CLINICAL POLICY
Did Not Attend (DNA), Was Not Brought (WNB) and Non-Access

Printed or downloaded copies of this document are not controlled – In exceptional circumstances where hard copies or downloaded versions are required, these will only be valid on the day printed or downloaded – please always ensure that the most up-to-date version is accessed through the Policy section of Gloucestershire Health and Care NHS Foundation Trust (GHC) Policy section of GHC Intranet. If any updates or changes to this document are required, please contact the Clinical Policy Group on: c[redacted] prior to making any amendments. Documents are password protected to prevent any unauthorised changes.

Policy Number	CLP160
Version:	V2
Purpose:	The purpose of this policy is to provide clear guidance for all health care staff delivering services within GHC for managing a patient who Did Not Attend (DNA) or Was Not Brought (WNB) to an appointment; or failed to make themselves available for a domiciliary visit at their home address or other identified location.
Consultation:	Performance and Development Leads, Deputy Service Directors, Associate Director of Patient Safety, Quality and Clinical Compliance, Business Intelligence Team, Clinical Systems Team, Head of Safeguarding Team, Individual service areas that have a Standard Operating Procedure in place, in relation to DNA/WNB or non-access visits: Dental Service, Health Visiting Service, Community Nursing Service Minor Injury and Illness Service, Pregnancy Advisory Service
Ratified by:	Clinical Policy Group
Date Ratified:	16/10/2025
Date of Issue:	12/11/2025
Review Date:	01/11/2028
Author / Reviewer:	Reviewed by: [redacted], Operational Governance and Performance Lead
Audience:	All GHC staff involved in delivering assessment and care interventions to patients
Dissemination:	The policy will be published on the GHC intranet, and its update will be listed on the Clinical Policy update bulletin
Impact Assessments:	This Policy has been subjected to an Equality Impact Assessment. This concluded that this policy will not create any adverse effect or discrimination on any individual or particular group and will not negatively impact upon the quality of services provided by the Trust.

Version History

Version	Date Issued	Reason for Change
V1	09/12/2022	New Policy – Damon Coombs
V1.1	16/05/2023	Health Visiting Standard Operating Procedure (SOP) added to Policy as Appendix 1
V1.2	06/05/2025	Location of service specific SOPs added under contents
V2	12/11/2025	Policy changes to align with the national definition of a DNA *"no advance warning given".* References added for NHS England. Health Visiting SOP updated to reflect changes. Policy aligns with Out of Hours Service, Home Visiting SOP, Treatment Centre SOP, MIIU SOP, ICT SOP. Updated safeguarding information. Information added in relation to making reasonable adjustments for patients as appropriate.

SUMMARY
The policy sets out the definition of DNA, and the importance of risk assessing patients who either DNA an appointment, patients who are not brought to an appointment, or when no access can be gained for a domiciliary visit.

TABLE OF CONTENTS

Service Specific SOPs are added as attachments to main Policy Intranet Page:
Did Not Attend (DNA), Was Not Brought (WNB) and Non-Access Policy (CLP160) - Interact

ABBREVIATIONS

Abbreviation	*Full Description*
DNA	Did Not Attend
GHC	Gloucestershire Health and Care NHS Foundation Trust
GP	General Practitioner
RTT	Referral to Treatment Time
SOP	Standard Operating Procedure
WNB	Was Not Brought

1. INTRODUCTION

There can be a number of reasons why people cancel appointments and withdraw their contact with NHS services. It is important that staff and services recognise the reasons for this and consider the differing needs of individuals to maximise engagement, service delivery, patient experience and health outcomes.

In England, under the NHS constitution, all staff are required to contribute towards providing fair and equitable services for all and play their part, wherever possible, in helping to reduce inequalities in experience, access or outcomes between differing groups or sections of society requiring health care.

Sometimes individuals might choose to cancel appointments or discontinue contact with NHS services, and this will not be a cause for concern. In other circumstances this could be an indicator that someone's physical and/or mental health is deteriorating, or that they are at risk of harm.

