Leicestershire Partnership NHS Trust

The Management of Non Attendance/ Did Not Attend (DNA)

The objective of this policy is to ensure that all patients who do not attend appointments or cancel appointments are followed up by Trust staff and where necessary concerns are escalated appropriately.

Key Words:	DNA	
Version:	4.1	
Adopted by:	Quality Assurance Committee	
Date Adopted	21 February 2017	
Name of Author:	Michelle Churchard-Smith - Head of Nursing AMH / LD Service. Victoria Peach – Head of Professional Practice and Education.	
Name of responsible Committee:	Patient Safety Group	
Date issued for publication:	January 2017	
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Expiry date:	August 2023	
Target audience:	All Clinical Staff	
Type of Policy	Clinical ✔	Non Clinical
CQC Standards	Regulation 12 – Safe care and treatment Regulation 13 – Safeguarding service users from abuse and improper treatment	

Contents

Version Control and Summary of Changes

Version number	Date	Comments (description change and amendments)
1	September 2015	Policy thoroughly reviewed and extensively amended following lessons learnt from incident reviews
2	February 2016	Policy reviewed following initial comments from services and Children's Safeguarding CQC Visit.
3	May 2016	Comments received from AMH Services incorporated and amendments made.
4	October 2016	Policy reviewed to ensure that FYPC considerations are incorporated.
4.1	November 2016	Reference made to FYPC Discharge guidance.

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Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all.

This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

In carrying out its functions, LPT must have due regard to the different needs of different protected equality groups in their area.

This applies to all the activities for which LPT is responsible, including policy development and review.

Due Regard

This policy has been screened in relation to paying due regard to the general duty of the Equality Act 2012 to eliminate unlawful discrimination, harassment, victimisation; advance equality of opportunity and foster good relations.

This is evidenced by the references and consideration given throughout the policy to how staff can ensure that patients/service users are actively engaged in their care and treatment, and the alternative communication methods that should be employed to take account of those with different needs from across all protected characteristics.

There is no likely adverse impact on staff or patient/service users from this policy.

The Due regard assessment template is Appendix 5 of this document.

Definitions that apply to this Policy

Patient	Patient refers to a person (adult or child) who is in receipt of health care services from LPT. For the purpose of this policy the term 'patient' is inclusive of clients, families and service users.
Non Attendance / DNA – Did Not Attend / No access / Failed to attend	The patient does not attend or was not brought to an appointment; this may be an initial appointment, outpatient clinic or an appointment that is part of ongoing care. The patient (or family) is not at home when visited at a pre-arranged time by a practitioner. The practitioner does not gain access to the patient's place of residence for a pre- arranged appointment.
Cancelled appointment	Any pre-arranged appointment (outpatient or home visit) that is cancelled by the patient (not LPT staff) or a representative acting on their behalf even if an alternative appointment is arranged.
Missing Patient	A community patient whose whereabouts are unknown and there is cause for concern.
Due Regard	Having due regard for advancing equality involves: • Removing or minimising disadvantages suffered by people due to their protected characteristics. • Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. • Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

1.0 Purpose of the Policy

1.1 The purpose of this policy is to promote the engagement and involvement of patients and their carers / families in their care and ensure that Trust staff have consistent procedures to follow when a patient does not attend a planned appointment in hospital, outpatients, community clinic or a community place or the patient's own home. 'Did not attend' refers to all connotations inclusive of was not brought, failed to attend, and no access (refer to definitions that apply to this policy).

1.2 The aim of the policy is to reduce any risks to patients or others supporting them and ensure patients (adults or children) are followed up where there are safeguarding concerns to them or others within their life.

1.3 Objectives of the policy are to:

- Encourage patients to remain or re-engage with services.
- Ensure any immediate clinical or safeguarding risks are managed.
- Ensure all cases of DNA are followed up or there is appropriate closure of the case.
- Ensure the appropriate safeguarding policies are considered in following up patients (adults or children) and consideration is given to other vulnerable adults or children in need or at risk within the patients' life.

