Please note that clinical key documents are not designed to be printed, but to be viewed on-line. This is to ensure that the correct and most up to date version is being used. If, in exceptional circumstances, you need to print a copy, please note that the information will only be valid for 24 hours

Worcestershire Acute Hospitals NHS Trust

Failure to Attend for Children and Young People with Diabetes

Key Document code:	WAHT-TP- 045	
Key Documents Owner:	Dr West	Consultant Paediatrician
Approved by:	Paediatric Quality Improvement meeting	
Date of Approval:	26th March 2021	
Date of review: **This is the most current document and should be used until a revised version is in place**	26th March 2024	

Key Amendments

Date	Amendment	Approved by
19th Nov 2020	Document extended for one year	Dr J West/Paediatric QIM
26th March 2021	Document reviewed and approved for 3 years	Paediatric Guideline Review Meeting

Introduction

Children and young people with diabetes are vulnerable to short-term and long-term complications which can cause serious morbidity and mortality. There is good evidence that these are related to the level of blood glucose control. The treatment goal for children with Type 1 diabetes is to achieve individually adapted optimal blood glucose control that reduces the risk of complications to a minimum (NICE Clinical guidelines CG15).

Main Risk factors

Risk of Diabetic Ketoacidosis is increased in young people with HbA1c levels above 86 mmol/mol (10 %)
Every child with HbA1c above > 86 mmol/mol (10%)- it is important to identify confounding factors e.g. depression/ eating disorders, psychosocial reasons
Risk of nephropathy if HbA1c is above > 75 mmol/mol (9.0%)
Risk of severe retinopathy if HbA1c above > 75mmol/mol (9.0%)

Aim of care

Maintain ideal HbA1c below < 48mmol/mol (6.5%)

Attend routine outpatient clinic appointments 4 times a year

Consider extra clinic appointments/extra support if HbA1c > 86 mmol/mol (10%)

Attend Annual Review appointments (screening for associated conditions and long term complications)

Concerns regarding failure to attend clinics or allow access at home visits

1. Any factors above & a pattern of failure to attend appointments or engage with health care services by parents or carers.

2. Service providers follow consistent procedures in relation to the management of children and young people failing to attend appointments/receiving advice or treatments or when access is denied for planned home visits/treatments are required.

There must be clear robust procedures that enable children and young people to receive the care they require. These must incorporate the responsibilities of the organisation to safeguard children and young people, promoting their welfare in conjunction with Trust Child Safeguarding Procedures (NB The Worcestershire Safeguarding Children's Board does not have a did not attend/was not

brought policy). This includes an assessment of any safeguarding concerns related to non-attendance, collaboration with other health care professionals and appropriate sharing of information.

Principles

1. Patients with diabetes require on-going follow-up until transition to adult services. This will include the time when they are in Transitional care.

2. All children and young people with diabetes fall into the **High Risk** category as there is a risk of significant harm as a result of non-attendance.

3. Active consideration needs to be given to any linked child safeguarding issues on each occasion that children fail to attend, or access is denied. In the event that the young person has failed to attend, or the parent/carer has failed to bring the child to an appointment, it is important to determine whether there are underlying reasons for non-attendance relating to parental neglect, mental health or other safeguarding factors.

4. This may be known already by the Diabetes Specialist Nurse, but further investigation may be warranted, such as discussion with Children Social Care Services, especially if the child or family are already known to the services.

5. Although children *without* chronic conditions may be referred back to the referring GP if investigation proved that there is no risk to the child, ALL children with diabetes require regular and continuing follow-up and should not be referred back to the GP unless they have frequent non-attendance and are over the age of 17 years, with prior discussion with the GP.

Details of Guideline - (see flow chart, Appendix 1)

1. After a failed appointment, or lack of arranged access by the diabetes MDT at home, a discussion will take place at the clinic meeting or home visit to discuss the presence or absence of other factors which would be concerning.

2. For No Access visits a written communication that you have called as arranged will be left at the home, and the action recorded in the nursing notes. This will be discussed at the next clinic and a record written in the medical case notes.

3. Following a failed appointment or no access visit, a further appointment in the usual MDT clinic will be sent to the child if:

a. they have attended the previous appointment
b. the HbA1c at the last attendance was less than 64 mmol/mol (8.0%)
c. there are no other factors in the family which suggest other risk factors for the child

If any of the above factors are not present, the Paediatric Diabetes Specialist Nurse would contact the family by telephone for advice/assessment to see if the patient would benefit from a home visit.

4. If a child with an HbA1c level of more than 86 mmol/mol (10%) fails to attend two consecutive clinic appointments, then the Paediatric Diabetes Specialist Nurse will contact the family and liaise with the consultant paediatrician for discussion about need for home visit by PDSN or an earlier clinic review. The consultant would write to the family that there is an expectation from The Department of Health that children and young people with diabetes should attend 4 clinic appointments per year.

5. If there have been more than 3 failed attendances over the previous year, or if a child has failed to attend 2 consecutive appointments, then in addition to point 3 above, the consultant should mention in

the letter to family that he would have to consider contacting Children's Social Care Services if they fail to attend (without a good reason) on a third occasion.

6. All letters to the family will also be copied to the GP and health visitor/school health nurse.

7. If the team is concerned about risk of neglect to the child, or if there have been multiple DNAs in the past, consider referral to children's social care services.