Individuals may fail to attend or withdraw from services due to challenges relating to their social circumstances and/or specific health needs, such as:

- Work / childcare / carer responsibilities
- travel restrictions
- limited finances
- limited mobility
- deterioration in physical and/or mental health since point of referral or last contact
- lack of understanding or insight into professionally agreed assessment and/or support needs
- domestic abuse
- safeguarding issues.

If a planned appointment or domiciliary visit does not take place, staff and teams should consider any potential risks for the patient. It is especially important that such decisions are not taken automatically and that each individual patient case is considered. Even when clinical information is limited, available information and the context of the presenting health concern must be considered. This includes both clinical risk factors, and innocent or practical reasons why an appointment is not kept, or contact is lost.

2. PURPOSE

The purpose of this policy is to provide direction for all health care staff delivering services within Gloucestershire Health and Care NHS Foundation Trust (GHC) for managing individuals that:

- **Was Not Brought (WNB)** - to be used when any child under 18 years, or any adult who has care and support needs was not taken to an appointment by a parent/carer.
- **Did Not Attend (DNA)** - a first or subsequent appointment
- **Non-Access** - did not make themselves available or denied access for a planned domiciliary visit.
- Were unavailable for an unplanned/emergency assessment and/or care intervention (e.g. Mental Health Act Assessment).

The policy provides a framework around which GHC services can develop Standard Operational Procedures for DNA, WNB and Non-Attendance.

The national definition for a DNA is defined as “no advance warning given”, therefore for any patient who does not turn up for an appointment and does not provide any notice they should be recorded as either a DNA or WNB. Any prior notice given that a patient is unable to attend their appointment should be recorded as a cancellation.

The principles that serve as the foundation to this policy are:

- GHC will ensure that the management of DNA, WNB and Non-Access is transparent, fair, and equitable.
- GHC will ensure that administrative processes within services are simple, efficient and provide a high-quality service to patients.
- GHC will act in the interest of patient safety in the event of DNA, WNB and Non-Access.
- All patients will experience equity of due process and impartiality in relation to incidents of DNA, WNB and Non-Access.
- Patients will be treated in accordance with their clinical need or priority.
- Patients will be offered care and treatment in the most suitable setting for their needs following assessment and discussion.

3. SCOPE

This document applies to all Physical and Mental Health services provided by GHC.

4. DUTIES

General Roles, Responsibilities and Accountability

GHC aims to take all reasonable steps to ensure the safety and independence of its patients and service users to make their own decisions about their care and treatment.

In addition, GHC will ensure that:

- All employees have access to up-to-date evidence-based policy documents.
- Appropriate training is provided dependent on service and identified needs and risks of the job role as agreed by the Trust.

Managers and Heads of Service will ensure that:

- All staff are aware of and have access to relevant policy documents.
- All staff are supported to access training and development as appropriate to individual

employee needs.
- All staff participate in the appraisal process, including the review of competencies.

Employees (including bank, agency and locum staff) must ensure that they:

- Practice within their level of competency and within the scope of their professional bodies where appropriate.
- Familiarise themselves with and adhere to relevant GHC policies and procedures.
- Identify any areas for skill update or training required.
- Participate in the appraisal process.
- Ensure that all care and consent complies with the Mental Capacity Act (2005) – see section on MCA Compliance below.

5. POLICY DETAIL

5.1 DNA and WNB First Contact

Individuals will be advised what to do if they need to change a planned domiciliary visit or appointment. They are deemed to have cancelled if they provide prior notice that they cannot keep the appointment visit. If they are a vulnerable adult or child and there is a safeguarding concern then the referrer, patient's GP and any other relevant professional supporting that patient will be informed in writing. The Referral to Treatment Time (RTT) clock stops where applicable (see Access Policy).

If an individual does not attend their first appointment, this is a DNA. Any child under 18 years, or any adult who has care and support needs and not taken to an appointment by a parent/carer this is a WNB.

The action taken for incidents of DNA or WNB to a first appointment will depend on the potential level of risk to the individual's health or welfare and will be based on professional judgement and service provision. As the person is not known to the service at this time, the assessment and action will be based on information within the referral and the context of the presenting health concern. If the referral information indicates potentially high-risk issues, then an action plan should be made to mitigate this. Contact with the referrer should be made as soon as possible to ascertain further information and support the formulation of a plan.

