



Non Attendees & Non Engagement / Unseen Child/Young Person Policy

Minimum Standards for all Health Services for Children and Young People (age 0-18 years)

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Responsible Director:	Director of Information Technology. HSCP Directors, Directors of Acute Services
Approved by:	NHSGGC Child Protection Forum
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1. Introduction

- 1.1 This policy is in keeping with the *Getting It Right for Every Child* (GIRFEC) approach that seeks to ensure that children have access to coordinated support when they need it.
- 1.2 For a variety of reasons accessing services can be difficult for some families. It is therefore essential that our appointment systems are flexible, effective and regularly evaluated.
- 1.3 This policy reflects NHSGGC's commitment to promoting equality and diversity as outlined in the Equality Act 2010. We are committed to developing and promoting policies and procedures to meet individual needs in a positive and supportive way. All procedures are implicit of people's rights not to be discriminated against regardless of race, gender, ability needs, sexual orientation, age or religion.
- 1.4 The following provides the minimum standards required whilst recognising that these standards may be exceeded.

2. Whom this Policy Applies to

- 2.1 This policy applies to all hospital, dental and community health services within NHSGGC who see children and young people up to the age of 18 years (19 years where the young person has special needs or is experiencing vulnerability (as referenced in Para 3.2 below). This policy also applies to independent contracted services.

3. Definitions

- 3.1 Non attendee (NA): A child or young person may be categorised as "a non attendee" when the service is not notified in advance that the child, or young person is unavailable to attend for any appointments. "Child/young person" is taken to include the individual child or young person or, as appropriate, their parent/carer. This also includes the persistent postponement of the appointment by the responsible person.
- 3.2. In attempting to define a child who is experiencing vulnerability it is useful to make reference to the current Health Plan Indicator (HPI) categories which outline core, additional (high risk) and additional (low risk).

4. Purpose of Policy

- 4.1. The purpose of this policy is to:-
 - Ensure that any risk to the safety and ongoing wellbeing of the child/young person is minimised and that identified health needs are addressed
 - Identify children and young people who require support due to vulnerability factors
 - Ensure that there is a robust and consistent process of supporting children and carers who fail to attend for health appointments
 - Provide additional support/measures to ensure very vulnerable children and young people attend health appointments
 - Improve the management of non attendees and to reduce non-attendance rates
 - Make effective use of available resources
 - Ensure the sharing of information on children and young people who do not attend where there are child protection concerns.

5. Basic Principles

- 5.1 All reasonable action should be taken by the referrer to ensure that the correct demographic information has been obtained.

- 5.2 The referrer will include the Health Plan Indicator where available as assessed by the Health Visitor or School Nurse.
- 5.3 The carer/young person should be given an appropriate and accessible appointment preferably agreed beforehand with the carer /young person (e.g. through telephone booking).
- 5.4 Sufficient notice of the appointment should be given (seven days advance notice except for urgent cases or cancellations).
- 5.5 Carers/young persons should receive clear instructions of whom to notify if unable to keep the appointment.
- 5.6 Carer's/young person's repeat appointment letters should include explicit details of the reason for the appointment and the follow up process for non attendance e.g. referral to social work.
- 5.7 Appropriate measures should be taken where English is not the carer's/young person's first language, e.g. appointment letter in patient's first language, and where the carer/young person has a disability and where there are problems with literacy e.g. using appropriate visual prompts.

6. **Flagging vulnerability**

- 6.1 All vulnerable children should be flagged on GP IT systems at the moment through appropriate use of READ codes and free text on the referral. GPs should flag vulnerability on the referral letter for the appointment. It would be helpful for HPI to be used also.
- 6.2 Where known include contact details for the child/young person's named person or lead professionals.

7. **Non Attendees – New Urgent Appointments (Appendix 1)**

- 7.1 If an urgent appointment is missed or cancelled by a carer/young person, demographic details should be checked by administrative staff on the CHI Database or with the GP.
- 7.2 The consultant should decide on the need for re-appointment based on clinical need and social risk.
- 7.3 Guidance for Clinic Reappointment following Non_attendance is as follows:

Clinical Need

Consider Reappointment if a medical condition has been identified that, if left untreated or unmonitored, will lead to the impairment of a child's growth and development.

