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The unseen child and safeguarding: 'Did not attend' guidelines in the NHS

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ABSTRACT

Background Organisations in England's National Health Service (NHS) are required to have 'did not attend' (DNA) guidelines to help deal with the 'unseen child'.

Aims To map DNA and associated guidelines in paediatric services, examine differences in safeguarding response and advice in the guidelines and explore the experience of guideline users.

Methods A mapping approach was used to locate current DNA guidelines on English NHS organisations' websites. Analysis of the guidelines was supplemented with qualitative data from those who produce, monitor or use them.

Results Fewer than 8% of English NHS organisations had up-to-date guidelines in the public domain, though a further 41% stated that they had a DNA/similar policy in place or had an out-of-date guideline on their website.

Advice to healthcare providers about the steps to take when a child DNAs fell into five categories: reflection and review; direct interaction with the family; indirect interaction with the family; liaison with internal colleagues; and external referral. Interviews with eight individuals led to the identification of four themes. The management of information flows was central to the effective management of DNA. Respondents also reported seeking support and advice from others. While all respondents spoke about the importance of supporting the family, the child's needs were central to dealing with non-attendance, and respondents demonstrated awareness of wider risk discourses.

Conclusions We consider the implications of the work and suggest that evidence-informed guidelines developed nationally but tailored to specific services might be helpful for providers and users alike.

INTRODUCTION

Nearly seven million outpatient hospital appointments in England are missed annually,¹ many in child health. A scoping review of the literature on paediatric non-attendance¹ identified studies suggesting that 'did not attend' (DNA) arise through administrative error, logistical barriers and parental forgetfulness.^{2,3} The development and implementation of paediatric DNA guidelines, and the perceived reasons for and consequences of non-attendance may be different between primary and secondary care settings. This paper's focus is largely on secondary services.

The safeguarding implications of non-attendance (and family disengagement more generally) have been identified as important, and National Health Service (NHS) organisations are required to have DNA guidelines as part of their child safeguarding

What is already known on this topic

- ▶ The relationship between child maltreatment and non-attendance at appointments (and family disengagement from services more generally) has assumed importance as a safeguarding issue.
- ▶ Organisations in England's National Health Service (NHS) are required to have 'did not attend' guidelines in place, aimed at helping healthcare practitioners deal with the 'unseen child'.
- ▶ There is variation in the advice provided and little research on the experience of using the guidelines.

What this study adds

- ▶ A minority of Trusts have DNA guidelines in the public domain.
- ▶ Most DNA guidelines focus on missed appointments as a result of parental factors.
- ▶ Guidelines need to be accessible as well as evidence based. Not all of those we interviewed were familiar with the guidelines in their Trusts.

policies.⁴ Of 685 missed paediatric outpatient appointments in one London district, for example, a third were known to Children's Social Care (CSC).⁵ An earlier scoping review¹ found some variation in advice. Given this, we aimed to map DNA guidelines in paediatric services, examine differences in safeguarding response and advice to practitioners and explore the experience of using the guidelines.

METHODS

Mapping the guidelines

The websites of all English NHS organisations listed by the NHS Information Centreⁱⁱ were searchedⁱⁱⁱ and a mapping approach⁶⁻⁸ used involving (1) retrieval of up-to-date DNA guidelines, (2) extraction of key data and (3) descriptive analysis of extracted text.

ⁱⁱ<http://www.nhs.uk/NHSEngland/thenhs/about/Pages/authoritiesandtrusts.aspx>

ⁱⁱⁱWebsites were searched using the following terms: 'DNA' 'did not attend' 'disengagement' 'child' 'family' 'no access visit' 'unseen' 'do not attend'. In addition, Google was searched using these terms with the name of the NHS organisation. Where a number of policies were found, only the most up-to-date policies were included.

ⁱ<http://www.england.nhs.uk/2014/03/05/missed-appts/>



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To be included, guidelines had to be focused on children/young people or family disengagement, include advice/information for healthcare providers (HCPs)/administrators, up-to-date in September 2013 and in the public domain. Data were extracted on guidelines' details, structure and purpose; the safeguarding response and advice to HCPs; and other relevant data.^{iv}

Interviews with key respondents

Results from the mapping were supplemented with qualitative data from the NHS staff involved in drafting guidelines, overseeing their implementation and/or implementing them. Contacts were identified through the NHS Research and Development (R&D) Forum.^v Interviews were audio-recorded and transcribed. We used a topic guide as a tool rather than a rule. Two researchers independently used thematic analysis⁹ to identify common issues.