2.0 Summary and Key Points

2.1 This policy describes the roles and responsibilities of LPT staff in the effective management of patients who do not attend planned appointments.

3.0. Introduction

3.1 Leicestershire Partnership Trust (referred to thereafter in this document as 'the Trust') recognises that some patients do not attend (N.B. refer to definition) a planned appointment in hospital, outpatients, community clinic, a community place or the patient's own home. The safety of patients is important to the Trust and implementing this policy minimises risks to patients or others.

3.2 This policy provides guidance and procedures to be followed when patients have not attended appointments, cancelled appointments (unless this is acceptable for the treatment being offered or appointments which are voluntary on more than one occasion), or are not at the place a community visit has been arranged for. For patients who then cannot be located and are subject to sections of the Mental Health Act the Absent Without Leave (AWOL) and Missing Patient Policy should be followed.

3.3 Services in the Trust that carry out specific health care treatments only, for example Podiatry / Medical and Neuropsychology and the Dynamic Psychotherapy Service may not have a full health and well-being assessment of the patient. Such services should comply with this policy if risks are identified on referral or from previous contact. Risks may be related to health care concerns such as falls or safeguarding concerns for the patient and / or others within their life. Some services such as Assertive Outreach, Crisis Response and Home Treatment in Adult Mental Health, and Psychosis intervention and Early Recovery have specific local procedures for the management of DNA and cancelled appointments due to the specific needs of those patients. Universal services within the 0 -19 services (health visitor and school nurses) may not discharged patients in accordance with the universal offer and specific local procedures in relation

to service; refer to Discharge guidance for Family, Young People and Children's directorate. All local guidance and procedures should be considered in conjunction with the requirements of this policy.

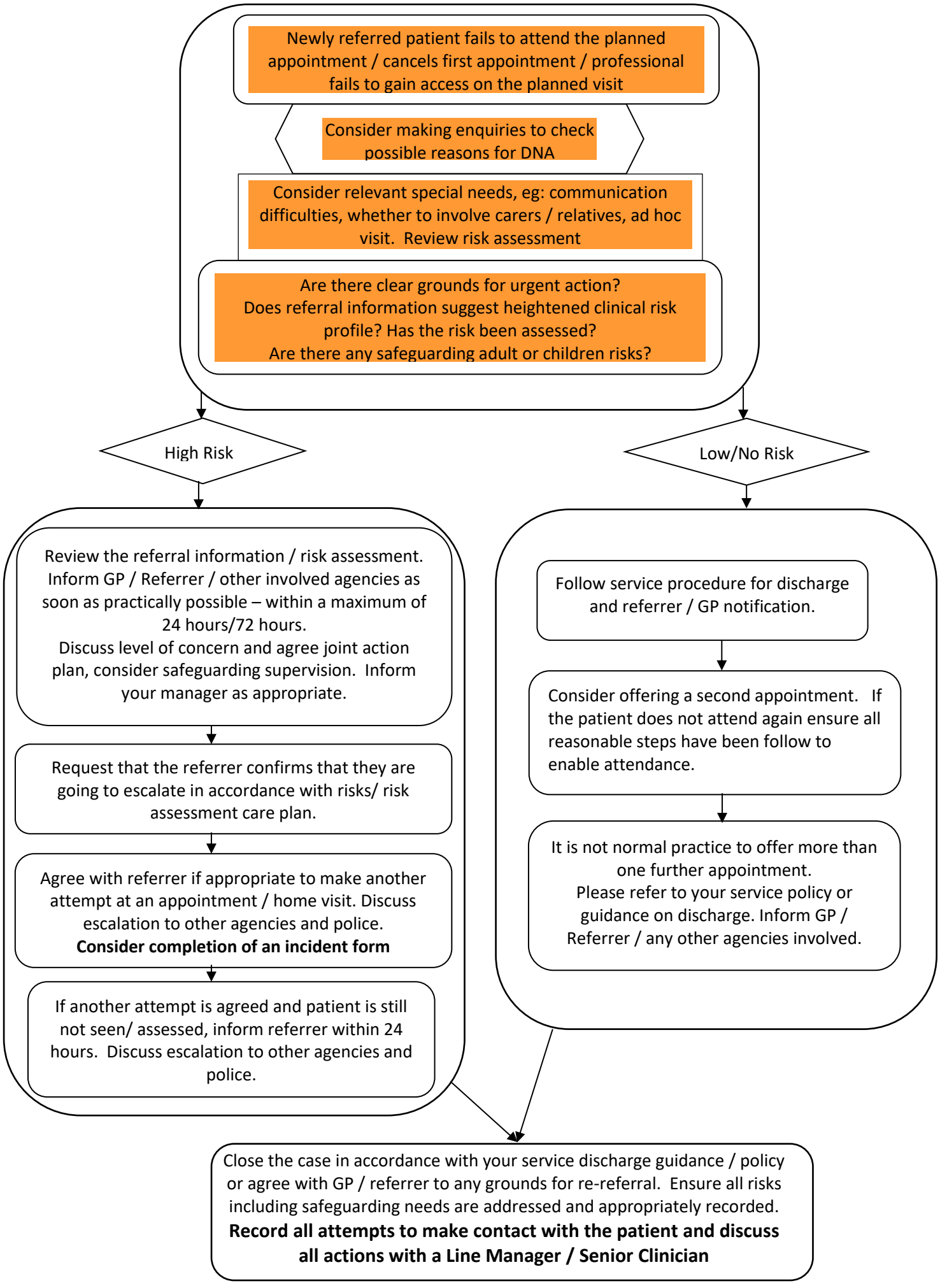
4.0 Flowchart / Process for Patients who Did Not Attend/Cancelled Appointment