If the patient is known to be an adult or child at risk and there are safeguarding concerns; the referrer, patient's GP and any other relevant professional supporting that patient will be informed in writing. All safeguarding concerns should be escalated as per GHC Safeguarding Adults and Children policies. Correspondence should be marked accordingly if it is not for patient view on GP records if there are associated risks: e.g. high-risk domestic abuse cases where perpetrators may see the victim's records.

Reasonable adjustments to support people to attend their appointment may need to be considered in individual circumstances. A reasonable adjustment is a small change that may mean that an autistic person, person with a learning disability or any individual who would meet the criteria of the nine protected characteristics of the Equality Act 2010 would be able to have more equitable access to healthcare.

Reasonable adjustments can be as such (this is not an exhaustive list):

- Easy Read appointment letters

- Text reminders for appointments
- Longer appointment times if someone needs more time
- Priority appointments for people who may find waiting difficult

5.2 DNA and WNB Subsequent Appointments

Individuals invited to attend subsequent appointments will already be receiving ongoing assessment, support and/or care interventions from GHC services. As with first appointments, they will be advised what to do if they need to change or cancel a planned appointment. If they cancel or need to change an appointment and provide notice, this will be recorded as a cancellation. If the individual does not attend a subsequent appointment, this will be recorded as a DNA or WNB.

The action taken for incidents of DNA or WNB to a subsequent appointment will depend on potential risks to the individual's health and/or welfare based on professional judgement and service provision. There will be a better understanding of potential risks as the individual is already known to services. Action plans to manage identified risks should be clearly documented within the patient's health record and escalated within the team via line management structures and/or other services and agencies as deemed necessary, e.g. knowledge and skills within the multidisciplinary team, other GHC services, other NHS and private sector providers, Social Services, Police.

If the patient is an adult at risk or child and there are safeguarding concerns then the referrer, patient's GP and any other relevant professional supporting that patient will be informed in writing. All safeguarding concerns should be escalated as per GHC Safeguarding Adults and Children policies. Correspondence should be marked accordingly if it is not for patient view on GP records if there are associated risks, e.g. high-risk domestic abuse cases where perpetrators may see the victim's records.

Practitioners concerned about an adult or children/young person frequently not brought to appointments can contact the safeguarding advice line for support and advice. GHC Safeguarding Advice Line: [redacted].

5.3 Non-Access: First Contact and Subsequent Appointments

If an individual is not present at or denies access to their address or other location within the community for a planned domiciliary visit; this is deemed as **Non-Access**. First contact domiciliary visits are carried out by various services within GHC; therefore, Non-Access applies to both first contact and subsequent appointments.

Individuals will be advised what to do if they need to change a planned domiciliary visit. They are deemed to have cancelled if they provided prior notice that they cannot keep the appointment visit. If they are a vulnerable adult or child and there is a safeguarding concern, then the patient's GP and any other relevant professional supporting that patient will be informed in writing. The RTT clock stops where applicable (see Access Policy).

Action taken in the event of Non-Access for first contact will depend on the perceived or known level of risk to the individual's health or welfare and will be based on professional judgement. Consideration of risk will be informed by the referral and the context of the presenting health concern. If the referral information indicates potentially high-risk issues, then an action plan should be made to mitigate this. Contact with the referrer should be made as soon as possible

to ascertain further information and support the formulation of a plan.

Action following Non-Access for subsequent appointments will be based on a better understanding of risk as the individual is already known to the service. Action plans to manage identified risks should be clearly documented within the patient's health record and escalated within the team via line management structures and/or other services and agencies as deemed necessary, e.g. knowledge and skills within the multidisciplinary team, other GHC services, other NHS and private sector providers, Social Services, Police.

For children not brought to appointments, consideration needs to be given to contacting services such as GP/Health Visitor, to establish whether there are any barriers preventing appointment attendance such as transport issues. Solutions to any barriers can then be identified for example, offering a home/school visit.