Social Risk

Consider Reappointment if:

- The child has been identified as at risk of maltreatment
- The referrer has raised concerns that the child is at risk of maltreatment
- The child is known to be on the child protection register
- Information, identified in previous interactions, suggests the child is at risk of maltreatment
- Record of significant child protection unit contact.

- Multiple clinic nonattendance recorded previously (should be escalated as well)
- 7.4 If the child/young person does not attend the second appointment, or cancels as above, a letter will be sent to both the carer/young person and referring clinician advising them of non attendance and also removal from the waiting list. Where a child has been identified as being vulnerable and/or on the child protection register the referrer should consider how to respond proactively (refer to section on difficult to engage families). The named person or lead health professional should be informed of non attendance.
- 7.5 Non-attendance should be noted in the chronology section of the child's file(s) and what action was taken (Childs Health Record, Community).
- 8. Non Attendees – New Routine Appointments and Non-Attendance at Return Appointments**
- 8.1 As per urgent/soon appointments but with due clinical priority.
- 9. Return Appointment – Telephone Cancellation**
- 9.1 If a carer/young person rings to cancel a return appointment that had not been left open ended*, administrative staff will pull the records/alert the responsible clinician using CHI numbers, and put them with the responsible clinician to be reviewed as per the policy above.
- * That is the clinician has given a return appointment but has told the family that if they do not consider a return visit necessary, they are free to cancel. This will be recorded in the case record.
- 9.2 If administrative staff receives the cancellation, the call will be acknowledged and passed on to the appropriate administrative team to action as above.
- 9.3 Where the child has been identified as vulnerable the partial booking system or opt in system should not be used.
- 10. Provision for Health Visitor/School Nurse to obtain an urgent appointment where there are concerns**
- 10.1. Where the Health/Visitor School Nurse has concerns there is the capacity for the Health Visitor/School Nurse to initiate an urgent appointment if a vulnerable child has been referred and has not attended. This is done by contacting the relevant Site Health Records Manager who will arrange in collaboration with Health Visitor/School Nurse.
- 11. Role of Social Work and Education Services**
- 11.1 Social Work Services will, in conjunction with partner agencies, as far as practically possible, facilitate the attendance at health appointments for vulnerable children/young people on Social Work caseloads. Social Work Services will give these health appointments due priority status and include attendance in the child's plan.
- 12. When there are difficulties in engaging families**
- 12.1 Several health services for children will visit a child at home as routine practice. However, this is not standard practice for clinic based services. In keeping with principles of person centred care, in cases where a child/young person has missed clinical health appointments (to any one or several health services) which are compromising the child's health and development, clinicians should seriously consider the following courses of action:-
1. Consider referral for a comprehensive medical assessment
 2. Assess and treat the child at home. While the clinic setting may be the optimum place for treatment, the home could be a second best option and should be considered

3. The child is seen in the early evening, after school or at weekends
4. The child is seen in school or nursery
5. Refer the child to Social Work Services and possibly to the Reporter where appropriate.

While it is recognised that, due to practical and time restraints, options 2-4 would not be possible for the vast majority of children, **they should nevertheless be seriously considered for the most vulnerable children whose health and wellbeing are being seriously compromised.**

12.2 Where there are concerns about staff safety please refer to NHSGGC Policy on Lone Working.

13. Hospital In-Patients/Day Cases

13.1 If the child/young person does not attend for the first appointment efforts should be made to find out the reason and depending on the outcome, one further appointment will be sent.

13.2 If the child/young person does need to attend a further appointment will be issued. Where a child/young person has been identified by the referrer as being vulnerable the referrer and GP will also be contacted with the second appointment details.

13.3 If the child/young person is given a second appointment and does not attend, the consultant will decide how to proceed based on clinical need and social risk.

13.4 If sequential treatment is necessary or it is known that non-attendance could cause harm to the child/young person, the responsible clinician should refer to social work using the shared referral form and can contact the CPU for further advice and support. The shared referral form should be copied to the named person/lead health professional and GP.

14. Diagnostic Imaging

14.1 Should a child/young person not attend for any imaging, a second appointment should be sent out. If there is failure to attend on a second occasion, the child/young person's consultant should be advised and if an appointment is still necessary, this will require being re-ordered.

14.2 To enable the above to function smoothly, should a member of medical staff not at consultant level run his/her own clinics, the staff in the Department of Diagnostic Imaging require to know the name of the authorising consultant.

