FACTSHEET

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Management of 'Did not attend' (DNA) letters

According to the Health Service Executive (HSE) Acute Hospitals Division, in 2016, 478,765 patients did not attend their outpatient appointment in Ireland, which represented an overall DNA rate of 13%.

Following most non-attendances, a "DNA letter" is sent to the patient's GP. In many cases, when a patient fails to attend, they are referred back to the care of their GP to reassess if the appointment is warranted and requesting the GP to re-refer if necessary. These letters can create an additional administrative and clinical burden for GPs.

Reasons for non-attendance

Common reasons for patients failing to attend hospital clinics may be that the hospital holds an incorrect address and contact details or sometimes, post sent to the correct address may have gone astray. In other cases, patients may have received their hospital appointment but as a result of particular vulnerabilities, they may have not been aware of the appointment. These may include patients with visual difficulties, literacy and, intellectual difficulties and, where English is not their first language. Other times, patients may have missed appointments due to sickness / incapacity or simply due to error. Sometimes patients may have received treatment for the condition via another pathway e.g. during a recent hospital admission or having been seen in a private capacity whist on a public waiting list.

GP responsibility

Medisec frequently receives calls from members asking about the extent of the GP's responsibility in these circumstances. GPs should be aware of the relevant sections of the Medical Council's Guide to Professional Conduct and Ethics for Registered Medical Practitioners, 9th Edition, 2024 (available on the Medical Council website), which states:

1. **Good medical practice**

Good medical practice depends on doctors working together with patients and colleagues toward shared aims and with mutual respect. Such partnership depends on establishing trust, providing patient-centred care, working collaboratively with patients and colleagues, advocating for patients and communicating effectively with patients, colleagues and others.

33.1 It is in the best interests of the patient that the overall management of their care is under the supervision and guidance of a general practitioner. The general practitioner should be informed, in a timely and prompt manner, of any treatment, referrals and plans for care provision. 38.1 It is in the best interests of the patient that the overall management of their health is under the supervision and guidance of a general practitioner.

If a patient is in danger of losing their critical clinical appointment, GPs should act in their best interests to ensure that where necessary the outpatient department (OPD) appointment is safeguarded and that the patient is seen as planned. Patients are best served by GPs being responsible for their overall management and once a GP is on notice of DNA, they must take appropriate steps.

In some cases, patients may be unwilling to adhere to advice to attend out-patient appointments. It is important to consider unique patient circumstances (e.g. poor understanding, anxiety, denial etc) that might constitute barriers to adhering to medical advice. In some cases, despite best efforts to encourage attendance at appointments, a patient may decline to engage. The Medical Council's Guide to Professional Conduct and Ethics for Registered Medical Practitioners, 9th Edition, 2024 recognises that if the breakdown of the therapeutic relationship means a doctor is unable to provide effective care, patient consent should be obtained to transfer their records to another doctor. This should be documented in the patient's medical records.

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Best Practice tips on management of referrals

- At the time of referral, check that all contact details for the patient are correct including the address and telephone number. Some patients may prefer to use parents' / family members' more permanent addresses e.g. students in rented accommodation. When referring particularly vulnerable patients, you may wish to provide additional contact details for a family member / carer. When doing so, it is important to ensure you have the patient's consent to send these details and explain that correspondence containing their medical information may be sent to the family member / carer.

- You may wish to advise patients of the importance of keeping their contact details up to date. This could be achieved via a poster in your waiting room, TV screen, and / or and as a footnote on prescriptions.

- Where possible, advise the patient of any expected waiting times in order to manage expectations and that they should contact the practice or the hospital after an agreed timeframe if they have not received an appointment.

- The practice should develop a robust policy on the management of DNA letters that clearly outlines the roles and responsibilities of those involved in the process. All staff members should be made aware of the policy.

Best practice tips on management of DNA letters

- On receipt of a DNA letter, it should be given to the referring doctor who should decide on what course of action to take.

- The GP should determine if the patient is still in need of the service or if they have received the treatment via a different pathway. It may in some cases be necessary to contact the patient to ascertain if they have cancelled and rescheduled the appointment themselves.

- The following should be established:

    - the patient's contact details are correct
    - whether there has been any change in the patient's clinical condition
    - whether the level of urgency of the referral has changed
    - whether the original referral had the appropriate level of urgency highlighted
    - the reason for non-attendance.

- A decision should then be made as to what further action is required such as arranging a further consultation with the patient, re-referring the patient, writing to the secondary care service and provide the updated contact details of the patient, etc.

- The DNA letter should be dated, signed and scanned into the patient's medical records. It is important that any comments or requested actions attached to letters by doctors are also scanned and that a record of completion of the actions is made.

- All attempts at contacting the patient should be documented in the medical record including where no response is received. Any information given by the patient should be recorded in the notes, including confirmation of their contact details and whether there has been any change in their condition.

- The GP's decision on whether further action is warranted and the reasons for the decision should be clearly documented.

- Where necessary, the GP may need to re-send the original referral with an appropriate level of urgency indicated.

Children and vulnerable adults

When assessing DNA letters concerning children or vulnerable patients, GPs should bear in mind the possibility that the non-attendance at such appointments can in some cases be an indicator that the welfare of a patient is at risk.

If you have any further queries regarding DNA hospital letters and referrals, please do not hesitate to contact Medisec for advice.

The contents of this publication are indicative of current developments and contain guidance on general medico legal queries. It does not constitute and should not be relied upon as definitive legal, clinical or other advice and if you have any specific queries, please contact Medisec for advice.

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