All staff will ensure that on admission to Trust services patients will be asked for the details of other contact people as well as their next of kin in case they DNA appointments and we need to ensure they are safe and well. This information will be retained within the patient record.

The flowchart with the process to follow for new referrals who 'Did Not Attend' / Cancelled Appointment or are not in for community visits is on page 7.

The steps with the process to follow for known patients who 'Did Not Attend' / Cancelled Appointment is on Page number 8& 9.

4.1 Flowchart- New Referrals Who DNA/ Cancel Appointments



4.2 Process to follow when known Patients 'Did Not Attend' / Cancelled Appointments

When a patient known to the service does not attend planned appointment or cancels an appointment or the professional fails to gain access on a planned home visit, staff will need to consider risk factors and review the patient risk assessment. Specifically consider the patients relapse indicators, previous suicide attempts, violence and any safeguarding risks to the patient or for others particularly family and children. If unsure seek support from your immediate Supervisor / Managers / Senior Clinician / Consultant/ Safeguarding Team.

4.2.1 The following steps will need to be followed by the staff in the order mentioned below when **high risk/concern** for patient is identified:

Step 1

- If the patient has not attended a hospital or clinic appointment, attempt to contact the patient by telephone to check welfare and agree new appointment. If attempting to complete a home visit and the patient is not available, try to contact the patient by telephone and at the patient's residence look for signs of habitation, leave a contact card / details asking patient to contact you. If appropriate, repeat home visit attempt within 24/ 72 hours; record decision making and outcome.
- Confirm with GP Surgery regarding last contact and any other known services accessed by the patient.
- Consider discreet enquiries to neighbours or identified persons from patient records (**without breaking confidentiality**).
- Staff will discuss the failed attempt to gain access with their line manager / senior clinician.
- Staff should attempt a second home visit within 24 hours in the week and within 72hours at weekends (Friday pm to Monday am).
- Staff will document in the patient's records all discussions, actions and decisions reached.