If the patient is a known adult or child at risk and there are safeguarding concerns then the referrer, patient's GP and any other relevant professional supporting that patient will be informed in writing. All safeguarding concerns should be escalated as per GHC Safeguarding Adults and Children policies. Correspondence should be marked accordingly if it is not for patient view on GP records if there are associated risks, e.g. high-risk domestic abuse cases where perpetrators may see the victim's records.

Practitioners concerned about an adult or child where Non-Access occurs can contact the safeguarding advice line for support and advice. GHC Safeguarding Advice Line: [redacted]. However, if this is out of hours and there is a concern about imminent risk of significant harm, then it would be a call to emergency services. Additionally, the Local Authority Emergency Duty Team are available for reporting concerns about a child and/or an adult outside of normal office hours on [redacted] or email to [redacted]

In the event of Non-Access at the address/location of the domiciliary visit; GHC staff should phone the home number or patient's mobile before leaving to attempt to establish what has happened. If phone contact is made, the appointment can either proceed as planned if the patient is present, or a new appointment can be agreed providing there are no immediate high-risk concerns. If phone contact is unsuccessful, take other measures to try and ascertain if the patient is at the address as appropriate, e.g. keep knocking/ringing, look/call through the letter box, look through windows, knock on window. Staff should endeavour to discuss any high-risk concerns with a senior colleague before leaving the location.

Any action taken at the location of the domiciliary visit will be led by known or perceived risks or safeguarding concerns. Patient confidentiality should be respected and maintained at all times.

5.4 Assessing and Managing Clinical Risk and Safety

Risk assessment is an integral part of the assessment, support and treatment of each patient when in contact with GHC services. It is not possible to eliminate all risk, but potential risks to an individual's health and welfare should be considered at all times, throughout the patient's journey. Risk should not be viewed as different for individual's receiving physical or mental health care. The type of risks may vary between patient groups for a number of reasons, e.g. the type and acuity of the presenting health concern, capacity, age, social circumstance; but risk is multifaceted and can apply to any individual with differing health needs.

Possible risk factors associated with incidents of DNA, WNB or Non-Access should be considered

across all services in line with the service provision. Systems and processes to mitigate known or perceived risks should be transparent, fair, and equitable and act in the interest of patient safety and positive health outcomes.

Effective risk assessment and risk management systems should be integral to all GHC services in accordance with relevant GHC Policies (see Associated Documents section).

5.5 Vulnerable Patients and Safeguarding

GHC will make every attempt to ensure that where safeguarding issues have been identified or when patients are considered vulnerable, they are supported to attend their appointment. These patients will routinely be offered a second appointment following DNA, WNB and Non-Access for first contact.

Where safeguarding risks are known, e.g. children subject to child in need/child protection plans and children in care, information on non-access visits should be shared with relevant professionals. If new concerns arise following non-access visits, practitioners should follow GHC Safeguarding Children policy guidance.

Further guidance is available from the GHC Safeguarding Team and by reference to GHC and other Multi-Agency Safeguarding Policies (see Associated Documents section below). Practitioners concerned about an adult or child/young person at risk can contact the safeguarding advice line for support and advice. GHC Safeguarding Advice Line: [redacted].

Consideration should be given to people at risk from others who may be coerced into not having contact with professionals. Communication methods should be considered as to how the person can be contacted safely and safe locations that the person can be seen alone. Correspondence can be intercepted or monitored by perpetrators of abuse.

5.6 Mental Capacity Act Compliance

When DNA, WNB or Non-Access has occurred, the person's mental capacity to make decisions about attending appointments should be considered. If there are concerns that the person may lack mental capacity to consent to an appointment, then the referrer should be approached to ask if they have any concerns about the person's mental capacity or if they have completed a mental capacity assessment in relation to this person's ability to engage in attending appointments. If there is clear evidence that the person lacks mental capacity to engage in attending appointments then a best interest decision should be made to contact a family member, carer, close friend or any attorney under a lasting power of attorney for health and welfare or court appointed deputy, to seek their support in gaining access to the person.

