Leicestershire Partnership NHS Trust

Policy for Children and Young People who Was Not Brought (WNB) or Did Not Attend (DNA) Health Appointments (including No Access Visits (NAV) FYPC and LDA

The purpose of this policy is to provide pragmatic guidance relating to the management of Was Not Brought/ Did Not Attend contacts from both a clinical and safeguarding perspective for children and young people in (FYPC/LDA) services

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Version Control and Summary of Changes:

Version Number	Date	Comments (description change and amendments)
1	22nd February 2021	Changes to flowchart to include timeframes
1.1	3rd March 2021	Flowchart updated following further feedback to include 'telephone' contact
1.2	8th March 2021	'Service guidance' included in flowchart
1.3	14th March 2021	Flowchart amended to specify 'attempt telephone contact'
1.4	20th May 2021	Discharge added to Title and High Risk/ Low Risk defined in Flowchart
2	7th August 2023	Autism added to the directorate title. Updated title Leicestershire Partnership NHS Trust Children Safeguarding Policy, Leicestershire Partnership NHS Trust Adult Safeguarding Policy to LPT safeguarding and public protection policy. Page 8 updated capacity to reflect MCA from age 16. Page 12 updated in relation to communication to be more broader. Page 5 Care Programme Approach removed and replaced to reflect changes in CPA.
2.1	25th August 2023	Added definition for missing person. Page 8 additional sentence in relation gaining access to baby/child when visiting a home to check welfare.
2.2	19th October	Further information added to the definition of DNA. Due Regard completed. Removal of Hyperlinks
2.3	17 November 2026`	Extension agreed for 2 months to allow review

For further information contact:
Deputy Head of Nursing FYPC/LDA

1. Definitions that apply to this Policy

FYPC/ LDA	FYPC / LDA Families Young Peoples Children's and Learning Disability and Autism Division
No access visit	The practitioner does not gain access to the patient's place of residence for a pre-arranged appointment or the patient (or family) is not at their place of residence, or the agreed community setting when visited at a pre-arranged time by a practitioner.

Discharge	Discharge is the end of an episode of care or the lack of engagement of the person with legal responsibility for the child with the service offered. In some cases, some services will not have commenced. At the point of discharge the responsibility of the professional and service providing that care ends and reverts back to the referrer.
Was Not Brought	Children and young people who do not attend appointments and are dependent on others bringing them should be classed as 'Was Not Brought'. For statistical purposes this still classes as a DNA but ensures the safeguarding aspects are considered
Transfer of Care	Transfer of care is where care is transferred within an organisation or to another organisation
Episode of Care	An episode of care is an inpatient episode, a day case episode, a day patient episode, a haemodialysis patient episode, an outpatient episode or an Allied Health Profession episode. Each episode is initiated by a referral (including re-referral) or admission and is ended by a discharge
Missing Person	A child/family receiving care and treatment from the Trust in the community whose whereabouts are unknown and there is cause for concern.
Did Not Attend (DNA)	"Where the patient fails to attend an appointment where no prior notice was given by the patient to the service" (NHS Data Model and Dictionary) the young person must have the mental capacity (16+)/Gillick Competency otherwise this is a Was Not Brought.
Declined	"Where young person has the mental capacity (16+)/Gillick Competency to act and make their own decisions" and chooses to decline the appointment/ care offered
Cancellation	Where an appointment is cancelled by the service, family or young person.
Disengage	Where a parent/ carer/ young person withdraws the child / young person from involvement / treatment
Standard Operating Guidance	The standard operating guidance provides evidence based guidance to individual services within FYPC and LDA services for clinical and non- clinical staff

2. Purpose of the Guidance

The purpose of this policy is to provide pragmatic guidance relating to the safe management of Discharge and Was Not Brought/ Did Not Attend contacts from both a clinical and safeguarding perspective for children and young people in (FYPC/LDA) services. It also provides guidance for practitioners on how to safely discharge children and young people from specialist services.

3. Summary and scope of the guidance

All health providers are expected to have clear local guidance on what to do if Children and Young People are not being presented for health assessments or treatments in order to safeguard the child/ young people and promote their wellbeing.

Examples of disengagement include parental refusal for the children to be assessed or repeated non-attendance for medical appointments. It includes those who discharge their children/ young people against medical advice, including those who do not wait for medical care.

Parents / carers may disengage with health care for themselves: this may be a precursor to something more serious happening within the family. It is therefore imperative that a whole family approach is adopted, supporting a holistic risk assessment/ identification of any known vulnerabilities and this takes into account any impact on individual/ partners/ children or young person.

Professionals need to analyse / assess risk situations where was not brought/ did not attend or disengagement is a feature and take appropriate action in the best interests of the child/ young person.

The need to provide high quality care at the right time, in the right place, delivered by the right people is of paramount importance in reducing pressure on hospital and community services. Equally important is the need to ensure that service users have a good experience whilst in our care. Where a child/ young person was not brought to an appointment, practitioners are guided to follow this up and if the decision is made to discharge from a service, this is carried out following a review of all available information, risk assessed and completed in a safe, timely, co-ordinated, and well communicated manner.

