Appointment Management Guidelines for Torbay Drug and Alcohol Service

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Partners in Care

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Document Information

Document Title:	Appointment management guidelines for Torbay Drug and Alcohol Service		
Purpose of document:	To provide guidance to staff working within the Torbay Drug and Alcohol Service to help maximise the attendance of service users at appointments		
Date of Issue:	26 May 2017	Next Review Date:	26 May 2020
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Author:	Service Manager, Drugs and Alcohol Service		
Owner:	Public Health		
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Care and Clinical Policies Sub Group		17 May 2017	
Links or overlaps with other policies:			
Lone working policy			
TSDFT Safeguarding Adults policies			
TSDFT Mental Capacity Act policies			
TSDFT Child Protection Policies			

Amendment History

Date	Version no	Amendment summary	Completed by:
24 September 2007	1.1	Initial draft	Service Manager, Drugs and Alcohol Service
23 January 2008	1.2	Ratification	CCPSG
22 January 2010	2.0	Policy review date	CCPSG
24 February 2011	3.0	Serious Case review	J Pinder
18 August 2011	3.1	Feedback from C&P group	Service Manager, Drugs and Alcohol Service
1 March 2015	4.0	Periodical review	Service Manager, Drugs and Alcohol Service
26 May 2017	5.0	Revised (Periodical review)	Service Manager, Drugs and Alcohol Service Care and Clinical Policies Sub Group
19 February 2018	5	Review date extended from 2 years to 3 years	

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Quality Impact Assessment (QIA)

Who may be affected by this document?	Please select			
	Patient / Service Users	☒	Visitors / Relatives	☒
	General Public	☐	Voluntary / Community Groups	☐
	Trade Unions	☐	GPs	☐
	NHS Organisations	☐	Police	☐
	Councils	☐	Carers	☐
	Staff	☒	Other Statutory Agencies	☐
	Others *(please state):*			

Does this document require a service redesign, or substantial amendments to an existing process?	☐
If you answer yes to this question, please complete a full Quality Impact Assessment.	

Are there concerns that the document could adversely impact on people and aspects of the Trust under one of the nine strands of diversity?	Age	☐	Disability	☐
	Gender re-assignment	☐	Marriage and Civil Partnership	☐
	Pregnancy and maternity	☐	Race, including nationality and ethnicity	☐
	Religion or Belief	☐	Sex	☐
	Sexual orientation	☐		

If you answer yes to any of these strands, please complete a full Quality Impact Assessment.

If applicable, what action has been taken to mitigate any concerns?	

Who have you consulted with in the creation of this document? *Note - It may not be sufficient to just speak to other health & social care professionals.*	Patients / Service Users	☒	Visitors / Relatives	☐
	General Public	☐	Voluntary / Community Groups	☐
	Trade Unions	☐	GPs	☐
	NHS Organisations	☐	Police	☐
	Councils	☐	Carers	☐
	Staff	☒	Other Statutory Agencies	☐
	Details *(please state):*			

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Contents

1   Introduction

1.1   ***Key principle:*** *Engagement and retention in treatment is a key factor in reducing drug and alcohol related harm and drug related deaths, therefore all efforts should be made to engage and keep the service user in treatment for the duration of their recovery plan.*

1.2   These guidelines have been produced to help guide Torbay and South Devon NHS Foundation Trust (TSDFT) staff regarding the attendance expectations and management of appointments within Torbay Drug & Alcohol Service (TDAS). It should be borne in mind that as with all guidance this document does not intend to replace the clinical decision making processes of the multi-disciplinary team, which must consider any risk posed as a result of decisions made regarding any change in treatment, as well as advocating an individualised approach to the treatment of every service user. This guidance does not intend to replace or supersede any pre-existing and over-riding organisational policy or protocol.

1.3   The service user must be central to this process, and appointments should always be made to meet their individual needs wherever possible.