RESULTS

Mapping the DNA guidelines: search and analysis results

Details of 447 organisations across four organisational types (acute trusts, clinical commissioning groups (CCGs^{vi}), mental health trusts (MHTs) and health and care trusts^{vii} (HCTs)) were available from the NHS Information Centre.

Of 159 Acute Trusts, two websites could not be searched. Of the remainder, 16 had DNA/related guidelines meeting our criteria. Of 211 CCGs, four websites could not be accessed. Of the remainder, we identified seven with current DNA/similar policies in the public domain. A search of the websites of 50 MHTs led to identification of nine DNA guidelines. Just one policy was identified from a search of HCT websites. In total, 7.5% (33/439) of organisations had 35 guidelines meeting inclusion criteria (table 1).

A further 41% had a statement on their site indicating that they had a DNA policy in place or used the Local Safeguarding Children Board (LSCB) policy.^{viii} Around half (224/439) showed neither a current nor an out-of-date DNA/similar policy available in the public domain nor a statement indicating a policy was in place.

For the purpose of analysis, we excluded DNA/other guidelines of no more than a few lines embedded in larger safeguarding policies, leaving a sample of 24 guidelines.

Classification and organisation of guidelines

Most guidelines contained an inception and/or policy implementation date, were general in nature and applied to all paediatric services. We found only one aimed at diabetes DNAs and three for Child and Adolescent Mental Health Services. All referred to other documents (legislation, regulatory review, statutory guidance, clinical guidelines, research) to contextualise their advice. Thirteen provided flow diagrams to aid decision

^{iv}The search is valid only for the period October to December 2013. Even during these months, there were changes to organisations' websites with some previously available policies disappearing. As the full effects of organisational change take place, further changes are likely to be reflected on the organisation's websites and in policies.

^v<http://www.rdforum.nhs.uk/001.asp>

^{vi}Clinical commissioning groups (CCGs) are organisations setup following the Health and Social Care Act (2012) to organise the delivery of NHS services in England.

^{vii}NHS Health and Care Trusts provide both health and social care.

^{viii}These are similar to NHS DNA/related guidelines. For an example, see: <http://www.lewisham.gov.uk/myservices/socialcare/children/Safeguarding-Children-Board/Documents/DNAInformationSheet.pdf>

Table 1 DNA guidelines meeting inclusion criteria

Organisation type	Number of organisations with DNA guidelines/sample size*	Number of guidelines identified
Acute trusts	16/157	18
CCGs	7/207	7
MHTs	9/50	9
HCTs	1/25	1
Total	33/439	35

*Sample size refers to the available websites.

CCG, clinical commissioning group; DNA, did not attend; HCT, health and care trust; MHT, mental health trust.

making and three included sample letters to parents. Guidelines varied in the steps to take when an appointment is missed. For example, the guideline from one mental health trust (MHT5) invites the family to attend another appointment after a first DNA. After two, a letter is sent but no further appointment offered. Another guideline (MHT7) adopts a similar approach but makes reference to the child's right to receive healthcare and the need to inform other services and partners about non-attendance. Most guidelines do not specifically define DNA and associated terms, other than stating that DNA means 'did not attend'.

Safeguarding advice to HCPs

Risks of non-attendance are described generally as risks to well-being. We identified only one referring to a specific condition (diabetes). The advice on how to deal with non-attendance was broadly similar across the sample, though in some the advice was general, in others more prescriptive with specific steps suggested depending on risk and/or perception of risk. These steps fall into five categories:

1. *Reflection and review*: consider whether the appointment is necessary and the child's health needs are being met; review records and other data to check address and contact details are correct and ascertain the level of risk; consider making a referral to CSC;
2. *Direct interaction with the family*: offer another appointment; attempt to make contact with the family; send a letter to the family;
3. *Indirect interaction with the family*: attempt to contact wider family members and/or neighbours;
4. *Liaison with internal colleagues*: seek advice from safeguarding leads in own organisation;
5. *External referral*: liaise with/contact other professionals outside own organisation including general practitioners (GPs); make a referral to CSC; contact the child's social worker; contact the police; issue a missing family alert.

Recording of activities is emphasised in all the guidelines.

Other findings

Some guidelines describe potential barriers to attendance by reference to the social determinants of health, service access and use. For example, the authors of MHT2's policy observe that: "Service users are often embedded in complex multiple pressures and demands, including poverty, discrimination, social exclusion, and multiple personal burdens..." (p. 4).

Some acknowledge that DNAs may or may not be a problem: "The missing of a health appointment on its own may be of no concern, or one missed health appointment may be very significant" (CCG2, p. 5).