Step 2

- Review the patient's risk assessment and the risk to others such as vulnerable adults and children.
- Consideration must be given to the patient's potential of being a vulnerable adult and whether there are children in need or at risk in contact with the patient.
- If risk and/or safeguarding concerns have been identified, raise concerns with immediate Supervisor / Manager/ Senior Clinician as appropriate.
- Consider a Police referral for a welfare check or to access a warrant to gain entry.
- Contact Safeguarding Team for advice or guidance as necessary.
- Patients subject to sections of the Mental Health Act who cannot be located are Absent Without Leave (AWOL) and Missing Patient Policy should be followed and maintain communication with the police and missing person's alert notice may be required
- Complete an **e-IRF incident form** as appropriate.

Step 3

- Attend multi-agency / multi-disciplinary meetings as requested or keep in contact with Police / other agencies to confirm the outcome of welfare check or safeguarding matters. If appropriate agreed, consider a missing person's report and complete e IRF incident form and document details within the patient records.
- Consider the immediate risk to patient or others and consider if a MHA assessment may be required; where appropriate discuss with the police to gain a warrant to gain entry to the home. Complete e-IRF incident form as necessary and document details within the patient records.

Step 4

- Notify GP / referrer and other significant professionals of the outcome in writing.
- To ensure that all discussions, actions and decisions reached are documented in the patient's records.

4.2.2 The following steps will need to be followed by the staff in the order mentioned below when **low risk/concern** for patient is identified:

- Where there is low or no risk or safeguarding concern, contact the patient (by telephone or letter) to offer and agree a new (second) appointment where possible confirm attendance with the patient. Document this within the patient records.
- If still no response, discuss the patient with colleagues according to service requirements (MDT review, Team / Service allocation meeting, and safeguarding supervision) review the risk profile and agree a plan of action.
- Continue to try to engage patient and pursue another appointment
- Write back to GP / Referrer to indicate DNA and intention to discharge as per service requirements.
- If still no response, follow LPT CPA Policy and the relevant LPT service discharge policy.
- Write to patient to advise how to get back in touch, inform GP / relevant professionals involved in the patient's care.
- Record your actions and how you escalated your concerns to others. **Record all attempts to make contact with the patient and discuss all actions with a Line Manager / Senior Clinician.**

4.2.3 When Patient DNA for second time

If the patient DNA for a second time staff will discuss the patient with their professional peers and /or line manager or at the next team / service allocation meeting / multi-disciplinary team meeting to review the patient's risk profile / safeguarding concerns and agree a plan of action. Staff will reconsider the above points (4.2.1 or 4.2.2) to gain required information to determine risks and safeguarding concerns Staff will follow Trust CPA Policy or service discharge policy. Staff will inform the patient in writing advising them how to get back in touch with the service and inform the GP / relevant others involved of such.

5.0 Duties within the Organisation

5.1 The Trust Board has a legal responsibility for Trust policies and for ensuring that they are carried out effectively.

5.2 Trust Board Sub-committees have the responsibility for ratifying policies and protocols.

5.3. **Chief Executive**
As the accountable officer, the Chief Executive must ensure that responsibility for the management of patients that DNA is delegated to an appropriate executive lead.

5.4 **Chief Nurse**
As nominated executive lead, the Chief Nurse, must ensure that appropriate and robust systems, processes and procedures are in place for ensuring that where patients DNA the risks of harm to themselves or others is considered and any follow up actions taken.

5.5 **Service Managers**
The Service Managers are the Trust leads for the development; implementation and monitoring of this policy and for ensuring there are service procedures in place for discharging patients, where appropriate, who are not at risk and DNA.

5.6 **Team Managers/Ward Managers**
All team / Ward managers have delegated responsibilities for the correct and consistent implementation and monitoring of this policy and the correct completion of any documentation and sharing lessons learnt from incidents, investigations or complaints.

5.7 **Medical Team and Clinical Staff**
All Trust staff who provide clinical care to patients are responsible for following the procedures in this policy.

6.0 Professional Judgement and Safeguarding Responsibilities

6.1 It is the responsibility of the professional concerned to document in the patient's health care records the decision making process following a did not attend. Where appropriate this must include consultation with other key professionals / carers / relatives / safeguarding team and police.

