

Was Not Brought/ Did Not Attend

Management of non-attendance of health care appointments in CAMHS and SCYPS

Version number :	5.0
Consultation Groups	Safeguarding Committee, CAMHS and CYP&SRH Governance Group
Approved by (Sponsor Group)	Safeguarding Committee, CAMHS and CYP&SRH Governance Group
Ratified by:	Quality Committee
Date ratified:	22 nd September 2021
Name and Job Title of author:	Percy Aggett, Ruma Bose, Sarah Gibbs, Dermot Ryall, Ian McKay. Updated by Graeme Lamb, Sarah Rolfe, Dermot Ryall, Lawford Clough, Ian McKay and with comments from Reagender Kang (Newham CCG) Reviewed 2021 by Cathy Lavelle, Julie Proctor, Jo Beckmann.
Executive Director lead :	Sarah Wilson, Director of Specialist Services
Implementation Date :	September 2021
Last Review Date	September 2021
Next Review date:	September 2024

Services	Applicable to
Trustwide	√
Mental Health and LD	
Community Health Services	

Version Control Summary

Version	Date	Author	Status	Comment
1	June 2012	PA, RB, SG, DR, IMcK	Agreed by CAMHS and CYPS	Replaces single directorate 'Patient DNA Policy'
2	Nov 2015	Percy Aggett Graeme Lamb	Agreed by CAMHS and CYPS	Update on V1
3	Nov 2017	As above and with additional comments from Lawford Clough, Sarah Rolfe and Reagender Kang (Newham CCG)	Agreed by CAMHS, CYPS and Safeguarding Committee	Replaces DNA policy
4	April 2018	As above with additional comments from Graeme Lamb		Replaces DNA policy and V3
5.	June 2021	As above with amendments by Cathy Lavelle, Julie Proctor, Jo Beckmann and Tim Bull	Agreed by CAMHS & SCYPS-	Replaces WNB/DNA Policy

Contents

Paragraph		Page
	Summary	5
1	Introduction	5
2	Rationale and purpose	6
3	New referrals and barriers to engagement	6
4	Re-referrals	7
5	Service users who fail to attend	8
6	Auditing the standards	9
Appendix	CHN pathway	10

Summary

This policy contains guidance for procedures to be followed should a child, young person and/ or family fail to attend/ was not brought (WNB) to an appointment, or there is a no access health visit.

A child or young person is anyone who has not yet reached their 18th birthday. The fact that a child who has reached 16 years of age or may be competent to make decisions about their own healthcare (often referred to as 'Gillick competency') does not change this status.

Failure to attend / was not brought to an appointment by a parent/carer of a child/young person or service user (young person) should always be documented in the electronic record progress notes.

The staff member has an individual professional responsibility to respond to failure to attend/ was not brought to an appointment, as well as a duty to safeguard children by recognising potential indicators of abuse and taking appropriate action. The response will be in a manner based on an assessment of the child/young person's clinical risk and need status.

It is not acceptable to discharge a child/ young person from a service for non-attendance without a reassessment or liaison with the original referrer (or GP) being undertaken.

Various options may be considered with regards to the next step should a child/young person fail to attend/ was not brought to an appointment. These are detailed within the main body of the policy.

Evidence from serious case reviews, including recent reviews which ELFT have contributed to, demonstrate a link suggests that missed healthcare appointments are an indicator of possible neglect and can be early indicators of wider safeguarding concerns. Early intervention and prevention is the key to safeguarding children.

Key lessons from these reviews are that staff members need to be more curious about the reasons why a child is not being brought and to look for patterns of incidence. They should thoroughly explore potential options for support and have clear mechanisms for recording events in order to identify themes, patterns and trends. A question each staff member should ask when a child is not brought to an appointment or there is a no access visit is 'why were they not brought?'

The United Nations Convention on the Rights of the Child states that "Children have the right to good quality health care" (Article 24).