4. Introduction

FYPC and LDA deliver a range of both universal and specialist services across a multidisciplinary spectrum. Requirements for discharge or transfer will be different for early intervention and prevention services. Mental Health,Learning Disability and Autism services in FYPC/LDAFollow the core principles of care coordination, using a range of frameworks which will be identified in the care plan.. All services will apply principles of whole family approaches, and principles of lead professional responsibilities, co-ordination of care and multi-agency working. These guidelines address all these aspects.

Specialist services deliver care to children with a range of needs. Children/ young

people are referred via several access routes and may have a range of services delivering interventions e.g. Specialist CAMHS and Mental Health Services, Therapies, Medical, Children's Community Nurses, Dietetics etc. The inpatient facility for CAMHS and Eating Disorders is accessed via community mental health teams or on call protocols. The guidelines recognise that all children have differing needs at different times. There will be times when input will be more frequent and other times when the children can be discharged, and care transferred back to the General Practitioner or other FYPC/LDA services. Discharge will take place at the completion of an episode of care from the specialist service or where there is a lack of engagement with the service offer and it is considered clinically appropriate, non- detrimental to the child/ young person's health and safe to proceed with the discharge.

This concept of current needs and end points of phases of care is central to delivery of care to children with long term conditions. Access and discharge from the service at differing points is related to the needs of the child and family.

Diana Services work with children with complex and life-limiting/threatening needs who sometimes need admission to the acute unit. This may occur out of hours. Emergency admissions for mental health will be facilitated using the on-call procedures.

Universal Services including the 0-19 Healthy Together Service provide a public health function to all children. Within that scope there are packages of specific care which might be delivered to children in response to identified need.

All Children are entitled to receive services to promote their health, well-being and development. It is the responsibility of all services and staff whether clinical or non-clinical to safeguard and promote the welfare of children. This policy must be used in conjunction with the Standard Operating Guidance for the individual FYPC/LDA services and with Leicestershire Partnership Safeguarding, Local Safeguarding Children's board policies and procedures and Public Protection Policy and where the following situations occur:

- Children/ Young Person is vulnerable/ at risk/ known to Early Help or Social Care Services
- The child/ young person is 'Looked After'
- There are concerns regarding the child/ young person's health and wellbeing
- Escalating risk impacting on child/ young person's mental health
- Refusal or withdrawal from universal services.
- Health or medical services for children are refused without good reason to do so.
- Multiple attendances at Emergency Department
- Repeated cancellation of health appointments for a child/ young person with identified health needs without rationale
- Repeated incidence of children not being brought for health appointments.
- Repeated non-availability for home visits
- Child(ren) are found to be left alone or unsupervised
- Child(ren) go missing or move area and there are safeguarding concerns

The guidelines apply to FYPC/LDA staff and those staff working in a contracted capacity who are involved in clinical decision making for case load management, review and discharge or transfer of care, and the supporting administration staff.

5. Guidance

Was not brought (WNB)/ Did not attend (DNA) and access to services are inextricably linked. People aged 14 and over with co-existing severe mental illness and substance misuse are followed up if they miss any appointment (DNA) in adherence to NICE Quality Standard (NICE, QS188, 2019). Children who do not attend appointments and are dependent on others bringing them should be classed as 'Was Not Brought'. The NICE guidelines on when to suspect child maltreatment state the clinician should 'consider neglect if parents or carers repeatedly fail to attend essential follow-up appointments that are necessary for their child's health and well-being.

https://www.nice.org.uk/guidance/cg89/evidence/full-guideline-pdf-243694625

Ensuring access to appropriate medical care or treatment:

1.3.9 Consider neglect if parents or carers fail to administer essential prescribed treatment for their child.

1.3.10 Consider neglect if parents or carers repeatedly fail to bring their child to follow-up appointments that is essential for their child's health and wellbeing.

1.3.11 Consider neglect if parents or carers persistently fail to engage with relevant child health promotion programmes, which include:

- Immunisation
- Health and development reviews
- Screening

1.3.12 Consider neglect if parents or carers have access to but persistently fail to obtain treatment for their child's dental caries (tooth decay).

1.3.13 Suspect neglect if parents or carers fail to seek medical advice for their child to the extent that the child's health and wellbeing is compromised, including if the child is in ongoing pain or deterioration in their mental health.

Ref: National Institute for Health and Clinical Excellence (2009) When to suspect child maltreatment: www.nice.org.uk/CG89.

In addition, missed appointments are a prominent feature in the Child Safeguarding Practice Reviews (SPRs) and /child death literature (albeit this represents small numbers). When children are not brought for appointments they would be recorded as DNA and therefore the safeguarding considerations and communications links must be paramount in terms of following actions. Within the electronic healthcare record, this should be recorded in the journal as 'was not brought'. Practitioners are guided to

include the DNA and WNB in the chronology. Informing the referrer and the GP, liaising with all health/ social care practitioners involved in child/ young person's care should be standard practice so any necessary follow up actions can be taken. As FYPC delivers a significant proportion of child/young person contacts in the family home, the following is also included in our definition of WNB/DNA:

Where a member of staff arrives at a family's home or other care setting for a pre-arranged appointment and there is no one home or the child is not available.' In this situation best practice is for the service involved to leave a calling card with contact information and explaining that the practitioner had attempted to see the child at home as arranged. In addition staff members are advised to make telephone contact with the parent/ carer advising of the no access and follow up plan.

