DUTIES.....	1
4	APPOINTMENT LETTERS.....	2
5	ROLES AND RESPONSIBILITIES.....	2
6	LOW RISK – RAG RATING GREEN.....	2
7	MEDIUM OR HIGH RISK – RAG RATINGS AMBER OR RED.....	3
8	SINGLE POINT OF ACCESS (SPOA)	4
9	PATIENTS WHO CANCEL AN OUTPATIENT APPOINTMENT	4
10	RECORD KEEPING	5
11	IMPLEMENTATION INCLUDING TRAINING AND AWARENESS.....	5
12	EQUALITY IMPACT ASSESSMENT SUMMARY	5
13	HUMAN RIGHTS	5
14	MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THIS DOCUMENT	6
15	EXCEPTIONS.....	6
APPENDIX A	ACUTE CARE GROUP UNABLE TO CONTACT PROTOCOL.....	8
APPENDIX B	NEUROPSYCHIATRY AND NEUROPSYCHOLOGY SERVICES DID NOT ATTEND (DNA) AND PATIENT CANCELLATION GUIDELINES.	9
APPENDIX C	ADDENDUM TO POLICY RE: SPECIALIST PERSONALITY DISORDER SERVICES	11
APPENDIX D	ADDENDUM TO DID NOT ATTEND POLICY: CRIMINAL JUSTICE LIAISON AND DIVERSION SERVICE – SUPPORT, TIME, AND RECOVERY FUNCTION.....	14

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 be 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 and risks will be considered in the implementation of this policy.

6 LOW RISK – RAG RATING GREEN

DNAs – Actions taken will depend on risks identified

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. If so, then it should be booked collaboratively. If that appointment is subsequently not attended (DNA) then the following process is to be followed;
- 6.1.2 If the patient cannot be contacted 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. If it is agreed that risk is higher (Amber or Red) follow medium or high risk process below. Note rationale for decision clearly in progress notes on RiO and action it.
- 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)

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 high risk and actioned as per this section.)
- 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**, as soon as clinically indicated and agreed with senior staff. 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 **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 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.

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 PATIENTS WHO CANCEL AN OUTPATIENT APPOINTMENT

9.1 Patients (assessment 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 in line with CAPA.

9.2 Assessment

9.2.1 New patients cancelling appointments on **more than two consecutive occasions** will be discharged back to their GP/referrer. The GP/referrer will be informed by letter indicating the reasons, actions taken to encourage attendance and re-access information. Staff must sign and ensure contact information is provided for the GP.

9.3 Follow up appointments

- 9.3.1 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. 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. Staff must sign and ensure contact information is provided for the GP

10 RECORD KEEPING

- 10.1 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).
- 10.2 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.**

11 IMPLEMENTATION INCLUDING TRAINING AND AWARENESS

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

12 EQUALITY IMPACT ASSESSMENT SUMMARY

- 12.1 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.

13 HUMAN RIGHTS

- 13.1 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.

14 MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THIS DOCUMENT

<i>What will be monitored</i>	<i>How will it be monitored</i>	<i>Who will monitor</i>	<i>Frequency</i>	<i>Evidence to demonstrate monitoring</i>	<i>Action to be taken in the event of non compliance</i>
Compliance with DNA policy	Local governance meeting structure	Team leaders	Weekly	Minutes of meetings	Individual and team feedback and additional training if required. Required change to practice to be actioned within a specific time.
Compliance with DNA policy	Quality checks	Quality leads	Monthly	BI report of DNAs. Results of a sample audit of these to be presented at quality governance meeting and minuted.	Individual 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.
Compliance with DNA policy	Audit of policy implementation	Quality Managers / leads	Bi-annually	Audit report	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 ACUTE CARE GROUP UNABLE TO CONTACT PROTOCOL

Acute Service Line Protocol Unable to make Contact Protocol

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 (eg. 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 <http://i-connect.kmpt.nhs.uk/document-library/information-governance-briefing-notes/118> 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.

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 users 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.

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.

APPENDIX B 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.

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.

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 to 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 D: 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 if the individual wishes to self-refer back into the service.

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.