Trust Policy

Was Not Brought (Did Not Attend) Policy for Children and Young People
– including appointments/ planned surgery/ investigations

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**Purpose**

When considering action if a child is not brought for a planned hospital appointment, the health, safety and welfare of the child must be paramount. Action must be taken to ensure a child is not disadvantaged by non-attendance and staff must be aware that non-attendance may point to wider concerns about the child’s welfare including possible ‘neglect’.

Trust Policy must never be cited a reason to discharge children from secondary care.

**Who should read this document?**

All staff groups

**Key Messages**

- Children who do not attend hospital appointments don’t purposefully miss appointments, they are not brought and need to be given all opportunity to have their health needs met.
- The medical risk to the child of not being seen or treated must be assessed and acted upon appropriately. It is the lead clinician who holds the responsibility for this. It is the responsibility of all other staff to raise this to the lead clinician.
- If children are not brought for appointments this can have serious implications for their health and safety. This could raise issues of neglect. If this is the case there may be a need for a multi-agency response under early help or Child Protection procedures.
- It is the responsibility of the lead clinician to ensure multi-agency involvement is instigated to expedite attendance when there is considered to be a significant risk to health through non-attendance at medical appointments.
- Alerts will be placed on the child’s record to highlight an issue with attendance when it is felt there is a significant risk to the child’s health from not being brought to appointments.
- Parents may need support to attend appointments with their children from community services and so communication is key to ensuring health needs are met.

**Core accountabilities**

- **Owner**: Alison O’Neill, Named Nurse Safeguarding Children
  Sarah Pulley Senior Safeguarding Nurse Advisor
- **Review**: Safeguarding Steering Group
- **Ratification**: Greg Dix Director of Nursing (Executive lead for Safeguarding)
- **Dissemination (Raising Awareness)**: Safeguarding Steering Group
- **Compliance**: Safeguarding Steering Group

**Links to other policies and procedures**

- PHNT Child Protection Policy
- PHNT Information Sharing Policy

**Version History**

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The Trust is committed to creating a fully inclusive and accessible service. Making equality and diversity an integral part of the business will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available on Trust Documents. Larger text, Braille and Audio versions can be made available upon request.
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Introduction

Children cannot assume responsibility for themselves and are usually dependant on their parents to bring them to hospital appointments. Families that are struggling to manage are the least likely to respond to a request to contact the department to arrange another appointment.

The National Service Framework for Children 2004\(^1\) states that children and young people failing to attend clinic appointments “…may trigger concern, given that they are reliant on their parent or carer to take them to the appointment. Failure to attend may be an indicator of families’ vulnerability, potentially placing the child’s welfare in jeopardy.”

Whilst there may be policies for adults not to be sent repeat appointments, this will rarely be appropriate practice for children.

It is essential that children’s care and treatment is not delayed by repeated re-appointments or continued non-attendance.

Reconceptualising missed appointments as Was Not Brought (WNB) rather than DNA promotes child centred practice, reminding practitioners to think about the child’s vulnerability and their daily lived experiences.

The issue of WNB requires a shift in thinking, which needs to move to positive action in practice. Following a non-attendance at an appointment the clinician and/or administrator will need to investigate why the child was not brought for an appointment and try to facilitate attendance at the next appointment or refer back to referrer to manage the medical problem.

The contact details of the child should be verified with other health agencies or other multi-agency partners or referrer.

A child should only be discharged from a service after non-attendance if it is considered that they no longer require the service, or, if a more acceptable service can be provided elsewhere.

If it is likely that the child’s health may be compromised by non-attendance or if non-attendance may be a pointer to wider concerns about the child’s welfare, including possible neglect, the clinician should be proactive in arranging another appointment and helping to facilitate attendance. Dependent on the level of concern this may mean referring into the child’s social care.

It is essential that the delay in accessing treatment is addressed. This may mean communication with community partners and/or a referral to social care is made to ensure that the family are given support and opportunity to access treatment.

If it is not possible to engage a family, and by non-attendance the family are not meeting the needs of the child, the reasons why should be considered and the medical risk to the child by not being seen or treated should be assessed and acted upon. Dependent on the significance of the medical condition this may mean referring into the child’s social care.