It is important to ensure whilst visiting a baby/child/young person and their family/carers that practitioners gain access, and the baby/child/young person is physically seen to confirm wellbeing.

Clinicians are guided by their local Standard Operating Guidance and Child/Young Person Was Not Brought/ Did Not Attend Pathway and discharge support tool (where applicable).

If a parent and child, young person or young adult WNB/ DNA or there is No Access in terms of these definitions the following actions should occur prior to agreeing discharge from the universal or specialist service.

As part of the session in which the WNB/ DNA occurred, clinician reviews electronic patient health records during the time of the scheduled appointment to identify:

- Any access issues e.g. language, disability, carer responsibilities e.g. siblings
- Changes to demographic details which may have resulted in parent/ carer not receiving appointment details
- Consideration to family/parent/carer's mental health and wellbeing is impacing on their ability to engage.
- Contact to parent / carer by telephone to discuss WNB/DNA and agree plan of action/ offer of another appointment. Ideally this should be carried out and the agreed action documented during the time of the scheduled appointment or within one working day of the scheduled appointment

Consideration must be given to young person's mental capacity (age appropriate e.g. Mental Capacity Act applies from 16 years of age), any safeguarding issues and risk rating for children and young people on a vulnerable/ medium to high risk caseload. For example: a young person known to CAMHS services would necessitate an ongoing review by the Lead Practitioner and review of any known changes to presentation or escalating risk and recent/ current involvement with other services/ agencies. The following should be taken into consideration:

- Any clinical reasons why the child/ young person does not require another appointment. (use of discharge support tool to support clinical decision making where applicable to service and as per standard operating guidance for service).
- Whether the children / young person is subject to a Child Protection Plan/ Early Help or Looked after Child and consider all associated actions for WNB/DNA and

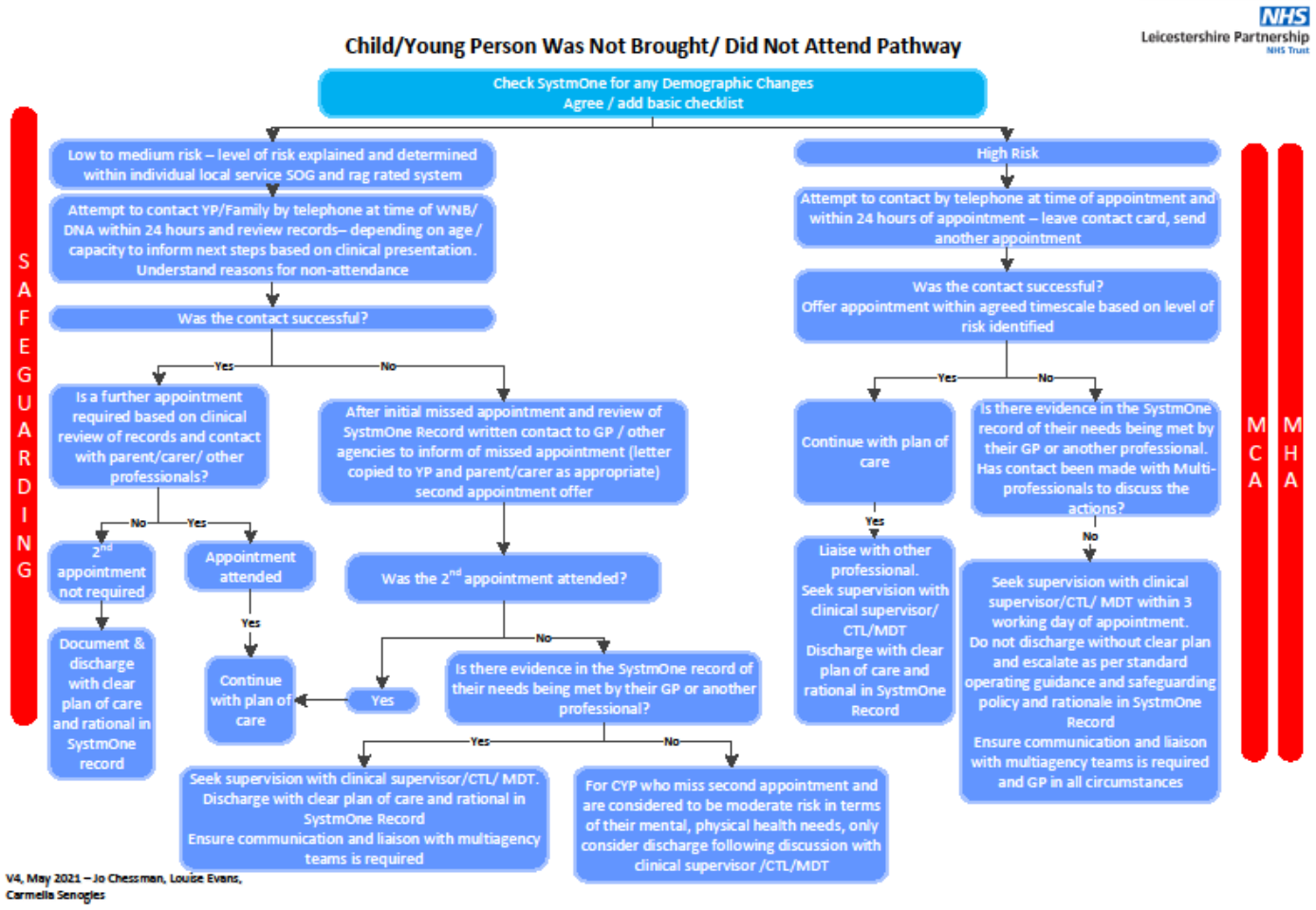
non-attendance.