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2   Statement/Objective

2.1   The Objective of this policy is to offer a flexible approach to appointments for users of the service, whilst at the same time ensuring as much as possible that staff time is utilised in the most effective way possible. This guidance aims to provide a framework from which practitioners are able to work within, and to inform decision making regarding the management of non-attendance at appointments. This guidance is meant to support the clinical decision making process of all clinicians working in the substance misuse field.

3   Roles & Responsibilities

3.1   This guidance is aimed at all staff working within the Torbay Drug & Alcohol Service.

3.2   Staff affected by this procedure include all managers, team leaders, Recovery Coordinators and support staff (including volunteers and learners on placement in the organisation).

3.3   Medical staff are advised to exercise their clinical judgement in relation to the timescales mentioned in this document. It is acknowledged that due to the shorter nature of medical consultations, and processes to rearrange these, it will not always be possible to afford the same considerations. It is also acknowledged that clinical risk concerns can override this guidance where deemed necessary.

4   Meeting the needs of the service user - Time

4.1   Appointments should always be made in consultation with the service user, wherever possible, and take into account their personal circumstances and needs. For example, evening appointments for those who work or have child care responsibilities in the day, or avoiding times of religious festivals and observance of times of prayer.

4.2   Ideally, appointments should be arranged on a face-to-face basis, or over the telephone. Letters of appointment should be sent out only if a verbal conversation is not possible, and then should invite the client to contact the service to discuss any difficulties they may have with any proposed arrangement.

4.3   If the service user has a mobile phone or e-mail address, and has given consent to be contacted by this method, then a text/e-mail message should be sent to arrange, confirm or remind them of an appointment, eliminating the need for a written letter.

4.4   A full record of the content of any arranged appointment in any format, as

well as any response to a text or e-mail message must be made on the electronic case management tool (HALO).

5 Meeting the needs of the service user – location

5.1 **Drugs Team** - Initial meetings with service users in the drugs team should always take place at Walnut Lodge or Shrublands House, or other agreed and properly risk assessed premises without exception (Open Access sessions in Castle circus health centre for example).

5.2 **Alcohol Team** – Initial meetings with service users in the alcohol team should always take place at the individuals GP surgery where possible, or other agreed public premises e.g. Torbay Hospital, Paignton Wellbeing Centre, Walnut Lodge.

5.3 On-going appointments will take place at Walnut Lodge, GP Practice or a mutually agreed community venue. This may occur as a joint appointment with another agency/worker such as Children and Families team, Specialist Health Visitor, housing department, Employment Training and Education (ETE) worker or another specialist drug or alcohol agency worker.

5.4 **Home Visits** - Service user views should be taken into account regarding the location of the appointment. Home visits should not be considered in the vast majority of cases, unless a risk assessment has been conducted, signed off by a manager, and the client has a valid reason for not being able to attend Walnut Lodge, GP Practice or other agreed community venue.

5.5 Valid reasons for considering a home visit may include the following (list is not exhaustive):-

· Chronic physical ill health / disability
· Poor engagement with associated high risk factors should the client "drop out" of treatment
· Where there are serious concerns about the welfare of the service user or significant other; either where a risk has been identified or there is cause for concern that such a risk may exist
· For the purposes of undertaking/monitoring a home detoxification programme
· For the assessment of the home/family environment, including the issue of a lockable medicines storage box and completion of a Dependents Needs Support Assessment (DSNA).

5.6 A home visit for the purpose of an assessment of the service users home circumstances can be justified (for example where there may be concerns about children living in the home), and these visits should be conducted jointly

with another member of staff from the team or with staff from other agencies unless a thorough home risk assessment has been approved by the individual worker and approved by a manager, having indicated it is safe to conduct a home visit alone.

5.7   The Lone working policy and Health and Safety policies concerning personal safety should always be followed when conducting any community / home visits without exception. A written record of out of office visits should be in place within the team – all visits should be clearly marked in a Recovery Coordinators electronic diary including the service users name and location of the appointment (this should include the service users address if this is a home visit). Any proposed initial home visit should always be cleared/agreed by the team manager **before** arranging this with the service user.

5.8   In a lone worker situation, the TSDFT lone working policy must be followed with the staff member utilising a lone working device. This includes the requirement to log in/out of visits.