1. Introduction

1.1. This policy applies to all referrals to Newham Specialist Children & Young People's Services (SCYPS), Looked after children, the adult component of the Sickie Cell and Thalassaemia Service and to all ELFT Child and Adolescent Mental Health Services and all staff working within these services. 'Was Not Brought' (WNB) applies to all children accessing services who are of an age where they require parental/carer assistance to attend appointments. Young adults and adults who are capable of arranging and attending appointments without parental/carer input are referred to as 'Did Not Attend'

(DNA).

1.2. The policy should be read in conjunction with the Trust Safeguarding Children Policy. Repeated and/or persistent DNA or WNB can be an indicator of safeguarding issues and, consequently, it is imperative that there is a responsive system for notification of DNAs or WNBs back to referrers and GPs.

1.3. The policy acknowledges that although it is the responsibility of the parents/carers to bring children/young people to their appointments, some parents/carers may not have the capacity to do so, or may have other vulnerabilities requiring further support and not bringing children to their appointments may be an indicator of a child/young person's vulnerability and put the child/young person's welfare at risk.

1.4. The remit of Newham SCYPS is to provide specialist and targeted health services to families with children aged under 5 years and to children of school age up to 18 years (or up to 19 years of age for those at JFK School or with life-limiting conditions).

1.5. The CAMH Service remit is to engage, assess and treat children and young people up to 18 years old with severe, complex and persistent mental health problems. The reasons for service user non-attendance or disengagement are complex.

1.6. Service users are often embedded in complex multiple pressures and demands, including poverty, discrimination, social exclusion, and multiple personal burdens. These complex processes implicate service managers and clinicians in modelling services from the outset which are relevant, user-friendly, engaging, respectful, and acknowledge the subtle power of exclusion and discrimination.

1.7. From first contact, services should be sensitive to issues of language and stigma.

2. Rationale and purpose

2.1 CAMHs and Newham SCYPS each have in place a service specification or service level agreement in line with the Trusts contractual arrangements and responsibilities related to ensure effective service delivery. Managing DNAs or WNBs effectively and safely is part of this delivery.

2.2 Was Not Brought to appointments must be monitored and actioned as these can be indicators of abuse/neglect. The following documents should be read in conjunction with this policy to understand the context of WNB;

- http://www.cqc.org.uk/sites/default/files/20160707_not_seen_not_heard_report.pdf
- Children and young peoples missed health care appointments: reconceptualising 'Did Not Attend' to 'Was Not Brought' – a review of the evidence for practice, Powell & Appleton, Journal of Research in Nursing, 17:2,193-194, 2012

3. New referrals and barriers to engagement

3.1. There are a number of barriers of which teams should be aware which may impact on a family's engagement with a service. These might include:

- Lateral referrals; where a referral has been made by a peripheral worker, **not** the community key-worker, or where a referral has not been fully understood by a service user, family or care giver
- The referrer has not adequately explained the reason for the referral to the family
- Disability; where for example the parent/ carer or child has mobility problems
- Access issues; including literacy and language, ESOL, cognitive impairment or injury, or other communication needs
- Lifestyle related issues (e.g. substance misuse, alcohol dependency etc.) which make service access harder to achieve
- Low health literacy and or cultural issues affecting take up of service offer (including cultural norms for mediating health service access, relative unfamiliarity with health care systems in the UK, familiar access to healthcare patterns e.g. A&E rather than primary care)
- Multiple and sometimes conflicting demands upon the family or care giver to attend
- Errors in address, telephone number or email contacts
- Location and timing of the appointment
- Poor previous experience of healthcare provision
- Fear of stigma resulting from or tangential to the condition being addressed by the referral
- Is the young person vulnerable? – Are there known risk factors such as domestic abuse, maternal/paternal mental health problems, parental learning difficulties, substance misuse, disability in the family or neglect issues which may or may not be deliberate? Is the child subject to a child protection or a child in need plan?

3.2. Team managers and clinicians need to be aware of potential barriers to engagement and should take these into consideration when arranging appointments.

3.3. Waiting times should be monitored via appropriate systems; there should be clear and timed care pathways for new referrals. Information regarding waiting times should be communicated regularly to service users and referrers (see Community Health Newham *Referral Handling Procedure*).

3.4. First contact letters to new service users must contain clear information about the nature of the service offered, be unambiguous and be available in translations appropriate to local communities.