- Any Safeguarding concerns about the child/family this information should be shared with other professionals who have continued involvement and consider a direct referral to Children's Social Care/ advice from safeguarding team where necessary.
- Communication in the form of telephone contact at the time of the missed appointment and within one working day. Task and/or letter to referrer and parent/ carer should be recorded in the EPR to inform of the WNB/ DNA and in all cases copied to the GP using shared electronic records.
- Communication with professionals involved in care delivery by telephone contact and documentation in patient's electronic healthcare record.
- Increased attendance at ED, police involvement, CRISIS intervention
- The service ensures that relevant professionals (including GP) and young person / parent / carer receive a copy of the letter relating to WNB/DNA of appointment and action to be taken by service as per flowchart. Page 10
- Consider alternative approaches or venues for next appointment (ideally in agreement with young person/ carer/ parent).
- If more than one appointment is offered the reason must be recorded in the notes and the plan of action following the WNB/DNA explicitly recorded in the electronic patient held record.

Children/ young people can only be discharged from specialist service following review of records/ liaison with other professional involved in care provision and following sound, safe clinical judgement with regard to assessing risk to the child, young person or young adult following the WNB/DNA. This will be in adherence to local standard operating guidance and WNB/ DNA flow chart in section 5.A second appointment should always be offered from the specialist service. All discussions from supervision or MDT meetings should be documented in the EPR.

Clinicians should always exercise their clinical judgements and discretion where repeated non-attendances occur. Repeated missed appointments in an education setting should prompt rearranging the child's appointment to a virtual, home or health setting for intervention.

Child/ Young Person Was not Brought / Did not attend pathway



6. Access to Service

Where access is identified as an issue, the referrer and care navigator should be contacted to find out how best to facilitate access and the engagement process, reasonable steps should be taken to address any barriers to access. This would include seeking the support of adult services in adherence to a whole family approach.

For example, the following could help:

- Use of appropriate first language through interpreting / language services
- Copy information about appointment details to Health Visitor, Lead Practitioner, family outreach worker or another appropriate person involved in the child/ young person's care.
- Joint visiting with other agencies involved in care
- Use of virtual clinic/ tele health appointment where this has been risk assessed as appropriate
- Consider alternative locations for service delivery
- Request chaperoning
- Use of Telephone or mailed texted reminders
- Use of volunteer drivers, taxi service, joint visiting with practitioner from other service involved in child/ young person'/ families care.

If parents/ carers fail to attend or contact the service for first assessment or follow up appointment, safeguarding and clinical risk issues should always be considered in these cases. The referrer and GP should always be informed via letter and task within electronic healthcare of the non-attendance and subsequent discharge if this has been agreed following WNB after offer of 2nd appointment.

7.0 Roles and Responsibilities

FYPC/LDA deliver commissioned services that support the provision of universal and specialist care across providers and they will transfer care as part of a national requirement.

Whilst under the age of being able to provide informed consent or where the young person lacks mental capacity, it is the responsibility of those with parental responsibility to act on behalf of their Child/ren, to ensure they are recipients of these services.

In circumstances where they are denied these services by their parents/carers, Health staff including General Practitioners (GPs) must consider that it is their professional responsibility and duty to act on the child's/ young person's behalf.

All communication should be provided in a form that is accessible to individual needs of Child/ren, family members/carers, and ensuring that our offer is accessible, and appropriate resources are provided, for example a digital offer will not hinder their ability to engage due to digital poverty.

- Health Professionals must take account of each child's/young person's circumstances and the possible implications of the failure to receive appropriate services. Babies and very young children are particularly vulnerable.
- Health Professionals must ensure that they are appropriately trained in the identification of child maltreatment to ensure effective judgments are made as to whether the child's/ children's health or development is subject to impairment.
- Health staff should ensure that parents have understood the significance of withdrawing from or refusing services.
- Consideration must be given to parents'/carers' level of understanding i.e. any learning disability, literacy and language or communication difficulty.
- Parents/carers may have their own health/mental health problems. Attempts should be made to communicate with parents/carers in a way that is appropriate to their needs.
- The potential impact of cultural and religious beliefs must be considered.
- Health staff must remain child-focused even when the refusal/withdrawal from services relates to the parents/carers issues e.g. mental health, substance misuse or domestic abuse.
- If after encouragement all attempts to work in partnership with parents have failed, consideration must be given to the potential consequences for the child/ren.
- If the child's/children's development or welfare is likely to be significantly impaired, a referral clearly stating concerns should be made to the
- Local Authority Children's Social Care under the Local Safeguarding Children's Partnership Board.
- Health staff must be able to demonstrate that attempts to gain parents'/carers co-operation have been made and recorded.
- During periods of children and young people not being brought for appointments, all appointments for routine health surveillance, immunisation and screening tests must continue to be sent.
- If the child is not registered and the whereabouts of the family become unknown health staff should discuss this with the Named Professional for their organisation and follow their local standard operating guidance and escalate where appropriate.