15. Emergency Departments

15.1 Every child/young person who fails to attend for an Emergency Department Review Clinic appointment should have their Emergency Department case note reviewed by one of the Emergency Department Consultant medical staff. If urgent action is subsequently deemed necessary, the child/young person's carers should be contacted by telephone, or failing that, the GP and/or named person/lead health professional contacted, by one of the Emergency Department Consultant medical staff. For those children/young person's where more urgent action is not deemed necessary, a standard letter offering a further appointment should be posted to the parents, with a copy to the GP. If no follow up is required a letter should be sent.

15.2 Emergency Departments should have systems in place to ensure that children/young people who, following registering at the ED, either do not wait to be seen or leave before treatment is complete, are identified and appropriately followed up. The GP and HV/School Nurse should always be informed of such episodes.

15.3 When other health professionals request that children are seen on an urgent basis for example GP referring to hospital based receiving services or transfer of a sick child from NHS 24 to an emergency department. Referring services should have in place systems that ensure that the child reaches the destination and is seen by that receiving health professional

16. Sandyford Sexual Health Services

16.1 This policy applies to all young people aged 0-17 years inclusively although consideration/conclusions about information sharing may be different in an older young person to one under the age of 16.

16.2 The confidentiality policy remains unaffected by this policy and information sharing should take place with full involvement of client if possible and safe to do so in line with GMC/NMC guidance.

16.3 There are 3 categories of presentation by young people to Sandyford sexual health services (though young people may move from one category to another):-

- *Young People who self present to the Sandyford and never attend the first appointment*

This presentation is most typically seen in the TOPAR (Termination of Pregnancy and referral) service though can occur to other services within Sandyford. If the reason for referral is known and of concern – e.g. pregnancy, the young person would be followed up by either the Young Persons team or the TOPAR team and encouraged to attend/attend another service such as their GP (which can then be verified by Sandyford staff). If staff is unable to verify that the young person has sought care from another Health professional or appropriate person e.g. parent/social worker then information would be shared with (most likely) the GP or school nurse even without the young person's consent.

- *Young People who self present to the walk-in services and subsequently do not attend for planned follow up:*

This presentation is the most common scenario. Clients are assessed throughout the service as self referrals and may be advised to return for follow up depending on their initial presentation. Any young person advised to return is recorded on a diary system on the electronic patient record and action taken to remind them to attend if they do not. This would usually be done through text reminder or email (or whatever the young person has agreed). If they subsequently do not attend there will be a Multi Disciplinary Team review of the notes by the young person's team and a decision made about whether information about non attendance needs shared. This would typically be through the school nurse, LAAC nurse or GP.

- *Young People referred by partner agencies (social work, school nurses, GP's, Archway SARC) who fail to attend either the first appointment or subsequent follow up:*

Any young person who does not attend an appointment arranged by a partner agency will be offered a further appointment. If there is a second failure to attend the partner agency will be notified. If the young person or parent cancels the appointment then the partner agency will be notified.

17. Unseen child/non engagement – home visits (Appendices 2 and 3)

- 17.1 This section covers situations where parents/carers adamantly refuse staff entry to the home or access to the child/young person and situations where lack of access is an issue due to parents / carers giving plausible explanations for this (disguised non compliance). Some families will continually reschedule appointments as an evasive tactic. The key issue is that the child/young person is not seen, rather than the reasons for this. The unseen child/young person may be a minimum of one of the following:
- No access to the home of the child/young person.
 - Access is gained at the home but the child is not physically seen by any professional.
 - Access is specifically denied by the parents.
 - The parents have repeated explanations for the child/young person's absence.
- 17.2 Primary care in particular may see a pattern of partial engagement with a number of health services. For a child/young person it is important that this is analysed and prompt action taken - a mixture of 1 or 2 appointments attended/partial engagement often results in a delay in referral or only some or part of child/young person's health needs being addressed.
- 17.3 Where services are visiting to deliver a voluntary programme rather than to do an assessment or meet a specific health need, as well as provide a Health Visiting Service (for example Family Nurse Partnership), careful consideration needs to be given to this aspect. Parents have a right not to engage with this programme and may begin to withdraw without there being risk for the child. Where there is risk and/or where there are unmet health needs in the child, and/or where there are actions set out in the Childs Plan (or Child Protection Plan contained therein) then the flow chart at Appendix 3 should be followed. Where this is not the case the flow chart at Appendix 2 should be followed. Given the specific nature of this programme it may be that known, responsible, family members have seen the child (for example grandparents) and this should be considered. In both scenarios ongoing attempts should be made to re-engage the family. As clinical supervision is weekly in this programme then any family where there are two missed contacts should be discussed in supervision.
- 17.4 National guidance for Child Protection in Scotland, 2014, Scottish Government indicates:
- “Evidence shows that some adults will deliberately evade practitioner interventions aimed at protecting a child. In many cases of child abuse and neglect, this is a clear and deliberate strategy adopted by one or more of the adults with responsibility for the care of a child. It is also the case that the nature of child protection work can result in parents/carers behaving in a negative and hostile way towards practitioners.
- The terms “non-engagement” and “non-compliance” are used to describe a range of deliberate behaviour and attitudes, such as: failure to enable necessary contact (for example missing appointments) or refusing to allow access to the child or to the home; active non-compliance with the actions set out in the Child's Plan (or Child Protection Plan contained therein); disguised non-compliance, where the parent/carer appears to co-operate without actually carrying out actions or enabling them to be effective; and threats of violence or other intimidation towards practitioners.