Table 2 Respondents' details

Region in which organisation situated	Organisation type	Number of individuals in interview	Data collection method	Respondents' roles
East Midlands	MHT	2	Telephone	Service managers
		1	Telephone	Health visitor (HV)
North West	Acute trust	1	Telephone	Service manager/safeguarding role
London	CCG	1	Telephone	Safeguarding nurse
London	Acute trust	1	Face-to-face	Consultant paediatrician
London	Acute trust	1	Face-to-face	Consultant paediatrician/safeguarding doctor
London	Acute trust	1	Face-to-face	Administrator

CCG, clinical commissioning group; MHT, mental health trust.

Interviews with those who create and use the guidelines

Our second stage explored the perspectives of those involved in the creation and use of the guidelines. All 24 organisations in our sample were contacted. In a period of considerable organisational churn, many R&D contacts were no longer in post, or email addresses or Trusts themselves had changed. After a poor response, we contacted the R&D departments of organisations with less substantial up-to-date DNA policies in the public domain (n=9) and, using random sampling, organisations in the larger sample with out-of-date DNA guidelines/using the LSCB guidelines/with a statement on non-attendance on their website (n=182). Snowballing methods were also used. Fifty-six organisations were contacted between January and March 2014 as a result of which we interviewed eight people in the course of seven interviews (see [table 2](#)).

Following transcription, qualitative data were analysed using thematic analysis. This entailed a reading, several times over, of transcripts, then coding and aggregation of themes. Eight themes were then categorised into four overarching themes: (1) managing information flows: gathering, processing and recording; (2) seeking help and support from others; (3) the child at the heart of the policy: supporting children and families; and (4) wider risk discourses and events.

Managing information flows: gathering, processing and recording

Respondents described information gathering and processing as having a number of functions, including helping them identify a 'true' DNA. 'True' DNAs were those where a child had been booked into the appointment, expected to attend and the family were aware of this but the child had not attended. 'False' DNAs were the result of the organisation's mistake:

So we would look...is it a true DNA, have we rearranged the appointment because sometimes that happens? You rearrange clinics, you send letters out, they don't receive them in time. (Service manager, safeguarding children role, Acute Trust)

Information was also used to demonstrate that the 'correct' actions had been followed, such as recording non-attendance.

Several respondents expressed anxiety about not knowing what is happening to a child and whether failure to attend an appointment represented a risk or not. For a child already 'known' to CSC, either because they were on a child protection plan (CPP) or had previous interaction with CSC, information might be held by social workers. However, since most children who miss appointments are not on a CPP, trying to establish the level of risk was difficult.

Seeking help and support from others

All respondents reported that they could seek help from others and being well supported within their organisations in managing DNAs.

When dealing with colleagues outside their own organisation, respondents sometimes referred to the challenges that different professional practices presented, including higher thresholds in CSC than those in their own organisation. Most respondents spoke about 'multiagency' working, and managing information flows between organisations was central to this.

The child at the heart of the policy: supporting children and families

As noted earlier, respondents recognised that not all DNAs are 'true' DNAs. Where non-attendance was established as a 'true' DNA, understanding non-attendance was important because this determined the type of support needed. While respondents talked about having systems in place to support families, these tended to be general rather than specific to a family's needs. One spoke about "...focusing on families that need extra support to get them to appointments. We have looked at that and we have put transport on ..." (service manager, CCG).

Yet, while HCPs talked about supporting families, their concerns were primarily with the child and their unmet needs. One described non-attendance as children's rights issue, and the prospect of a child missing out on healthcare and possibly suffering was a concern, evident in respondents' references to issues being 'flagged up', the imperative to 'spot problems' and the dangers of children 'slipping through the net'.

Negotiating the difficult terrain between supporting families and focusing on the unmet needs of children was a delicate balancing act requiring sensitivity. Though, as another respondent pointed out, a narrative built on the premise that parents always work in the best interest of the child is not always helpful:

...actually if the child [is]...not getting healthcare...then that's neglect whether you're a lovely [parent] or not a lovely [parent], really your loveliness doesn't come into it. (Safeguarding paediatrician, Acute Trust)

For professionals, the task is to ensure the child's health needs are met without damaging the professional-family relationship. Respondents recognised that heavy handedness could be counterproductive. There was a perception that a referral to CSC, or even the suggestion of it, could be damaging.

Wider risk discourses and events

Respondents were aware of wider societal anxieties and pre-occupation with risk. Some referred to high-profile deaths and

serious case reviews, as well as target setting. This awareness was strongly linked to the first theme—the imperative to collect and record information to demonstrate the ‘right’ steps had been taken. Just as the HCP is concerned with assessing the needs of the unseen child, she/he is also subject to scrutiny and accountability including providing assurance of adherence to central and local policies.