7.0 Training needs

7.1 All clinical staff are expected to attend mandatory safeguarding training.

7.2 All clinical staff are expected to be aware of the requirements and standards set out within this policy and any relevant local procedures within their service area.

8.0 Monitoring Compliance and Effectiveness

8.1 Compliance with this policy will be overseen by the LPT Patient Safety Group. The purpose of monitoring is to provide assurance that the agreed approach as set out in this policy in relation to service users who DNA is being followed. Our monitoring will therefore be proportionate, achievable and deal with specifics that can be assessed or measured.

Ref	Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
1	How the organisation ensures patient DNA's are followed up by all services.	Documentation in patients' records. P: 8, 9, section 4.2.1, 4.2.2	Compliance with this policy will be monitored through the annual DNA Audit.	The outcome of the audit will be reported to the Patient Safety Group. Patient Safety Group Divisional Patient Safety Groups	Annual
2	How the organisation raises awareness about reducing the number of patients who DNA - All incidents of DNA where patients are assessed as high risk are captured on the Safeguard incident reporting system.	Completion of an e-IRF incident form. P: 9,10, section 4.2.1	Reported via the Quarterly Quality and Patient Safety Reports in Divisions and Corporately to Patient Safety Group.	Divisional Patient Safety Groups and actioned locally in terms of investigation and action plans	Quarterly
3	Lessons learnt from instances should be shared through team meetings and/or trust wide learning events.	Sharing of lessons learnt are the responsibility of Team and Ward Managers. P: 10, section 5.	Monitored through the annual DNA Audit.	Divisional Patient Safety Groups and actioned locally in team meetings.	Annual

9.0 Standards/Performance Indicators

TARGET/STANDARDS	KEY PERFORMANCE INDICATOR
CQC standards for Patient Safety	Audit results, Incidents Lessons learnt from incidents

10.0 References and Bibliography

10.1 This policy was drafted with reference to the following:

- Multi agency Safeguarding Policy
- AWOL Policy
- Clinical Risk Assessment Policy
- Care Programme Approach Policy

10.2 Links to other documents

http://www.leicspart.nhs.uk/_PoliciesDocuments.aspx

- AWOL Policy
- Incident Reporting Policy
- Care Programme Approach Policy
- Clinical Risk Assessment Policy
- Safeguarding Policy

Appendix 1

The NHS Constitution

The NHS will provide a universal service for all based on clinical need, not ability to pay. The NHS will provide a comprehensive range of services

Shape its services around the needs and preferences of individual patients, their families and their carers	✓
Respond to different needs of different sectors of the population	✓
Work continuously to improve quality services and to minimise errors	✓
Support and value its staff	✓
Work together with others to ensure a seamless service for patients	✓
Help keep people healthy and work to reduce health inequalities	✓
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	✓

Appendix 2

Stakeholders and Consultation

Key individuals involved in developing the document

Name	Designation
Michelle Churchard-Smith	Head of Nursing AMH/LD Services
Vicky McDonnell	Trust Lead – Risk and patient safety
Steve Walls	Local Security Management Specialist
Victoria Peach	Head of Professional Practice and Education
Helen Burchnall	Clinical Director FYPC