8. If there has been no contact with patient/family or clinical review within one month and if child/patient under 16 years of age, then the Consultant will discuss with the Paediatric Diabetes Specialist Nurse and the MDT will consider if any safeguarding alert is required (if unsure discuss with Duty Team Children's Social Care Services).

9. All actions and outcomes will be documented in the case notes.

Monitoring and Compliance

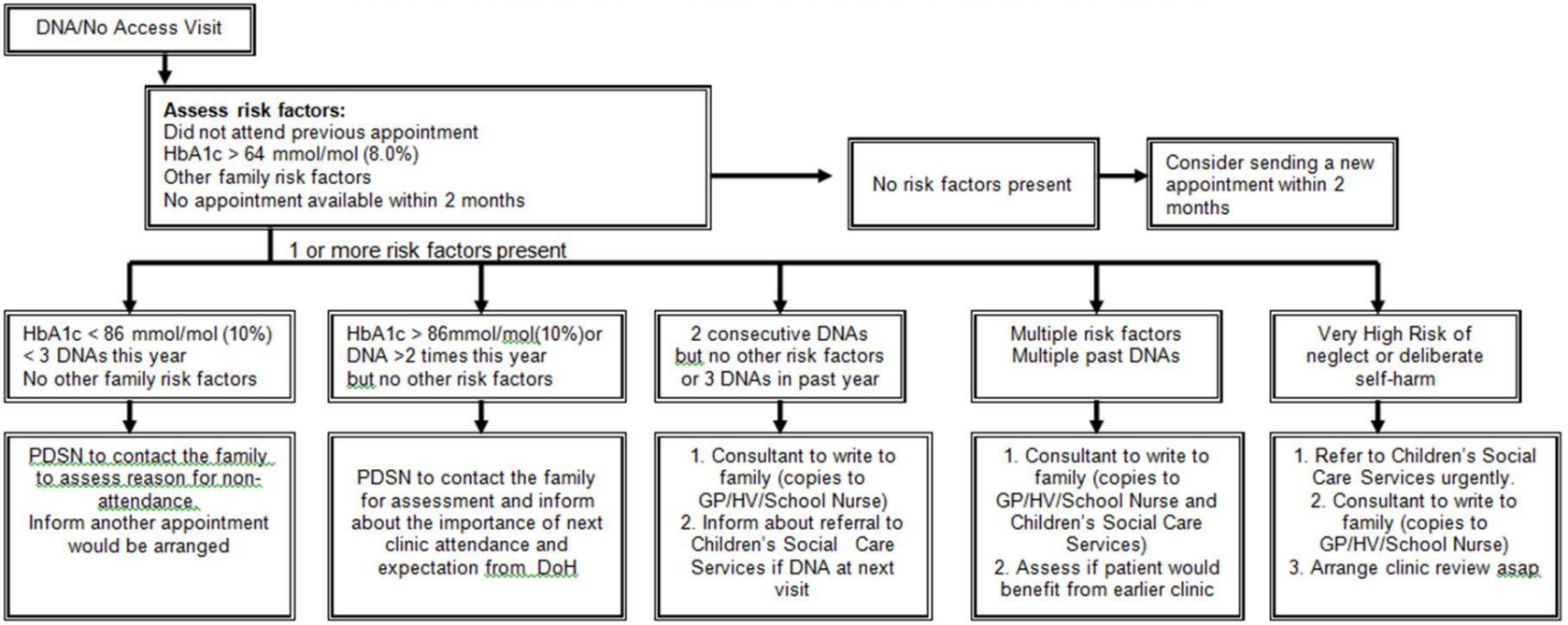
This section should identify how the Trusts plan to monitor compliance with and the effectiveness of this Treatment pathway. It should include auditable standards and/or key performance indicators (KPIs) and details on the methods for monitoring compliance.

WHAT?	HOW?	WHO?	WHERE?	WHEN?
These are the 'key' parts of the process that we are relying on to manage risk.	*What are we going to do to make sure the key parts of the process we have identified are being followed?*	*Who is responsible for the check?*	*Who will receive the monitoring results?*	*Set achievable frequencies.*
The management of type 1 diabetes in children and young people	Submit data to the National Paediatric Diabetes Audit	Dr James West	The paediatric multidisciplinary diabetes team and the paediatric department. The CCG's.	Annually
The management of diabetic ketoacidosis in children and young people	Submit data to the West Midlands Paediatric Diabetes Network DKA audit when requested. If not regularly requested a local audit will be performed.	Dr James West and Dr Naeem Ahmad	The paediatric multidisciplinary diabetes team and the paediatric department.	Annually
Paediatric & adolescent diabetes transitional care	Submit data to the West Midlands Paediatric Diabetes Network transition audit when requested. If not regularly requested a local audit will be performed.	Dr James West	The paediatric multidisciplinary diabetes team and the paediatric department.	Every 2 years

Please note that clinical key documents are not designed to be printed, but to be viewed on-line. This is to ensure that the correct and most up to date version is being used. If, in exceptional circumstances, you need to print a copy, please note that the information will only be valid for 24 hours

Appendix 1

Flowchart for DNA and No Access Visits for Children with Diabetes



References

1. NICE Guidelines for Diabetes 2004 , last amendment Aug 2011 http://www.nice.org.uk/nicemedia/live/10944/56133/56133.pdf
2. Clinical guideline 'High HbA1c Policy' Oxford Children Hospital-Oxford University Hospitals Trust 2012