17.5 Consideration needs to be given to determining which family member(s) is or are stopping engagement from taking place and why. For example, it may be the case that one partner is “silencing” the other and that domestic abuse is a factor. Service users may find it easier to work with some practitioners than others. For example, young parents may agree to work with a health visitor/public health nurse but not a social worker.

17.6 When considering non-engagement, practitioners should check that the child protection concerns and necessary actions have been explained clearly, taking into account issues

of language, culture and disability, so that parents or carers fully understand the concerns and the impact on themselves and their child.

- 17.7 If there are risk factors associated with the care of children, risk is likely to be increased where any of the responsible adults with caring responsibilities fail to engage or comply with child protection services. Non-engagement and non-compliance, including disguised compliance, should be taken account of in information collection and assessment. Non-engagement and non-compliance may point to a need for compulsory or emergency measures. In what will often be challenging situations, staff may need access to additional or specialist advice to inform their assessments and plans.
- 17.8 There is a risk of “drift” setting in before non-engagement is identified and action taken. If letters are ignored, or appointments not kept, weeks can pass without practitioner contact with the child. If parents/carers fail to undertake or support necessary actions, this should be monitored and the impact regularly evaluated.
- 17.9 Good records must be kept, including contacts and whether they are successful or not, particularly during periods of high risk when children are not in nursery or school, for example, Christmas and summer holidays. Staff need to be clear what action should be taken when contact is not maintained. Where the child is subject to compulsory measures of supervision, the Reporter should be notified if agencies are unable to gain access to the child.
- 17.10 Core groups need to work effectively and collaboratively to deal with and counter non-engagement. Different agencies and practitioners will have different responsibilities. Effective multi-agency approaches provide flexibility so that, for example, responsibility for certain actions can be given to those practitioners or agencies that are most likely to achieve positive engagement. All services should be ready to take a flexible approach.
- 17.11 Given the nature of child protection work, non-engagement can sometimes involve direct hostility and threats or actual violence towards staff. All agencies should have protocols to deal with this, including practical measures to promote the safety of staff who have direct contact with families. In addition, staff should have the opportunity for debriefing after any incidents.
- 17.12 Families or carers who are directly hostile are very challenging to practitioners. However, services to children should not be withdrawn without putting other protective measures in place. Local child protection guidance should state that key safeguards and services should be maintained for children who are at risk of harm.
- 17.13 Key messages for practice are:
- Local protocols should provide details of specialist advice that can be sought when assessing concerns about non-compliance.
 - Records should include details about contact, or lack of contact, with a family.
 - Where the child is subject to compulsory measures of supervision, the Reporter should be notified if agencies are unable to gain access to the child.
 - All agencies should have protocols for dealing with threats to staff.
 - Services should not be withdrawn unless other protective measures have been put in place for the child.”

18. The unseen child – where there are no concerns – home visits

18.1 See Flowchart – Appendix 2

19. The unseen child – where there are child welfare/child protections concerns – home visits

19.1 See Flowchart – Appendix 3

20. Recording

20.1 Records should include details about contact, lack of contact, and rescheduling of appointments. The records should indicate any follow-up action taken.