8. Criteria for Ending Episodes of Care following a declined, was not brought or no access appointment:

Discharge to GP/ Universal service should only be considered following a no access, was not brought or declined appointment ideally in collaboration with other agencies/ practitioners (where applicable), a child or young person, adult and their family. This is on review of all available information, at the end of an episode of care and if any of the following criteria are met:

1. No clinical or functional gain is expected from continued intervention from

specialist services.

2. Achievement of potential following previous intervention
3. The child, young person or their family has become confident in self-management of the condition for which the referral was made.
4. There is no added value of the particular service continuing to be involved with the child's care, young person and/or the child/young person's, needs could be met within other LPT, primary care, education, local authority or voluntary services
5. Needs are being met by a GP or other professional
6. Disability is having minimal impact on family function and the impact would not be reduced by further input from specialist services.
7. Deterioration is not expected in the person's functional abilities that could be prevented or the impact minimised by further input from specialist services. Needs are being met by opportunities provided by other services or in everyday activities and environments. Identified healthcare needs have been resolved by FYPC/ LD.
8. Withdrawal of consent to treatment. Communication with appropriate services must be carried out. Consider Gillick / Fraser Competencies: and Mental Capacity Act (2005) for those persons over 16 years of age
9. The prescribed course of treatment is not followed. Communication with appropriate services must be carried out and safeguarding issues (adult and child) must be considered
10. Children/ young people receiving medication can be discharged back to primary care providing there are clear guidelines for the receiving practice in terms of continuation of medication, weaning of medications where appropriate and a mechanism for re-escalation of care if necessary.

9.0 Discharge process

Discharge decision-making is supported by the individual service standard operating guidance, clinical pathway and Flowchart (Section 5). Discharge should ideally be made with negotiation and discussion with parents/carers and the child/ young person/ adult and clinician involved in care provision.

Clinicians should make use of their local processes and support tools to inform their decision to discharge.

A child, young person or adult should be discharged with advice, contact details and on-going activities and information about how to obtain further advice or input from the service, including the referral routes back to the service if required.

Essential actions on discharge include:

- Letter/ Discharge Summary to be sent to referrer and General Practitioner, parent/ carer and all other relevant professionals. The General Practitioner as the end custodian of care should be informed through the shared electronic record and included in copies of letters. The letter should include information the parent/ carer needs on discharge, routes for re-referral to the service,

whom to contact in the event of equipment failure/breakdown, signposting to other services and links to the website etc. and should be filed in the patient paper or electronic record.

- The discharge letter must be issued to the GP within 24 hours when being discharged from an inpatient unit and accompanied by a task. Forward planning for this point is common practice in some services and can be continued. For discharge of non-inpatients, the discharge letter must be issued as soon as possible and within 4 weeks, unless clinical judgement indicates that urgent communication is needed (e.g. actions required by another service, or any concerns). This should be copied to the young person / their parent / carer. Rationale for not doing so should be clear within the EPR.
- Consider use of individual service safe discharge tool and local standard operating guidance where appropriate, documenting rationale for discharge
- Record discharge in patient record.
- Refer to discharge Checklist Proforma (Appendix E) to ensure all actions complete.
- Complete SEND annual review if appropriate, stating discharge and informing the relevant education/ health agencies of the service to which the young person has been transferred if applicable.
- Ensure safeguarding issues are recorded in the patient record and managed safely in accordance with Leicestershire and Rutland Safeguarding Children's Partnership Board or Leicester Safeguarding Children Partnership Board. https://lrsb.org.uk/lrscp.
- Where emerging or actual safeguarding concerns exist, alert the receiving professional by telephone, refer to social care and follow up with clear documented plan of action and communication within 1 working day.

Other actions should include:

- Telephone contact with other professionals or agencies, clinical supervision, support from care navigator and consideration of a multi-disciplinary meeting to review care provision prior to any discharge from service where applicable
- Children Young People and adults with equipment prescribed by FYPC/LDA and Duty of Care:
- The child, young person or adult who has equipment prescribed by health professionals from FYPC can be discharged if the duty of care has been fulfilled. Providing the health professional has taken all reasonable steps to ensure that the needs of the child, young person, adult and family have been addressed, considered and properly documented with any concerns shared appropriately with relevant others then the duty of care will have been met (Community Equipment Code of Practice - A quality framework for procurement and provision of services (England 2011) Brian Donnelly (Community Equipment Solutions Ltd).
- Individual consideration is required relating to individuals who are moving away from the area.

10. Training

These guidelines should be included in all new starters' service induction / preceptorships.

All staff should be made aware of these guidelines through their manager's dissemination of policies.