Paediatric patients with safeguarding concerns raised about them for repeated “was not brought” incidences should have alerts placed on the ED (EDIS) and other IT systems following a referral to University Plymouth Hospitals NHS Trust (UHPNT) Safeguarding Children’s Team.

Paediatric patients with safeguarding concerns raised about them for repeated “was not brought” incidences should be registered on the RAPA system to alert UHPNT Safeguarding team and the responsible clinician following an attendance.

Following “Trust Policy” should never be cited as a reason for discharging children from medical care.
This policy sets out guidance for clinicians on what action should be taken when children and young people, up to the age of 18 years, are not brought or do not attend a University Plymouth Hospitals NHS Trust (UHPNT) appointment.

The policy applies to all settings within the Trust which are accessed by children and young people up to their 18th birthday.

There are 4 underlying principles which emerge from the policy

1. In the event of a missed appointment, contact will be attempted with child’s family/carers
2. Early action when a child is not brought for their appointment should ensure a child receives the medical input required in a timely manner.
3. The medical risk of the child not being see or treated should be considered in order to inform the outcome for the child.
4. Multi-agency involvement will be explicitly considered prior to the discharge of any child

All staff are responsible for ensuring that the principles of this policy is followed

### Definitions

- **Safeguarding**: the process of protecting children from abuse, preventing impairment of their health and development, and ensuring that they are growing up in circumstances consistent with the provision of safe and effective care, enabling optimum life chances.
- **Children**: refers to all children and young people up to the age of 18 years.
- **Parent**: a person with parental responsibility for a child.

### Duties

#### 4.1 Trust Board

- Ensure compliance with care quality committee 2009 (Registration) regulations3, 4.
- Ensure compliance with the NSF for Children, Young People and Maternity Services; Standard 51.
- Ensure systems are in place to meet the requirements of; the Children Acts (1989 and 2004)5, 6 and Working Together to Safeguard Children (2018)7.

#### 4.2 Chief Executive

- Introduce and monitor systems to ensure that no child is discharged following non-attendance at an appointment without the approval of the consultant or lead clinician for the child’s care.
- Introduce and monitor systems to ensure that where there are child protection concerns about a child who has not been brought for an appointment or where attendance prompts such concerns that action is taken according to statutory safeguarding guidance.

#### 4.3 Managers

- Disseminate this policy to all staff with responsibility for caring for children.
- Establish systems to implement and monitor the policy.
- Identify and address issues affecting a safe and effective response when children are not brought for a hospital appointment.
- Facilitate staff training.
4.4 All Health Professionals

All health professionals must:

- Be familiar with UPHNT and national policy and guidelines.
- Work in partnership with children and families.
- Take into account individual needs of the child and family.
- Work in partnership with other agencies to plan the ongoing care of children.
- Liaise with the relevant Social Care agency if there are any Child Protection concerns.
- Share information appropriately in accordance with PNHT and National Guidance\(^8,9\).
- Participate in Child Protection and Early Help meetings for the child.
- Follow information governance policies. Maintain clear, concise documentation of any concerns, discussions (including telephone conversations), action plans, risk assessments and decision-making processes in the child’s health record.

4.5 Consultants/lead clinicians

- Provide expert leadership in managing appointments for children.
- Consider the medical risk to the child not being seen or receiving treatment.
- Seek supervision and consultation when uncertain as to the action to be taken in the event of a child not being brought for an appointment.

4.6 Clerical staff

- Check contact details for family are correct if a child is not brought for an outpatient appointment with other health agencies e.g. GP, Health Visitor, School Nurse, mental health services or other multi-agency partners e.g. Social Care or education.
- Follow instructions from a senior clinician to re-appoint or discharge a child after non-attendance.
- Take into account special family circumstances when re-arranging appointments.
- Ensure no child is discharged without the approval of a senior clinician.
- Ensure lead clinician informed if parent/carer reschedules appointment on 2 or more occasions, noting re-schedule date and forward the medical record to lead clinician for review.