6   Managing the system

6.1   **Key principle:** *Missed appointments can cause a great deal of administrative follow-up and are a significant drain on staff time. Reduction of missed appointments will ensure that resources are deployed where they will have the maximum effect. Further, concordance with attendance at arranged appointments will also increase the support available to service users in achieving their treatment goals.*

6.2   When attempting to manage the appointment process, the aim is always to avoid being punitive in approach, and support the service user in their recovery journey, and also to manage risk whilst still offering choice. Poor attendance of a service user carries an inherently higher level of risk, and services need to manage this in a manner that ensures an appropriate and safe level of monitoring and compliance is achieved. There will be differing expectation of levels of attendance dependent upon a service users progress in treatment; and the service will apply appropriate judgement to the clinical decision making process regarding the frequency at which the service user should be reviewed.

6.3   For those in the first twelve weeks of treatment, it is expected that the service user will have frequent contact with the Recovery Coordinator/prescriber and groupwork programme. Following this period, a recovery plan review, Client Evaluation of Self at Intake (CESI) and Client Evaluation of Self in Treatment (CEST) questionnaire along with the Treatment Outcome Profile (TOP) will determine the progress made to date, and will include the service users views about their preferred level of contact. The recovery plan review should also include discussion regarding the relaxation (or not) of daily supervised

consumption dependent upon concordance with the treatment plan.

6.4 **Key principle:** *Whatever the outcome of frequency of contact that is agreed, the issue remains how appointments are arranged and the response to missed appointments. Additionally, the responsibilities of Recovery Coordinator, prescriber and service user in respect of appointments should be spelt out from the outset of treatment and included in the treatment agreement.*

6.5 This guidance intends to provide a framework for the approach to be utilised in appointment management, and should be applied consistently across all the service. In order to deliver effective services, the psycho-social support that enhances a substitute prescription is paramount in terms of achieving positive outcomes for service users, and appointments offered should not become a substitute for the medical consultation regarding issues arising from the prescribing component of drug treatment. Discussions concerning medication used, dosages and collection frequency should usually be deferred to the named prescriber.

6.6 In order to set a standard for an appointment system there must be consistency of practice. The following model is designed to achieve this consistency, and all workers within the service are expected to follow this. In designing the model, it is important to stress that the sections of this guidance concerning service user focus, choice and flexibility must be applied at all times, and the offer of unachievable expectations of attendance (i.e. letters sent a day before the appointment is due, or at times that are known to be difficult for the service user to attend must always be avoided). Any offered appointments (either verbal, by text message or e-mail) should be clearly recorded in the case record on HALO.

6.7 **Key principle:** *In managing the occurrence of missed appointments there must be a balance between respecting an individual's right to choose not to attend an appointment and appointments that are genuinely 'forgotten about', or are subject to unavoidable cancellation, and the need to monitor the well-being and safety of individuals open to the treatment system.*

6.8 Where a service user fails to attend for an arranged appointment and there is a history within the past 12 months of significant harm to self (i.e. suicide attempt, suicidal ideation), or harm from others (eg: domestic abuse, threats from others, gang repriasals etc.) consideration should be given by the team to taking a more assertive approach to making contact with the service user to review the situation. Where there is a significant level of concern regarding the client's non-attendance and contact cannot be made with anyone else to establish the service user's well-being then consideration should be given by the team to contact other agencies or services (where consent is agreed) which might be involved with the service user to ascertain whereabouts and/or raise concerns. In such circumstances, a home visit should be considered and

should be authorised by the line manager (or deputy in their absence). Any such visit should follow the TSDFT policy on lone working, risk and home visiting:-
http://nww.torbaycaretrust.nhs.uk/sites/PoliciesAndProcedures/Published%20D ocuments/Lone%20Worker%20Policy.pdf (last accessed 08/05/2017).

Consideration should also be given to any current or historical concerns regarding mental capacity. As is standard practice all decision making processes should be accurately recorded in the client notes on HALO.