It is the responsibility of the Clinical Team Leaders and Operational Team Leaders to undertake a **TRAINING NEEDS ANALYSIS** of all staff who are involved in clinical decision making, caseload management and liaison with other services/ agencies in regard to children and young people who WNB/DNA:

- Practitioners have undertaken training on S1 electronic health care record and can navigate the system competently to find, share and document information correctly.
- Ensure all staff are compliant to mandatory training to include information governance, mental capacity act training, record keeping policy, mental health act, safeguarding children level 3 and whole family approach.
- Ensure all staff are aware of the Trust Policies and how to access these
- All staff are expected to follow standard operating guidance for their service
- Records of all training must be retained on ULearn system. Compliance to be monitored by the Clinical Team Leaders and Operational Team Leaders
- Not to deviate from this guidance without prior discussion with Team Leader/ safeguarding team (where appropriate) and recording in patients' records.
- Escalate and report concerns using the Trust electronic incident reporting system.
- To undertake competencies and training as required and maintain that competency. Comply with guidance outlined in this document.
- Ensure that risk assessments are regularly reviewed, shared and communicated between colleagues.

11. Monitoring Compliance and Effectiveness

On-going internal monitoring through clinical supervision and caseload reviews ensures that WNB/DNA and discharges are clinically appropriate. Incident forms relating to discharge practice will be reviewed through clinical governance structures.

Ref	Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
	Discharge requirements for all patients included within care plan	Care planning results	Discharge requirements to be considered as part of the teams or services monthly care planning audit	Service managers or team leaders	6 month review of position based on the care planning audit
	Information to be provided to the receiving healthcare professional (as well as GP)	Discharge letter provided to the referrer and any other relevant individuals- case load reviews	Discharge letter spot checks in case load reviews and audit	Service managers or team leaders with data provided from data team	Quarterly audit of consultant led services: Discharge summary letters

	Information to be given to the patient when they are discharged	Evidence of verbal/ written information from the EPR or copy of letter in notes (evidence of adherence to service standard operating guidance/ process)	Discharge information shared with patients to be considered as part of the teams or services monthly care planning audit	Service managers or team leaders	6 month position based on the care planning audit

12. References and Bibliography

- The guidelines are in line with recommendations from the Royal Colleges for Paediatrics and Child Health, College of Occupational Therapy, Royal College of Speech & Language Therapists, Chartered Society of Physiotherapy and Health Professions Council Standards of Conduct, Performance and Ethics, Nursing and Midwifery Council, Royal College of Psychiatrists
- FYPC LDA Standard Operating Guidance 0-19 Healthy Together Service (2019)
- LPT Record Keeping and the Management of the Quality of Records Guideline
- Transition planning for Young People from Children's to Adult Health Services. Protocol for good practice
- CAMHS Community Did Not Attend (DNA)/Was Not Brought (WNB) Process to follow for children on high risk, moderate risk, low risk caseload
- Inpatient Discharge Guideline
- LPT management of non-attendance/ did not attend (DNA) guideline (2016)
- Information Sharing Guideline
- LPT CPA Guideline
- LPT Safeguarding Children Guideline
- Think Family
- Discharge from Hospital: pathway process and practice (DH 2003) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/912199/Hospital_Discharge_Policy_1.pdf
- Mental Capacity Act 2005
- Consent to examination or treatment guideline
- LPT Infection Control Policies
- Risk Management Strategy

- Medicines Management Guideline
- NHSLA Version 1: Publication Date- January 2012.
- CPA Association Handbook
- ‘A Positive Outlook: a good practice guide to improve discharge from in-service user health care’ (CSIP/NIMHE, 2007)

  Safer Services: A toolkit for specialist mental health services and primary care
- ‘Preventing Suicide: a toolkit for Mental Health Services’ (Healthcare Quality Improvement Partnership)
- Nursing and Midwifery Council (2015) The Code: Standards of conduct, performance and ethics for nurses and midwives.
- Chartered Society of Physiotherapy (2012) Quality Assurance Standards
- College of Occupational Therapy (2015) Code of Ethics and Professional Conduct for Occupational Therapists
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- NICE's guideline on coexisting severe mental illness and substance misuse: community health and social care services, recommendation 1.6.5]
- https://www.nice.org.uk/guidance/ng179/chapter/1-Advice-and-support-for-shared-decision-making-when-arranging-planned-care
- Decision-making and mental capacity NICE guideline [NG108] Published date: 03 October 2018
- https://pathways.nice.org.uk/pathways/transition-from-childrens-to-adults-services/transition-from-childrens-to-adults-services-overview
- NHS Improvement: Reducing Did Not Attends- https://improvement.nhs.uk/documents/2108/reducing-dna.pdf

Appendix A

Training Requirements

Training Needs Analysis

Training Required	YES	NO x
Training topic:	Management of Was Not Brought/ Did Not Attend	
Type of training: (see study leave guideline)	□ Mandatory (must be on mandatory training register) □ Role specific □ Personal development	
Division(s) to which the training is applicable:	□ Adult Mental Health & Learning Disability Services □ Community Health Services □ Enabling Services □ Families Young People Children □ Hosted Services	
Staff groups who require the training:	*Please specify…*	
Regularity of Update requirement:		
Who is responsible for delivery of this training?		
Have resources been identified?		
Has a training plan been agreed?		
Where will completion of this training be recorded?	□ ULearn □ Other (please specify)	
How is this training going to be monitored?		