3.5. Service users should always be invited to phone for clarification, and relevant phone numbers be made available on all contact letters. Service user mobile phone numbers and addresses should be sought and recorded/updated on data systems at the earliest opportunity.

3.6. Staff are to take into account the wider family context and possible pressures on the family unit for the child/young person and their parents/carers so that reasonable assistance can be given to help parents/carers present children and young people for scheduled health care appointments.

3.7. If it is clear from the referral that engagement problems might ensue, these should be taken into consideration and addressed proactively. For instance, such service users should be telephoned ahead of any planned appointment to enhance engagement and improve attendance. Language interpreters should be used for those parents/carers/young people who require language support with telephone communications

3.8. The use of reminder systems (e.g. text) should be put in place.

3.9. The decision to discharge should only be arrived at (having considered risk and complexity) and after having written to the family or young person and referrer allowing them two weeks to respond. In the case of Sickle Cell and Thalassaemia Services the local operational policy, which accords with the national guidelines, for carrier patients will apply.

3.10. The *DNA/WNB Flowchart* (Appendix 1) identifies the appropriate pathway to take, the healthcare professional having assessed the degree of risk associated with the child/young person having failed to attend/not been brought to one or more appointments.

4. Re-referrals

4.1. For re-referrals where there has been a history of disengagement, a number of judgements need to be taken by clinicians assessing fresh referrals as disguised compliance. Disengagement from a service/treatment programme may be indicative of complex family needs and can be a potential indicator of abuse or neglect.

4.2. The first question is whether or not the service user is high risk, in which case an assertive outreach approach may be necessary. If so, then clinicians should look at all available means to engage the service user. These might include home visits, telephoning, and arranging network meetings. For example, for children under 5 years old, staff could contact the Health Visiting team to ask for assistance contacting families.

4.3. Team leaders should be aware of unconscious processes in which teams inappropriately close off contact because some high risk service users are deemed difficult or non-motivated. In these circumstances good reasons should be given for closure once all appropriate efforts to engage have been taken. Team leaders should be aware of the team acculturation research into such unconscious processes, and the effects on professional systems.

5. Parents/Carers who fail to bring their children to appointments or Young people who fail to attend.

5.1. If a parent/carer does not bring their child to an appointment at the expected time, or if a young person does not attend the immediate safety of the child / young person needs to be considered.

5.2. It is good practice to telephone the parent/carer or young person during the appointment period in order to ascertain reasons for non-attendance and to enhance future engagement. If there are any reasons to suspect the child is at risk of immediate harm, the police should be called immediately and a referral made to children's social

care. Such activity should be recorded accordingly on RIO. The outcome of the appointment should still be noted as a non-attendance.

5.3. The clinician making the telephone call should exercise professional curiosity when discussing the reasons for non-attendance. All explanations provided should not be accepted at face value or viewed in isolation, but viewed in the context of the child / young persons history including previous missed appointments and any social and health vulnerabilities. It is expected that the records would be reviewed for all previous appointment attendance.

5.4. Failure to attend an appointment and, if known, the reason for the non-attendance should always be documented on RiO. If possible, it should also be recorded on the child's Personal Child Health Record. The staff member has an individual professional responsibility to respond to failure to attend an appointment in a manner based on an assessment of the service user's risk and their identified needs. Cases considered to be at some risk (e.g. Red / Amber RAG cases in CAMHS, or with child protection / child in need /LAC alerts on RiO) should be discussed in MDT meetings or with an appropriate supervisor/ manager/Service Lead/clinician

5.5. Failure of a parent/carer to bring their child or a ~~an older~~ young person to attend an initial appointment should always be communicated to the referrer, the GP and the health visitor/ school nurse/social worker if applicable. The services should liaise with these teams and request support from universal services to follow up children that are not brought to scheduled appointments.

5.6. Failure to attend/ Was Not Brought of a child/young person who is subject to Child Protection Plan / Child In Need Plan or LAC care plans must be brought to the attention of the child/young person's GP, Clinical Team and designated social worker for support in maintaining contact and attendance. Ideally the member of staff would update the social worker or the social worker's team via a telephone discussion. If an e-mail is sent to any professional advising of a missed appointment, the member of staff must ensure that a generic team e-mail is included in the recipient list to mitigate the risk that the named recipient is absent for any reason.