Where parts of this document relate to decisions about providing any form of care treatment or accommodation, staff using the document must do the following: -

- Establish if the person is able to consent to the care, treatment or accommodation that is proposed. (Consider the 5 principles of the Mental Capacity Act 2005 as outlined in section 1 of the Act. In particular principles 1,2 and 3) Mental Capacity Act 2005 (legislation.gov.uk).
- Where there are concerns that the person may not have mental capacity to make the specific decision, complete and record a formal mental capacity assessment on the GHC Trust approved MCA forms. These are available as templates on clinical record systems and on the GHC intranet.

- Where it has been evidenced that a person lacks the mental capacity to make the specific decision, complete and record a formal best interest decision making process using the best interest checklist as outlined in section 4 of the Mental Capacity Act 2005 Mental Capacity Act 2005 (legislation.gov.uk). Evidence of Best Interests decision making must be provided on the GHC Trust approved forms. These are available as templates on clinical record systems and on the GHC intranet.
- Where a person is admitted to hospital for the treatment of a physical health condition and is assessed as being unable to consent to admission, care or treatment, an application for an Urgent DOLS Authorisation must be submitted to the Local Authority. This applies in all cases where the person lacks capacity, regardless of their compliance with or objection to their admission. Establish if there is an attorney under a relevant and registered Lasting Power of Attorney (LPA) or a deputy appointed by the Court of Protection to make specific decisions on behalf of the person (N.B. they will be the decision maker where a relevant best interest decision is required. The validity of an LPA or a court order can be checked with the Office of the Public Guardian) Office of the Public Guardian - GOV.UK (www.gov.uk).
- If a person lacks mental capacity, it is important to establish if there is a valid and applicable Advance Decision before medical treatment is given. The Advance Decision is legally binding if it complies with the MCA, is valid and applies to the specific situation. If these principles are met it takes precedence over decisions made in the person's best interests by other people. To be legally binding the person must have been over 18 when the Advance Decision was signed and had capacity to make, understand and communicate the decision. It must specifically state which medical treatments, and in which circumstances the person refuses and only these must be considered. If a patient is detained under the Mental Health Act 1983 treatment can be given for a psychiatric disorder.
- Where the decision relates to a child under the age of 16, the MCA does not apply. In these cases, the competence of the child must be considered under Gillick competence. If the child is deemed not to have the competence to make the decision, then those who hold Parental Responsibility will make the decision, assuming it falls within the Zone of Parental control. Where the decision relates to treatment which is life sustaining, or which will prevent significant long-term damage to a child under 18 their refusal to consent can be overridden even if they have capacity or competence to consent.

6. PROCESS FOR MONITORING COMPLIANCE

Are the systems or processes in this document monitored in line with national, regional, trust or local requirements?	YES

Monitoring Requirements and Methodology	Frequency	Further Actions
Access targets are agreed locally with commissioners and reported via the organisation's performance dashboard. Access to services is monitored via Patient Tracking Lists (PTLs), which are managed by service and performance leads.	Annually	Performance exceptions are escalated through operational performance reporting and shared at Business Intelligence Management Group (BIMG) with oversight at resources and quality forums.

7. INCIDENT AND NEAR MISS REPORTING AND SPECIFIC DUTY OF CANDOUR REQUIREMENTS

To support monitoring and learning from harm, staff should utilise the Trust's Incident Reporting

System, DATIX. For further guidance, staff and managers should reference the Incident Reporting Policy. For moderate and severe harm, or deaths, related to patient safety incidents, Regulation 20 Duty of Candour must be considered and guidance for staff can be found in the Duty of Candour Policy and Intranet resources. Professional Duty of Candour and the overarching principle of 'being open' should apply to all incidents.

8. TRAINING

Training and information for staff involved in delivering assessment and care interventions to patients will be given initially on local induction to the Trust. Line Managers should ensure all appropriate staff members are aware of the local implementation of the policy.

Specific Training for Safeguarding Adults:

Safeguarding training is mandatory for all Trust staff. The level of training will depend on role and is specified in individual training profiles. Line managers have responsibility for ensuring staff are trained to the necessary level and are up to date with mandatory training.

The training requirements are based on guidance outlined in 'Adult Safeguarding: Roles and Competencies for Health Care Staff' (2018), Training needs should be reflected on individual profiles on Care to Learn and addressed in the annual appraisal process.