4.7 Safeguarding Team

When the clinician informs the safeguarding team they have concerns that a child not being brought to an appointment will significantly affect the child’s health; UHPNT Safeguarding team will:

- Check if the family have involvement with Social care
- Place an alert on the ED IT system (EDIS) and the main hospital electronic system (iPM) following a SALUS referral.
- Ensure that the child is registered on the RAPA system to alert Safeguarding and thus the responsible clinician following an attendance.
Whilst all staff will endeavour to reach a satisfactory outcome, and all reasonable efforts will be made to ensure this happens, it must be recognised that the parent/guardian has ultimate responsibility to attend or to inform UHNT re. address changes.
The same process should be followed when parents fail to respond to booking requests or re-schedule appointments repeatedly. **See flow chart**

Flow chart. Children who are not brought for an appointment/treatment/invited Failed to respond

**CLINICIAN to document and re-appoint as urgent or routine**

It is essential that children’s care and treatment is not delayed by repeated re-appointments or continued non-attendance.

**CLINICIAN**

If there are immediate concerns about the child’s health or welfare:
Follow Child Protection policy and procedures
- refer to Social Care (informing parents of referral if it is safe to do so)
  - Clinician to inform:
    - GP
    - Health Visiting or School Nursing (dependent on age of child)
    - Safeguarding Children Team via electronic SALUS

**CLERICAL STAFF**

- Check child’s details are correct by verifying with other health agencies (e.g. Health Visitor/School Nurse or GP) or multi-agency partners (e.g. Social Care or education) or with the referrer
- URGENT- telephone call to re-appoint and send letter, Example A (Appendix 1)
- ROUTINE-send letter, Example B (Appendix 2)

**CLERICAL STAFF**

Re-appointment declined or family not made contact

**NO**

- Contact referrer
- Ask referrer how they wish referrer to proceed
- If another appointment requested referrer takes responsibility for facilitating attendance
- Consider discharge with a letter to parents and relevant agencies to inform

**YES**

Clinician

Are there any risks to the child by their health needs not being met?

**Yes do not discharge**

Are the risks significant or likely to impact on the child’s health and development?

If there is a pattern of not being brought to other specialities or significant risk from not being brought COMPLETE AN ELECTRONIC SALUS FORM to UHPNT safeguarding team or send a copy of your letter to parents to the safeguarding team.
Consider sending letter to inform parents that if are not able to bring their child you may need to inform social care (see example letter Appendix 3 or 4)

**Yes**

Safeguarding team

- Contact community nurse practitioner (Health Visitor or School Nurse) as appropriate
- Check if child is known to social care and if needed inform the allocated Social Worker
- Ensure alert of hospital systems (EDIS iPM) to say child is missing appointments
- RAPA alert to be placed on the child’s record so that practitioners are alerted if the child attends

**CLERICAL STAFF**

Send appointment if indicated -urgent or routine Example C (Appendix 3)
We are sorry that you were unable to bring your child for his/her recent outpatient appointment. We are unable to find any record of you advising our team that you were unable to attend. We do hope that you received the appointment and have now checked to make sure that your contact details are correct.

Your doctor has asked that your child be reappointed urgently and you will be sent a letter asking you to make an appointment as soon as possible. We would be grateful if you could let us know as soon as possible if you are unable to bring xxxxx to this appointment.

Yours sincerely

Title

Copy: GP

Medical Records

Referrer

Health Visitor or School Nurse
Derriford Hospital
PLYMOUTH
PL6 8DH

Tel: 01752 xxxxxx  Direct Line: 01752 xxxxx
Fax: 01752 xxxxx
e-mail: xxxxxxxxxxxxxxxx@nhs.net

PRIVATE AND CONFIDENTIAL
ADDRESS

Re:   NAME DOB: xxxx   New NHS Number: xxxxxxxxxx

We are sorry that you were unable to bring your child for his/her recent outpatient appointment.

We are unable to find any record of you advising our team that you were unable to attend. We do hope that you received the appointment and have now checked to make sure that your contact details are correct.

It is very important that we review your child’s health and we would be grateful if you could book another appointment as soon as possible. If, you do not think that your child requires another appointment please let us know about this and with the agreement of the medical team your child’s name will be removed from the outpatient list and your child’s GP informed.

Yours sincerely

Title
Copy: GP

Medical Records
Referrer  Health Visitor or School Nurse
Our Ref: xx/xxxx/
Date Typed: xxxxxxxxxxxx

PRIVATE AND CONFIDENTIAL
ADDRESS

Re: NAME DOB: xxxx New NHS Number: xxxxxxxxx

We are sorry that you were unable to bring your child for his/her last outpatient appointment. The hospital doctor responsible for their care has now reviewed his/her records and considers that it is important that they have another appointment to be seen in his/her clinic. Please confirm this appointment as a matter of urgency.