7   Training

7.1   All new staff to the Torbay Drug & Alcohol Service will be introduced to and made familiar with these guidelines as part of their local induction. This includes students on placement and volunteers.

7.2   All staff to be familiar with this document and to attend any training, supervision and other learning opportunities in relation to this guideline.

8   Monitoring, Auditing, Reviewing & Evaluation

8.1   Monthly attendance reports are generated within the service which provide accurate information on attendance rates at appointments, both at the service base at Walnut Lodge and in the wider community. These reports are distributed quarterly to all staff and discussed at the team operational meeting.

8.2   This guideline will be monitored through the Torbay Drug and Alcohol Service Quality Safety and Performance (QSP) Group, which represents the internal governance forum for the service. Any concerning trends, issues or incidents arising will be taken to the TSDFT Quality Assurance Committee.

8.3   These guidelines will be formally reviewed after two years from the date of ratification, or sooner if the need arises or due to significant changes in working practices.

9   References

9.1   Review of the effectiveness of treatment for alcohol problems. National Treatment Agency for substance Misuse (NTA, 2006).

9.2   Medications in recovery: Reorientating drug dependency treatment. National Treatment Agency for substance Misuse (NTA, 2012)

10   Distribution

10.1 All staff employed within the Torbay Drug and Alcohol Service (TSDFT) will

be issued with this guidance following organisational ratification.

11   Appendices

11.1   Appointment Management flow chart- Guide part 1 alcohol team

11.2   Appointment Management flow chart- Guide part 1 drug team

The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

> **"The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves". (3)**

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare

http://icare/Operations/mental_capacity_act/Pages/default.aspx

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.

Appointment Management flow chart- Guide

The flow chart (below) is intended as a guide for workers in managing non-attendance at arranged appointments regardless of the frequency of contact that has been deemed appropriate. Whilst it is not possible to address every conceivable scenario that may arise, the flow chart provides the framework to which all staff should work to, and this should be explained to service users when they sign up to the treatment agreement at the outset of treatment. The particular risk factors associated with any possible discontinuation of treatment should be discussed within the multi-disciplinary team and include the prescriber in all instances.

These guidelines and associated flow chart do not address the issue of discharge planning, and asse rtive follow-up and re-engagement.

Appendix 1 – Appointment Management flow chart – Alcohol Team

DNA of arranged appointment with service user

DNA with contact made by the service user before scheduled appointment (or 20 mins following scheduled time of appointment)

DNA with no contact made by service user

Appointment arranged immediately and followed up by text/email or letter. Appointment to be offered within ten working days

Try to contact service user by phone – try to leave message for the client to contact their Recovery Coordinator

Service user contacted by Recovery Coordinator by phone/text

Service user uncontactable - consider appropriate response in relation to level of risk as outlined in guidance

Letter sent to service user to make contact within 10 working days to arrange next appointment

DNA **with either contact OR no contact** of **second** arrange appointment with service user. Consider appropriate response in relation to level of risk as outlined in guidance

Letter sent to service user inviting them to make contact with their Recovery Coordinator to review their Individual Recovery Plan (RP) within the next 10 working days. Advise service use that if they do not contact their case may be closed.

Service user makes contact – review IRP either over the phone or arrange face to face appointment for review

Service user does not contact – review case at clinical team meeting. Subject to risk assessment case closed – involved parties advised

In cases of high risk (e.g. domestic abuse, pregnancy, significant harm to self in past 12 months) more assertive engagement following a missed appointment may be required. Needs to be identified through clinical team meeting or discussion with team leader. In cases of significant concern consider the appropriateness of requesting a police welfare check.