5.7. If it is identified that the parent / carer may require further support to attend appointments, then a referral to Early Help Services should be discussed with the family and made with their consent. If it is thought the child / young person meets the threshold for a child in need or is at risk of significant harm then a social care referral should be made. Thresholds to help identify the level of risk and support required, as well as information on how to make a referral, can be found within the various local authority threshold / assessment of need documents which can be accessed below:

Newham:

<https://www.newhamscp.org.uk/wp-content/uploads/2020/02/Pathways-to-help-and-support-2020-21.pdf>

Hackney:

<https://drive.google.com/file/d/1pytfoeKcCX-ijhp0ojkv3TsjdpnwYDiP/view>

City of London

<https://www.cityoflondon.gov.uk/assets/Services-DCCS/the-city-of-london-corporation-thresholds-of-need.pdf>

Tower Hamlets:

<http://www.childrenandfamiliestrust.co.uk/wp-content/uploads/2010/09/TH-Multi-agency-Threshold-Guidance-FINAL-GDPR-changes.pdf>

Bedford Borough:

https://bbcdevwebfiles.blob.core.windows.net/webfiles/Files/FINAL_Thresholds_document_August_2015.pdf

Central Bedfordshire:

<https://www.centralbedfordshirelscb.org.uk/lscb-website/professionals/the-importance-of-thresholds>

Luton:

<http://lutonlscb.org.uk/wp-content/uploads/2016/11/threshold-framework-v16-Oct-17-2.pdf>

5.8. Staff members must also be alert in identifying children for whom appointments are repeatedly cancelled as this could result in the child not receiving treatment and may constitute neglect. In these cases, the referrer, GP and health visitor/ school nurse/social worker if applicable should be informed of the cancellations in order to request support for maintaining contact and attendance of appointments.

5.9. A coordinated response needs to be taken in cases such as these as it is often indicative of further missed appointments across the health landscape, and as such should be discussed with the safeguarding lead in the department, a senior member of staff or the member of the Trust safeguarding team for advice on further action. Such action may involve organising a professionals meeting including all professionals within the health network to gather information about any other missed appointments. It may necessary to involve a wider professional network at this stage including schools and social workers depending on the individual circumstances.

5.10. It is for the individual staff member to make a professional judgement based on available information to decide how to respond to non-attended scheduled appointments. Options include; writing to the service user asking them to contact the service to request a further appointment, offering a further appointment in writing or by telephone; involvement of the referrer or other appropriate professional; and discharge from care. Repeated offers of appointments which are not attended (e.g. after a maximum of two consecutive DNA/ WNBs) are not considered good practice and should be avoided. When communicating with service users about non-attendance, where appropriate, two weeks should be given as an opportunity to reply.

5.11. It is expected that, in managing responses to WNB/ DNA appointments, the professional will take every reasonable step to effectively communicate with the family and other professionals involved to ensure a satisfactory outcome for the child/ young person.

5.12. The appropriate action to be taken may be specified within the care plan or as a result of discussion with the supervisor or clinical lead.

5.13. In accordance with the Trust policy, discharge from care should only occur after careful consideration and in the context of safeguarding or child protection concerns. In all cases the GP and referrer must be informed of decision to close the case.

5.14. All decisions to close a case should be entered into the case notes or

recorded on RiO; administration must also be informed to ensure closure on RiO.

5.15. The GP, referrer and patient should be informed of the decision to close in writing, with a plan for future engagement of the service user as appropriate. As a matter of good practice, correspondence should be copied to other professionals involved in the service user's care, if consent to do so has been given. Such letters should be completed and sent out within two weeks of the decision to close the case.

5.16. Where a decision has been made to close a case, administrative closure should be completed as soon as possible, but within a maximum period of 2 weeks.

6. Auditing the standards

6.1. Compliance with the standards of the policy will be audited annually and presented to the service and Safeguarding Committee.

DNA/WNB FLOWCHART