Appendix B

The NHS Constitution

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

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

Appendix C

Key individuals involved in developing the document

Name	Designation
Bernadette Light	Deputy Head of Nursing for FYPC/LDA
Clare Hazeldine	Professional Lead for Speech and Language
Kelly Costello	Lead Nurse for Safeguarding C&YP
Katie Willetts	Senior Nurse- Specialist Nursing- Diana
Viki Elliott	Lead Matron CAMHS Community
Lyn Quinnell	Professional Lead Healthy Together

Circulated to the following individuals and groups for comment: all members of the senior clinical leadership forum and wider LPT colleagues

Name	Designation
Dr. Peter Felix	Consultant Community Paediatrician
Dr. Sandip Ghosh	Consultant Community Paediatrician
Neil King	Head of Safeguarding
Jane Hill	Child Health Information Service Team Lead
Lyn Quinnell	Professional Lead Healthy Together
Suzanne Ziegler	Clinical Lead, Children's Physiotherapy
Rebecca Pope	Clinical Lead, Children's Occupational Therapy
Teresa Norris	Lead Matron CAMHS- LD Community
Deanne Rennie	Deputy Clinical Director and AHP Lead
Tracy Ward	Head of Patient Safety
Michelle Churchard Smith	Head of Nursing DMH
Patient Safety Improvement Group	Trust Wide
Safeguarding Assurance Committee	Trust Wide
Transferring Care Safely	UHL, CCG, LPT strategic group
Clinical Leadership Forum	FYPC/LDA
Directorate Management Team Meet	FYPC/LDA
Christo Benite	Clinical Director for Community paediatrics
Gemma Clarke	LDA Quality Lea
Kelly Costello	Lead Nurse for Safeguarding C&YP

Appendix D

Due Regard Screening Template

Section 1	
Name of activity/proposal	New policy developed for: the management of Was Not Brought/ Did Not Attend contacts from both a clinical and safeguarding perspective for children and young people in (FYPC/LDA) services
Date Screening commenced	19/10/2023
Directorate / Service carrying out the assessment	Leicester Partnership Trust. FYPC/LDA
Name and role of person undertaking this Due Regard (Equality Analysis)	Bernadette Light Deputy Head of Nursing FYPC/LDA
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: The purpose of these guidelines is to ensure there is evidence based practice and sound underpinning decision making relating to the safe management of Was Not Brought/ Did Not Attend contacts from both a clinical and safeguarding perspective for children and young people in (FYPC/LD). This includes discharge or transfer of care from FYPC LPT with safeguarding paramount to the process.	
OBJECTIVES: The guidelines are intended to guide staff so that all Was Not Brought/ Did Not Attend and discharges are appropriately managed to minimise the risk to service users and to improve outcomes and quality of care. The policy guides practitioners to take appropriate action in the best interests of the child/ young person; to promote engagement with health care and health services and prevent the risk of harm.	
Section 2	
Protected Characteristic	**If the proposal/s have a positive or negative impact please give brief details**
Age	Service user: 0 – 18 years Staff: Staff are employed who are of working age. A key component of the guidelines is the communication between child/young person, parent/carer and professional.

	The guideline actively promotes equality of opportunity as it seeks to improve decision making and communication to improve outcomes and ensure all children and young people have their needs met.
Disability	LPT will respond appropriately to all requests for information in alternative formats and ensure that all attempts are made to ensure it is understood. Alternative methods of communication such as signs and symbols or Makaton may be required in order to ensure understanding where there is a disability. All children and young people are treated with sensitivity to meet their needs in accordance with local and national policy. Staff: Physical ability required to fulfil the role.
Gender reassignment	Service User: No negative impact. There is a referral criterion and all patients who meet these criteria are deemed suitable for the Service – individual risk assessment would be required. All children and young people and treated with sensitivity to meet their needs in accordance with local and national policy. Staff: No negative impact – persons can be employed in line with Trust Policy.
Marriage & Civil Partnership	Service User: No negative impact. There is a referral criterion and all patients who meet these criteria are deemed suitable for the Service. Staff: No negative impact: - persons employed in line with Trust Policy.
Pregnancy & Maternity	Service User: No negative impact. There is a referral criterion and all patients who meet these criteria are deemed suitable for the Service – individual risk assessment would be required. Where young people under 18 years are pregnant they will receive care from UHL community midwifery with communication and involvement from LPT Health Visiting services. No pregnant young person will be discharged Staff: No negative impact – Risk assessments completed for pregnant staff in line with Trust Policy.
Race	Service User: No negative impact. There is a referral criterion and all patients who meet these criteria are deemed suitable for the Service. All children and young people and treated with cultural sensitivity to meet their needs in accordance with local and national policy.