It is very important that you bring your child to this appointment so that he/she can receive the appropriate medical care required. If you are not able to attend and do not contact us Trust policy requires us to ensure that your child’s medical needs are met. To ensure you receive any help needed in meeting your child’s needs a referral to Children’s Social Care and your community health worker (Health Visitor or School Nurse) would be made as part of this process.

Yours sincerely

Title

Copy: GP
Medical Records
Referrer
Health Visitor or School Nurse
Re: NAME DOB: xxxx New NHS Number: xxxxxxxxx

We are sorry that you were unable to bring them for his/her last 2 outpatient appointments. The hospital doctor responsible for their care has now reviewed his/her records and considers that it is important that they have another appointment to be seen in his/her clinic. I am therefore sending an appointment for xxxxxxx

It is very important that you bring your child to this appointment so that he/she can receive the appropriate medical care required. If you would like to reschedule this appointment, please call to rearrange between the hours of 9am -5pm 439819,439820,439821,439822

If you are not able to attend and do not contact us Trust policy requires us to ensure that your child’s medical needs are met. To ensure you receive any help needed in meeting your child’s needs a referral to Children’s Social Care and your community health worker (Health Visitor or School Nurse) would be made as part of this process.

Yours sincerely
Title
Copy: GP

Medical Records
Referrer
Health Visitor or School Nurse
UPHNT Safeguarding team
1. **Referrals to Social care**

All referrals to social care must be copied to the safeguarding team [ph-tr.safeguarding@nhs.net](mailto:ph-tr.safeguarding@nhs.net)

All information re referral to the Local Authority is on the Safeguarding page of the intranet including online referral forms.

**CHILDREN:**
- **Plymouth** are often happy for a verbal referral but this must be followed up within 48 hours in writing so that they have written confirmation and we have evidence.

  During office hours phone: Plymouth 308600  Out of hours contact: 01752 346984

- **Cornwall** need a written referral using the correct template (see below). Urgent referrals must be followed up in writing within 48 hours using the same template. Cornwall have requested non-urgent telephone calls are not made as they have a sleeping on-call service. Non-urgent referrals must be made in writing using the recognised Cornwall referral form (See below).

  During office hours phone: Cornwall 03001231116  Out of hours contact: 01208 251300

  cornwall-inter-agency-referral-form 2016.docx

- **Devon** may accept verbal referrals via telephone however must have a written referral using the correct template within 48 hours (see below).

  During office hours phone: Devon 0345 155 1071  Out of hours: 01392 384050

  Devon MASH Enquiry Form 230617.docx

2. **Referrals to the children's safeguarding team including midwifery safeguarding.**

Please refer any safeguarding out of hours concerns to UHPNT safeguarding team using SALUS. See attached for referral process. This is an internal referral system and not to replace a children’s social care referral.

1 - Installing SALUS.pdf  2 - Sending alert.pdf

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**Midwifery**

TRW.SAF.POL.573.6 Did Not Attend (Was Not Brought) Policy for Children and Young People – including planned surgery/investigations
1. Principles

All women who fail to attend for appointments within Maternity Services should be ‘followed up’ and seen to ensure safe continuance of care. To achieve this, good communication between the hospital and community service is essential.

The responsibility of staff groups for the follow up of non-attendees is dependent upon the circumstances. The clinician / midwife with whom the appointment is arranged must initiate follow-up procedures - **See Appendix 1.**

**NB.** In the event of a non-attendance, it is always advisable to check with the GP, clinical iSoft or Viewpoint ultrasound report to see if the woman is still pregnant.

If the patient has experienced a pregnancy loss then cancel further appointments and the Community Midwife to inform GP and Health Visitors if appropriate.