Appendix 2 – Appointment Management flow chart – drug team

DNA of **first** arranged appointment with service user

DNA **with contact** made by the service user before scheduled appointment (or 20 mins following scheduled time of appointment)

DNA **with no contact** made by service user

Appointment arranged immediately and followed up by text/email or letter. Appointment to be offered within 10 working days

Contact pharmacist to discuss service user's attendance at chemist, and leave message for client to contact Recovery Coordinator (Suspend prescription if not collected for 3 consecutive days and arrange medical review)

Service user contacted by keyworker by telephone/text

Service user uncontactable - consider appropriate response in relation to level of risk as outlined in guidance

Text email/letter sent to service user to make contact within 5-10 working days to arrange next appointment

DNA **with either contact OR no contact** of **second** arranged appointment with service user. Consider appropriate response in relation to level of risk as outlined in guidance

Discussion with prescriber regarding safety/discontinuation of prescription

Suspension of prescription:
1. Service user contacted by telephone to inform of decision (or face-to-face if possible)
2. Medical review appointment given verbally to service user. Followed up by text/email or letter.
3. Chemist informed of suspension by e-mail/fax and followed up by phone call.

Continuation of prescription:
1. Chemist contacted to ensure service user has been compliant with collection arrangements
2. Medical review appointment given
3. Service user contacted to inform of decision and medical review appointment details

DNA **with either contact OR no contact** of **third** arranged appointment with service user – consider appropriate response in relation to level or risk as outlined in guidance

Treatment discontinued. Service user telephoned and letter sent to invite contact. 2 week window for re-contact offered. If no contact, discharge occurs.

In cases of high risk (e.g. domestic abuse, pregnancy, significant harm to self in past 12 months) more assertive engagement following a missed appointment may be required. Needs to be identified through clinical team meeting or discussion with team leader. In cases of significant concern consider the appropriateness of requesting a police welfare check.

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Rapid (E)quality Impact Assessment (EqIA) *(for use when writing policies)*

Policy Title (and number)	1885 - Appointment Management Guidelines for Torbay Drug and Alcohol Service	**Version and Date**	Version 5 March 2017
Policy Author	Service Manager		

An (e)quality impact assessment is a process designed to ensure that policies do not discriminate or disadvantage people whilst advancing equality. Consider the nature and extent of the impact, not the number of people affected.

Who may be affected by this document?					
Patients/ Service Users ☒	Staff ☒	Other, please state…			☐

Could the policy treat people from protected groups less favorably than the general population?
PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below

Age	Yes ☐ No☒	Gender Reassignment	Yes ☐ No☒	Sexual Orientation	Yes ☐ No☒
Race	Yes ☐ No☒	Disability	Yes ☐ No☒	Religion/Belief (non)	Yes ☐ No☒
Gender	Yes ☐ No☒	Pregnancy/Maternity	Yes ☐ No☒	Marriage/ Civil Partnership	Yes ☐ No☒

Is it likely that the policy could affect particular 'Inclusion Health' groups less favorably than the general population? (substance misuse; teenage mums; carers[1]; travellers[2]; homeless[3]; convictions; social isolation[4]; refugees)	Yes ☐ No☒

Please provide details for each protected group where you have indicated 'Yes'.

VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion	
Is inclusive language[5] used throughout?	Yes ☒ No☐ NA ☐
Are the services outlined in the policy fully accessible[6]?	Yes ☒ No☐ NA ☐
Does the policy encourage individualised and person-centered care?	Yes ☒ No☐ NA ☐
Could there be an adverse impact on an individual's independence or autonomy[7]?	Yes ☐ No☒ NA ☐

EXTERNAL FACTORS	
Is the policy a result of national legislation which cannot be modified in any way?	Yes ☐ No☒

What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)

Periodic review

Who was consulted when drafting this policy?

Patients/ Service Users ☒	Trade Unions ☐	Protected Groups (including Trust Equality Groups)	☐
Staff ☒	General Public ☐	Other, please state…	☐

What were the recommendations/suggestions?

Does this document require a service redesign or substantial amendments to an existing process? *PLEASE NOTE: 'Yes' may trigger a full EIA, please refer to the equality leads below*	Yes ☐ No☒

ACTION PLAN: Please list all actions identified to address any impacts

Action	**Person responsible**	**Completion date**

AUTHORISATION:
By signing below, I confirm that the named person responsible above is aware of the actions assigned to them

Name of person completing the form	Clinical Team Leader	**Signature**	
Validated by (line manager)	Service Manager	**Signature**	

Collated by Clinical Effectiveness

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