	Staff: No negative impact – persons can be employed in line with Trust Policy.
Religion and Belief	Service User: No negative impact. There is a referral criterion and all patients who meet these criteria are deemed suitable for the Service. All children and young people and treated with sensitivity to meet their needs in accordance with local and national policy. Staff: No negative impact – All religious beliefs can be accommodated. Dress must be in line with Trust Uniform and Infection Control Policy.
Sex	Service User: No negative impact. There is a referral criterion and all patients who meet these criteria are deemed suitable for the Service. Staff: No negative impact – male and female staff are employed.
Sexual Orientation	Service User: No negative impact. There is a referral criterion and all patients who meet these criteria are deemed suitable for the Service. All children and young people and treated with sensitivity to meet their needs in accordance with local and national policy. Staff: No negative impact. Persons employed in line with Trust Policy.
Other equality groups?	No concerns identified.

Section 3			
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.			
Yes		No	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	✓
Section 4			
If this proposal is low risk please give evidence or justification for how you reached this decision:			

This is relevant to all children and young people under the care of FYPC/LDA services but the guidelines seek to ensure that no group is disadvantaged through adherence to criteria for ending episodes of care. In line with the LPT Equality & Human Rights Policy. The Directorate provides services that are flexible and responsive to disability, gender, sexual orientation, age, ethnicity, spiritual, cultural, religious, physical and sensory needs, ensuring that anti-discriminatory practice underpins the services.			
Signed by reviewer/assessor	Bernadette Light	**Date**	19/10/2023
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed	Bernie Light	**Date**	19/10/2023

Equality Statement

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

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

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

In carrying out its functions, LPT must have due regard to the different needs of different protected equality groups in their area. This applies to all the activities for which LPT is responsible, including guideline development and review.

Due Regard

LPT must have due regard to the aims of eliminating discrimination and promoting equality when policies are being developed. Information about due regard can be found on the Equality page on e-source and/or by contacting the LPT Equalities Team.

The Due regard assessment – see Appendix D of this document.

Definitions that apply to these Guidelines

FYPC/ LDA	FYPC / LDA Families Young Peoples Children's and Learning Disability and Autism Division
No access visit	The practitioner does not gain access to the patient's place of residence for a pre- arranged appointment or the patient (or family) is not at their place of residence, or the agreed community setting when visited at a pre-arranged time by a practitioner
Discharge	Discharge is the end of an episode of care or the lack of engagement of the person with legal responsibility for the child with the service offered. In some cases, some services will not have commenced. At the point of discharge the responsibility of the professional and service providing that care ends and reverts back to the referrer.
Was Not Brought	Children and young people who do not attend appointments and are dependent on others bringing them should be classed as 'Was Not Brought'. For statistical purposes this still classes as a DNA but ensures the safeguarding aspects are considered
Transfer of Care	Transfer of care is where care is transferred within an organisation or to another organisation

Episode of Care	An episode of care is an inpatient episode, a day case episode, a day patient episode, a haemodialysis patient episode, an outpatient episode or an Allied Health Profession episode. Each episode is initiated by a referral (including re-referral) or admission and is ended by a discharge
Missing Person	A child/family receiving care and treatment from the Trust in the community whose whereabouts are unknown and there is cause for concern.
Did Not Attend (DNA)	"Where the patient fails to attend an appointment where no prior notice was given by the patient to the service" (NHS Data Model and Dictionary) the young person must have the mental capacity (16+)/Gillick Competency otherwise this is a Was Not Brought.
Declined	"Where young person has the mental capacity (16+)/Gillick Competency to act and make their own decisions" and chooses to decline the appointment/ care offered
Cancellation	Where an appointment is cancelled by the service, family or young person.
Disengage	Where a parent/ carer/ young person withdraws the child / young person from involvement / treatment
Standard Operating Guidance	The standard operating guidance provides evidence based guidance to individual services within FYPC and LDA services for clinical and non-clinical staff

Appendix E

Discharge Checklist: Ensure parents/ carer of Child/ young person has previously been offered a 2nd appointment following WNB/DNA guidance

		Initial or tick for electronic records	Enter date for paper records
1.	Child meets discharge criteria (refer to service standard operating guidance and flowchart and section 5)		
2.	Ensure all documentation is completed		
3.	Ensure all safeguarding needs are communicated, checked, recorded and acted on where necessary		
4.	Discharge has been discussed with key worker/ Lead Practitioner/ named professional/Health Visitor/School Nurse (where appropriate)		
5.	Discharge and outstanding health needs discussed with parent/carer (unless discharge related to DNA or child not brought- this should be included in all correspondence to parents/ carers/ GP and other agencies involved in care provision)		
6.	Re-referral routes, support networks explained and shared to parents/carers (telephone/ letter)		
7.	Check all equipment supplied through FYPC and ensure parent has information for service/repair		
8.	Check that unnecessary equipment has been returned		
9.	If child has a statement of special education needs, annual review to be completed with a note about discharging from annual review following communication with agencies involved in child's/ young person's care		
10.	Ensure that all Mental Health Care Co-ordination processes are fully completed		

11.	Inform GP and any other relevant professionals of discharge. Discharge summary, if relevant, circulated to referrer, GP and any other relevant professionals, and copied to parents (to GP within 24 hours from In Patient unit)		
12.	Notes secured and archived, discharge completed from electronic system where appropriate		