2. Pathway for women who have not attended (DNA) on first occasion

2.1 Pathway A

Women with **known complex social issues or** classified as **vulnerable**

**In Community**

- The caseload holder will contact reception to check if non-attendee is an in-patient.
- Midwife who identifies non-attendee must liaise with the caseload holder of that patient.
- If she is not an in-patient, the caseload holder will contact patient at home by phone or in person, re: further appointment.
- Check with GP surgery to determine whether moved house or out of area eg. Service personnel and migratory worker and ensure contact details are correct.
- Take not of any communication barriers.
- Consider Safeguarding issues.
- Complete Non attendance form (See Appendix 2) and file in patients main hospital notes.

**Consultant Clinic**

- Check with GP surgery to see if moved house or out of area eg. Service personnel and migratory worker and contact details are current.
- Contact patient by phone.
- Inform case holder of non attendance.
- Take note of any communication barriers.
- Inform G.P.
- Consider safeguarding issues. Consider whether an ALERT is required.
- Complete Non Attendance form and file in the patients main hospital notes.

**If ABLE to contact woman:**

- Discuss reason for Non attendance
- Arrange new appointment/visit.

**If UNABLE to contact woman:**

- Community Midwife is requested to visit at last known home address to try to make contact face to face.
- Send appointment in the post in unable to access patient.
- Inform safeguarding Midwives and consider gestation and urgency of care.
- Inform the GP
- Community Midwife to continue to visit /phone to try to access patient.
- Ensure all actions taken documented and filed in main notes.
2.2 Pathway B

Women with NO known issues

- Check with GP surgery to see if moved house or out of area eg.Service personnel and migratory worker and contact details are current.
- The caseload holder will contact reception to check if non-attendee is an in-patient.
- Send repeat appointment if appropriate
- If community midwife patient then case loader to be informed and to contact patient at home
- Complete Non Attendance form and file in the patient's main hospital notes.

3. Women that DNA on second or consecutive occasions.

If a patient does not attend the rearranged appointment, then

- Repeat/ follow Pathway A.
- Ensure that Community Midwives/GP informed
- Repeat DNA forms.
- Ensure Consultant who patient has been referred to is made aware. They will dictate letters to GP/MW regarding urgency of care together with plan of care if appropriate.
- Ask clinic Doctor to dictate letter to GP / CMW (Consultant if available)

NB. The Woman MUST be seen, where at all possible, as part of the follow up process.

4. Routine 'Booking' Appointments

- Check patient details and notes
- to check with the GP, clinical iSoft or Viewpoint ultrasound report to see if the woman is still pregnant.
- Give further appointment for ONE week or as required

5. Early Pregnancy Unit

- Contact patient’s GP. Will need re referral
- Contact source of referral if GP is not the source
- Contact patient if appropriate - i.e. repeat Notification form or βHCG

6. Day Assessment Ward

- Contact patient directly, as appropriate. Rearrange appointment if appropriate
- Contact CMW/GP when patient contact is not possible
- If women decline to attend and then document on DNA form, inform community midwife and GP(if appropriate)

In all situations, a record of follow-up process and communication between appropriate staff should be maintained and recorded to ensure patient is eventually seen. Accurate, contemporaneous record keeping is essential to ensure that the ‘follow up’ process is effective.

7. Record keeping and documentation

Ensure accurate and contemporaneous documentation of response to non-attendance. All Non Attendance forms and actions must be filed consecutively in Main notes.

It is expected that every episode of care be recorded clearly, in chronological order and as contemporaneously as possible by all healthcare professionals as per Hospital Trust Policy. This is in keeping with standards set by professional colleges, i.e. NMC and RCOG.

All entries must have the date and time together with signature and printed name.

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DNA Community Midwife/ Consultant Clinic

Confirm whether still pregnant via Clinical soft, viewpoint (USS) or GP surgery

NO

Women with known Complex/ Social /Vulnerable issues

YES

Women with No known Complex issues

1. Cancel further appointments
2. Inform GP and HV if appropriate (CMW)

Non Attendance forms to be completed and filed in Patients Main Notes on each occasion.

DNA Community Midwife/ Consultant Clinic

Confirm whether still pregnant via Clinical soft, viewpoint (USS) or GP surgery

NO

Women with known Complex/ Social /Vulnerable issues

YES

Women with No known Complex issues

1. Cancel further appointments
2. Inform GP and HV if appropriate (CMW)

Non Attendance forms to be completed and filed in Patients Main Notes on each occasion.