- **Level 1: (Universal) All staff including non-clinical managers and staff working in health care settings**
  All staff will complete Safeguarding Children and Adults Level 1 training as part of the Corporate Induction programme.

- **Level 2: (Targeted) Safeguarding Adults and Children – (minimum level required for non-clinical staff who have some degree of contact with children and young people and/or their parents/carers)**
  It is mandatory for all clinical staff to attend Level 2 training. If not undertaking level 3 adult or children safeguarding training - this needs to be updated every 3 years.

- **Level 3: (Specialist) Safeguarding Adults**
  This is mandatory for registered health care staff who engage in assessing, planning, intervening and evaluating the needs of adults where there are safeguarding concerns. This extends across physical and mental health services and includes health visitors in CYPS. This needs to be updated every 3 years.

- **Level 4: Specialist Strategic Safeguarding Adults**
  Level 4 adults training is specialist training for staff having responsibility to investigate under Section 42 of the Care Act 2014. This is mandatory for Team Managers in mental health working age adult teams, Social Workers band 6 and above, Social Care Specialists, Social Care Lead, Community Service Managers, Modern Matrons, Named Doctor for Safeguarding Adults, Named Lead for Safeguarding Adults and Head of Safeguarding.

- **Level 5: Designated Professionals**
  This applies to designated doctors and nurses, consultant/lead nurses for Safeguarding (Strategic).

Specific Training for Safeguarding Children:

Safeguarding Children Level 1 – Introduction to Safeguarding Children
This training is for all staff including non-clinical managers and staff working in all areas across the Trust.
This eLearning will need to be completed within three months of starting to work in the Trust and will be repeated every three years.

Safeguarding Children Level 2 – Recognition, Response and Record
For non-clinical staff who have some degree of contact with children and/or their parents/carers. For all clinical staff working within the Trust, irrespective of grade, should complete this level 2 Mandatory Training. Service managers should consider administrative and other staff undertaking these sessions if they have significant contact with service users and their families, either in person, on the telephone or virtually.

The agreed list of staff who have been identified on the Trust Training Matrix will undertake a refresher session every three years. This will negate the need to repeat the Safeguarding Children– Level 1.

This national eLearning programme will include a presentation about the local safeguarding child processes and arrangements and will include the Think Family approach.

Safeguarding Children Level 3 - Multi Agency Child Protection Training (Specialist)
It is essential for clinical staff working with children, and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child and parenting capacity where there are safeguarding/child protection concerns.

All qualified staff working with children should complete the multiagency Safeguarding Child Protection Inter-agency (CPIA Level 3) provided by the GSCP, details can be found on Care to Learn.

A refresher session should be undertaken every 3 years. This will negate the need to repeat the Safeguarding Children – Level 2.

Level 4 Specialist Strategic Safeguarding Children.
This is mandatory for Named Doctor for Safeguarding Children, Named Nurse for Safeguarding Children and Head of Safeguarding and repeated every 3 years.

Level 5 Designated professionals.
This applies to designated doctors and nurses, consultant/lead nurses for Safeguarding (Strategic).

9. REFERENCES

The National Institute for Health and Care Excellence (NICE) Guidance - CG138 Patient experience in adult NHS services: improving the experience of care for people using adult NHS services.

The National Institute for Health and Care Excellence (NICE) Guidance - NG204 Babies, children and young people's experience of healthcare.

NHS England - Reducing did not attends (DNAs) in outpatient services

NHS England – Did Not Attends (DNAs)

10. ASSOCIATED DOCUMENTS

- Service Specific Non-Access, DNA and WNB SOPs (Attachments to CLP160)
- Access Policy – Physical Health Services (CLP103)
- Assessment and Care Management Policy (CLP247)
- Safety Assessment in Mental Health and Learning Disability Clinical Practice Policy (CLP249)
- Safeguarding Adults Policy (CLP101)
- Safeguarding Children Policy (CLP071)
- Mental Health Act Information Policy
- Gloucestershire Multi Agency Mental Capacity Act Policy (MCAGG POL1).
- Domestic Abuse Policy (CLP102)