DISCUSSION

Study strengths and limitations

There are few studies with management of non-attendance at child health appointments as a primary focus, and fewer still where data are collected from those who create or manage DNA guidelines.

While our search was, in effect, a census of DNA guidelines in the public domain, this was a period of reorganisation in NHS that limited our ability to contact and interview personnel. Given that our sampling strategy involved guidelines in the public domain, there may be a response bias in favour of Trusts with a commitment to transparency and personnel with an interest in non-attendance. Data on guidelines are reported only from Trusts that chose to be transparent and/or had a good website manager. This does not, of course, imply that other Trusts do not have guidelines, but we are unable to report the contents of these guidelines, and we took the view that obtaining them—through email and/or Freedom of Information requests—would incur disproportionate time costs for both us and the Trusts.

A missing feature of this study is the views of children and families and, in particular, those who become involved in safeguarding procedures as a result of missing appointments. Also missing are the views of GPs, who were mentioned as key players by our respondents and whose views feature in a recent paper on this issue.¹⁰

Implications

Drawing on the documentary analysis and the interviews, we make five observations about the implications of this study for DNA guideline creation and implementation.

First, the effect that provider factors might have on DNAs was not a significant feature of most guidelines; guidelines focus primarily on parental factors. Yet respondents recognised that system errors result in ‘false’ DNAs. Well-designed online technologies that have brought us easy ways to purchase books or flights could mitigate some of these problems, although recent audits and studies of the procurement and use of IT^{11 12} in healthcare suggest that advances of this type may have some way to go.

Second, many guidelines are general, aimed at HCPs working in a range of areas, so that processes for dealing with non-attendance for both less and more serious conditions may not be evident. Economy of effort through core guidelines, enhanced through local expertise, underpinned by evidence and carefully tailored to the medical area or condition might be more useful for HCPs and better support children and families.

Third, guidelines might be more useful if authors made a distinction between different categories of ‘unseen’ child. Many conflate different categories—DNA with refusal of service, for example. The family that refuses all health services may be very different from the one that engages with practitioners but does so selectively or sporadically.

Fourth, guidelines, in order to be useful, need to be accessible and used. Not all of those we interviewed were familiar with the guidelines in their Trusts, though all had an informed awareness of the steps they would take if they had concerns about a child.

Finally, the NHS has made commitments to transparency. Given that there are no space restrictions on the web, and these policies affect both patients and the NHS, Trusts might wish to consider publishing them.

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REFERENCES

- 1 Arai L, Stapley S, Roberts H. ‘Did not attend’ in children 0–10: a scoping review. *Child Care Health Dev* 2014;40:797–805.
- 2 Barnardo’s South West. *Consultation to explore non-attendance rates in East Central Bristol Paediatric and Child and Adolescent Mental Health Service*. Bristol, UK: Barnardo’s, 2011.
- 3 Gurney K, Pearson V, Gibbs S. *Audit of hospital did not attend (DNA) appointments for 0–18-year-olds*. Devon: NHS Devon, 2012.
- 4 Care Quality Commission (CQC). *Safeguarding children: a review of arrangements in the NHS for safeguarding children*. London: Care Quality Commission, 2009.
- 5 Watson M, Forshaw M. Child outpatient nonattendance may indicate welfare concerns. *BMJ* 2002;324:739.
- 6 Arksey H, O’Malley L. Scoping studies: towards a methodological framework. *Int J Soc Res Methodol* 2005;8:19–32.
- 7 Arai L, Liabo K, Kunkler R, et al. *UK-based sexual health and HIV research scoping and mapping project: project report*. London: Child Health Research and Policy Unit, 2006.
- 8 Aicken C, Arai L, Roberts H. *Schemes to promote healthy weight among obese and overweight children in England*. London, UK: EPPI-Centre, Social Science Research Unit, Institute of Education, 2008.
- 9 Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006;3:77–101.
- 10 Cameron E, Heath G, Redwood S, et al. Health care professionals views of paediatric outpatient non-attendance: implications for general practice. *Fam Pract* 2014;31:111–17.
- 11 National Audit Office (NAO). *The National Programme for IT in the NHS: an update on the delivery of detailed care records systems (press release)*. London: National Audit Office, 2011. <https://www.nao.org.uk/press-releases/the-national-programme-for-it-in-the-nhs-an-update-on-the-delivery-of-detailed-care-records-systems-2/> (accessed 31 Jul 2014).
- 12 Greenhalgh T, Stones R, Swinglehurst D. Choose and Book: a sociological analysis of ‘resistance’ to an expert system. *Soc Sci Med* 2013;104:210–19.



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