6 Overall Responsibility for the document

TRW.SAF.POL.573.6 Did Not Attend (Was Not Brought) Policy for Children and Young People – including planned surgery/investigations
7 Consultation and ratification

Child Protection Committee
Safeguarding Steering Group

8 Dissemination and Implementation

Following authorisation by the PNHT Safeguarding Steering Group the Policy will be available electronically within the Safeguarding folder which can be found within the Public folder on the PHNT intranet. The policy will be brought to the attention of all service line leads, service line Managers and Matrons for immediate implementation.

It is the responsibility of all clinical leads and managers to ensure that the staff in their area are aware of the policy and adhere to it.

9 Monitoring compliance and effectiveness

An audit will be undertaken six months after implementation of the policy and annually thereafter, to ensure compliance.

All children who fail to attend 3 consecutive will be referred to the Safeguarding Team for review of records

10 References and associated documentation


3 Care Quality Committee (Registration) Regulations 2009

4 Care Quality Commission Guidance about Compliance with Essential Standards of Quality and Safety, 2010.


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Dissemination Plan

Appendix 8

TRW.SAF.POL.573.6 Did Not Attend (Was Not Brought) Policy for Children and Young People – including planned surgery/investigations
## Review and Approval Checklist

### Review

TRW.SAF.POL.573.6 Did Not Attend (Was Not Brought) Policy for Children and Young People – including planned surgery/investigations
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<td>Is it clear whether the document is a policy, procedure, protocol, framework, APN or SOP?</td>
<td>Y</td>
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<td></td>
<td>Does the style &amp; format comply?</td>
<td>Y</td>
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<tr>
<td><strong>Rationale</strong></td>
<td>Are reasons for development of the document stated?</td>
<td>Y</td>
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<tr>
<td><strong>Development Process</strong></td>
<td>Is the method described in brief?</td>
<td>Y</td>
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<td></td>
<td>Are people involved in the development identified?</td>
<td>Y</td>
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<td></td>
<td>Has a reasonable attempt has been made to ensure relevant expertise has been used?</td>
<td>Y</td>
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<td></td>
<td>Is there evidence of consultation with stakeholders and users?</td>
<td>Y</td>
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<tr>
<td><strong>Content</strong></td>
<td>Is the objective of the document clear?</td>
<td>Y</td>
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<td></td>
<td>Is the target population clear and unambiguous?</td>
<td>Y</td>
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<td>Are the intended outcomes described?</td>
<td>Y</td>
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<td>Are the statements clear and unambiguous?</td>
<td>Y</td>
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<tr>
<td><strong>Evidence Base</strong></td>
<td>Is the type of evidence to support the document identified explicitly?</td>
<td>Y</td>
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<td>Are key references cited and in full?</td>
<td>Y</td>
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<td>Are supporting documents referenced?</td>
<td>Y</td>
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<tr>
<td><strong>Approval</strong></td>
<td>Does the document identify which committee/group will review it?</td>
<td>Y</td>
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<td>If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?</td>
<td>N</td>
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<td>Does the document identify which Executive Director will ratify it?</td>
<td>Y</td>
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<tr>
<td><strong>Dissemination &amp; Implementation</strong></td>
<td>Is there an outline/plan to identify how this will be done?</td>
<td>Y</td>
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<td>Does the plan include the necessary training/support to ensure compliance?</td>
<td>N</td>
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<tr>
<td><strong>Document Control</strong></td>
<td>Does the document identify where it will be held?</td>
<td>N</td>
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<td>Have archiving arrangements for superseded documents been addressed?</td>
<td>NA</td>
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<tr>
<td><strong>Monitoring Compliance &amp; Effectiveness</strong></td>
<td>Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?</td>
<td>Y</td>
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<td>Is there a plan to review or audit compliance with the document?</td>
<td>Y</td>
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<tr>
<td><strong>Review Date</strong></td>
<td>Is the review date identified?</td>
<td>Y</td>
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<td>Is the frequency of review identified? If so is it acceptable?</td>
<td>Y</td>
</tr>
<tr>
<td><strong>Overall Responsibility</strong></td>
<td>Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?</td>
<td>Y</td>
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</tbody>
</table>
DNA Policy for Children and Young People who are not brought for a hospital appointment

What are the aims, objectives & projected outcomes?