Circulated to the following individuals for comment

Name	Designation
Jacqueline Burden	Clinical Governance Lead, AMH/LD
Noel O'Kelly	Clinical Director CHS
Claire Rashid	Trust Lead, Quality & Patient safety
Diane Postle	Trust Lead Nurse for Professional Standards
Adrian Childs	Chief Nurse
Mo Al-Uzri	Clinical Director AMH/LD
Greg Payne	Training Delivery Manager, LPT
Caroline Towers	Patient Safety Analyst
Helen Wallace	Regulation & Assurance Lead
Lynne Moore	Practice Development Nurse, LPT
Dot McGarrell	Ward Matron, The Willows
Rachael Shaw	Ward Matron, Thornton Ward
Jo Nicholls	Patient, Quality & Safety Manager
Samantha Roost	Senior Health Safety & Security Advisor
Lisa Calvert	Admin Manager
Chris Crane	CRISIS Service Manager
Dawn Holding	Assertive Outreach Manager
Fran Oloto	Specialist Safeguarding Named Nurse
Jenny Dolphin	Clinical Governance Manger, AMH/LD
Mia Morris	Incident Team Leader
Rosie Klair	Community Administrator
Baskara Lingam	Staff Side Representative
Fabida Nousha	Sp. Clinical Director
Louise Short	Clinical Trainer& Practice Development Officer
Fern Barrell	Risk Manager, Assurance
Satheesh Kumar	Medical Director
Alison Scott	Clinical Dietetic Manager-Primary Care
Nikki Beacher	Head of Service, Community Health Services
Michelle Brookhouse	Head of Learning & Development
Bal Johal	Deputy Chief Nurse, Quality & Innovation
Mark Griffiths	Service Manager
Kerry O'Reardon	Serious Incidents Lead, AMH&LD
Vicki Spencer	FYPC-Clinical Governance & Quality Lead

Richard Holland	Pier Team
Teresa Norris	CAMHS
Jo Wilson	Lead Nurse FYPC
Claire Armitage	Lead Nurse AMH/LD
Mat Williams	Senior Matron
Lynne Moore	PDN
Andy Watson	LD Service Manager
Bob Lovegrove	Security Management Specialist
Rachel Garton	Trust Lead Safeguarding Adult and Children

Appendix 3

Due Regard Screening Template

Section 1	
Name of activity/proposal	Did Not Attend Policy
Date Screening commenced	February 2016
Directorate / Service carrying out the assessment	Patient Safety Group
Name and role of person undertaking this Due Regard (Equality Analysis)	Michelle Churchard-Smith

Give an overview of the aims, objectives and purpose of the proposal:

AIMS: The purpose of this policy is to promote the engagement and involvement of patients and their carers/ families in their care and ensure that Trust staff have consistent procedures to follow when a patient fails to attend a planned appointment in hospital, outpatients, community clinic or a community place or the patients own home.

The aim of the policy is to reduce any risks to patients or others supporting them and ensure patients (adults or children) are followed up where there are safeguarding concerns to them or others within their life.

OBJECTIVES: The objective of this policy is to ensure that patients who are at risk of harm to themselves or others and do not attend appointments are followed up by Trust staff and where necessary concerns are escalated appropriately.

Section 2	
Protected Characteristic	**If the proposal/s have a positive or negative impact please give brief details**
Age	No impact expected for any protected characteristic
Disability	
Gender reassignment	
Marriage & Civil Partnership	
Pregnancy & Maternity	
Race	
Religion and Belief	
Sex	
Sexual Orientation	
Other equality groups?	

Section 3

Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.

Yes	**No✓**
High risk: Complete a full EIA starting click here to proceed to Part B	**Low risk: Go to Section 4.**

Section 4

If this proposal is low risk please give evidence or justification for how you reached this decision:

Discussion at PSG

Signed **by** Jo Nicholls **Date** 8.02.2017
reviewer/assessor

Sign off that this proposal is low risk and does not require a full Equality Analysis

Head of Service Signed **Date**

Appendix 4

Training Needs Analysis

Training Required	**YES**	**NO ✓**
Training topic:		
Type of training: **(see study leave policy)**	☐ **Mandatory (must be on mandatory training register)** ☐ **Role specific** ☐ **Personal development**	
Division(s) to which the training is applicable:	☐ **Adult Mental Health & Learning Disability Services** ☐ **Community Health Services** ☐ **Enabling Services** ☐ **Families Young People Children** ☐ **Hosted Services**	
Staff groups who require the training:	***Please specify…***	
Regularity of Update requirement:		
Who is responsible for delivery of this training?		
Have resources been identified?		
Has a training plan been agreed?		
Where will completion of this training be recorded?	☐ **ULearn** ☐ **Other (please specify)**	
How is this training going to be monitored?		