- Any charts in this document are available, and may be photocopied as necessary.
- This policy sets out guidance for clinicians on what action should be taken when children and young people, up to the age of 18 years, are not brought or do not attend a Plymouth Hospitals NHS Trust appointment.
- The policy applies to all outpatient, day-care and assessment clinical settings within the Trust which are accessed by children and young people up to their 18th birthday.
- When considering what action should be taken when a child is not brought for a planned hospital appointment, the safety and welfare of the child should be of paramount concern. Action should be taken to ensure a child is not disadvantaged by non-attendance and staff should be aware that non-attendance may be a pointer to wider concerns about the child’s welfare including possible ‘neglect’. Trust Policy should never be cited a reason to discharge children from secondary care.

Scope of the assessment

This is the initial EIA conducted for the Child Protection Committee.

All protected characteristics have been considered when designing the policy.

The policy will be adapted if necessary to address any future gaps or needs on equality and human rights issues.

Collecting data
| **Race** | Reasons for this category having an impact are:  
- Language, interpreter and translation services should be provided as required and information given in an appropriate format  
- Understanding of NHS (UK health system) and implications of children not attending appointment  
- Transient population (for some), ensuring up to date records of address and contact details  
Cultural issues that may arise are identified at an early stage and are fully documented in the child’s records. |
| **Religion** | Religious issues that may arise are identified at an early stage and are fully documented in the child’s records  
Individual needs that may arise as a result of religion are taken into account when planning appointments and care |
| **Disability** | Individual needs of the child and family arising from any disability are identified at an early stage, documented and taken into account when planning appointments and care. |
| **Sex** | There is no evidence to suggest an impact relating to sex however this will be monitored through the audit process and incident reporting system. |
| **Gender Identity** | Currently data is not collected to monitor impact on this group however this will be monitored via feedback from patients and staff. |
| **Sexual Orientation** | There is no evidence to suggest an impact relating to sexual orientation however this will be monitored through the audit process and incident reporting system. |
| **Age** | The policy is specifically targeted at children and young people under the age of 18. |
| **Socio-Economic** | In the 2006 pilot study; ‘A Confidential Enquiry into Maternal and Child’s Health; Why Children Die’², there were several cases reviewed where failure to follow up children who did not attend their appointments was associated with later death.  
Families that are struggling are the least likely to respond to a request to contact the department to arrange another appointment. Following “Trust Policy” should never be cited as a reason for discharging children from medical care. If it is not possible to engage a family, and by non-attendance the family are not meeting the needs of the child, safeguarding procedures should be instigated |
| **Human Rights** | No adverse impact on human rights has been identified. We will continue to monitor this. |
### What are the overall trends/patterns in the above data?

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<table>
<thead>
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<tbody>
<tr>
<td>Families that are struggling are the least likely to respond to a request to contact the department to arrange another appointment.</td>
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<tr>
<td>Families with a number of vulnerability factors are more likely to fail to attend appointments.</td>
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<tr>
<td>There is scope to adapt this policy based on future trends.</td>
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### Specific issues and data gaps that may need to be addressed through consultation or further research

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<tr>
<td>Compliance to new flowchart and process will require monitoring by audit.</td>
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### Involving and consulting stakeholders

#### Internal involvement and consultation

<p>| |</p>
<table>
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<tbody>
<tr>
<td>There has been engagement internally around the “Management of WNB’ and this includes.</td>
</tr>
<tr>
<td>➢ Child protection Committee.</td>
</tr>
<tr>
<td>➢ Safeguarding Steering Group.</td>
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<tr>
<td>➢ Staff Engagement.</td>
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</table>

#### External involvement and consultation

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<tbody>
<tr>
<td>Consultations with the following.</td>
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<tr>
<td>➢ NHS Plymouth 0-19 service.</td>
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</table>

### Impact Assessment

#### Overall assessment and analysis of the evidence

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<table>
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<tbody>
<tr>
<td>The policy recognises the need to consider the specific needs of the child and family when planning appointments and care.</td>
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</table>

### Action Plan

<table>
<thead>
<tr>
<th>Action</th>
<th>Owner</th>
<th>Risks</th>
<th>Completion Date</th>
<th>Progress update</th>
</tr>
</thead>
<tbody>
<tr>
<td>The planned regular audit, and data from Datix will be used to monitor any possible impacts on the protected group.</td>
<td>Alison O’Neill</td>
<td></td>
<td>23/01/2017</td>
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</tbody>
</table>
Appendix 1 (Source JSNA 2009)

Race

There is relatively little ethnic diversity in Plymouth. According to the 2001 census 98% of the population is of White British origin which is more than seven percentage points higher than the national average. The last Census recorded the ‘black minority ethnic’ (BME) population at 2.9% and this is believed to have grown to around 6% by mid 2006 (ONS mid-year estimate, 2008), particularly from the Accession Eight countries.

The largest ethnic minority group in Plymouth is the Chinese (just over 1,800 people), although they each account for less than half of one percent of the population. The city's Asian and Black communities are very small, with each making up less than 0.2% of the total population. Schools are required to report ethnicity of children in the City. Based on the 2009 School Census data, there are 36,621 children and young people in schools. Of these, 32,194 (87.9%) are classified as White British, and 2,400 (6.6%) as other ethnic groups. Details for a further 2,027 (5.5%) children and young people are not available.

In 2007/08 a total of 2,270 national insurance numbers were issued to foreign nationals in Plymouth. This was a rise of just 10 compared to 2006/07. Plymouth has been a dispersal area for asylum seekers since 2000 and has about 427 Asylum Seekers supported by the UK Borders Agency in the city at any given time including unaccompanied asylum seeking children. The changes depicted in the diagram above are projected to continue to 2015 but the overall impact on the city remains small.

Religion or belief or no belief

The 2001 Census of Population suggests that Christianity is the most common religion in Plymouth (73.56%), followed by 'no Religion' (18.27%), Muslim (0.37%) and 'any other religion (0.29%).

Disability

People with severe mental health problems generally die younger than other people and generally have a poorer quality of life. Some national studies have shown that on average they can die 25 years earlier than other people. Approximately 11,000 Plymouth residents are estimated to be affected by some form of mental health condition. Modelled estimates suggest that 3,559 residents aged 65+ years are likely to be suffering from depression, with 1,119 suffering from severe depression in 2009. A total of 2,957 residents aged 65+ years are estimated to be suffering from dementia in 2009 (PoPPi 2008).

The number of residents in receipt of mental health services indicates that the prevalence of related medical conditions is likely to be higher than that nationally. The number of adults in receipt of incapacity welfare benefits for mental illness in 2007/08 was higher in Plymouth (40.7%) than the average for England (27.7%), a total of 6,450 adults (APHO and Department of Health, 2009).
The evidence based has identified learning disabilities users are subject to increased inequalities in Plymouth. There are three factors likely to lead to this increased prevalence; increased survival rates of young people with severe and complex disabilities, reduced mortality rates amongst adults with learning disabilities and an increase of more severe learning disabilities in some ethnic groups.

Analysis undertaken for last year's JSNA suggests that people with learning disabilities have an increased risk of early death. They are more likely to die before 50 and the life expectancy is shortest for those with the greatest support needs. Respiratory disease is the leading cause of death and they are 3 times more likely to die of respiratory illness then the general population. They also experience more heart disease, bowel cancer and stomach disorders. 22% have epilepsy and dementia is four times more common.

**Gender**

Men, have higher rates of suicide and addictions. National studies suggest that women are more likely to experience mental health problems such as depression and anxiety – around 20% of women at any one time compared with about 12.5% of men. Men, have higher rates of suicide and addictions

**Sexual orientation**

Estimates of Lesbian, Gay, Bisexual and Transsexual (LGBT) people in Plymouth are between 17,500 and 30,000. It is possible that that as our population ages the need for services from these sections of the community will also grow especially for those who will have requirements given their civil partnership status.

**Age**

Overall, the demographic structure of the city is similar to that of England as a whole but the population of the city is thought to be slowly ageing with the GP register recording a 2 to 3% drop in the under 19 age group and a slight increase in the 65+ group and the 75+ groups to 2008. There is however a marked difference in the 20 – 24 years age group compared with England. This may in part be linked to expansion of the University Campus from 2000 to 2008 and the influx of economic migrants of this age during the period 2005 to 2008, or to a surge in births circa 1985 to 1989.