20.2 Records must contain a chronology which must be kept up-to-date

21. Monitoring Compliance

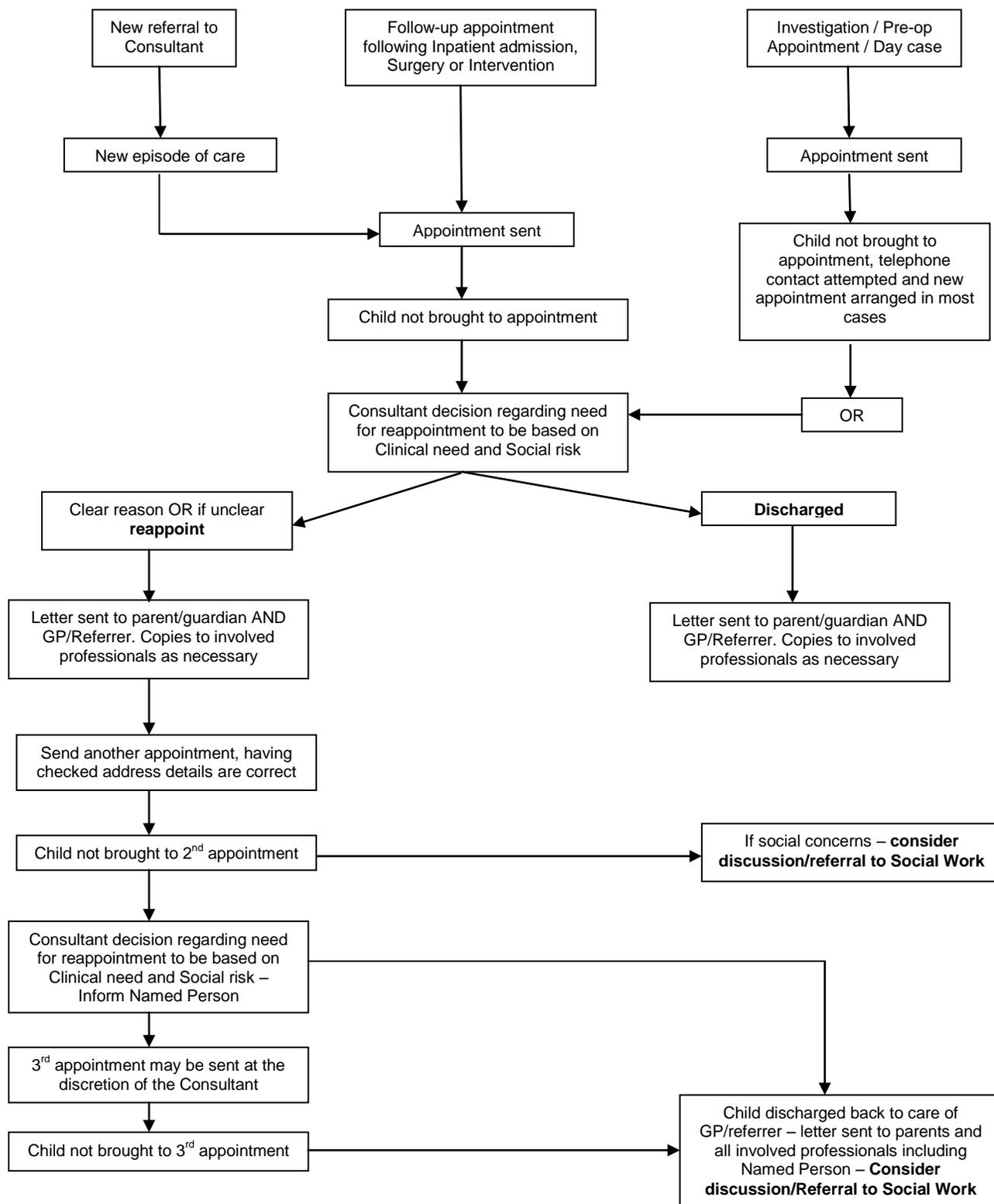
21.1 Compliance with this policy will be monitored by HSCP Directors and Directors of Acute Services. Guidance will be provided by CPU where required.

22. Specialist Advice

22.1 When assessing concerns about unseen child/non-engagement specialist advice can be sought via NHSGGC Child Protection Unit – Appendix 4.

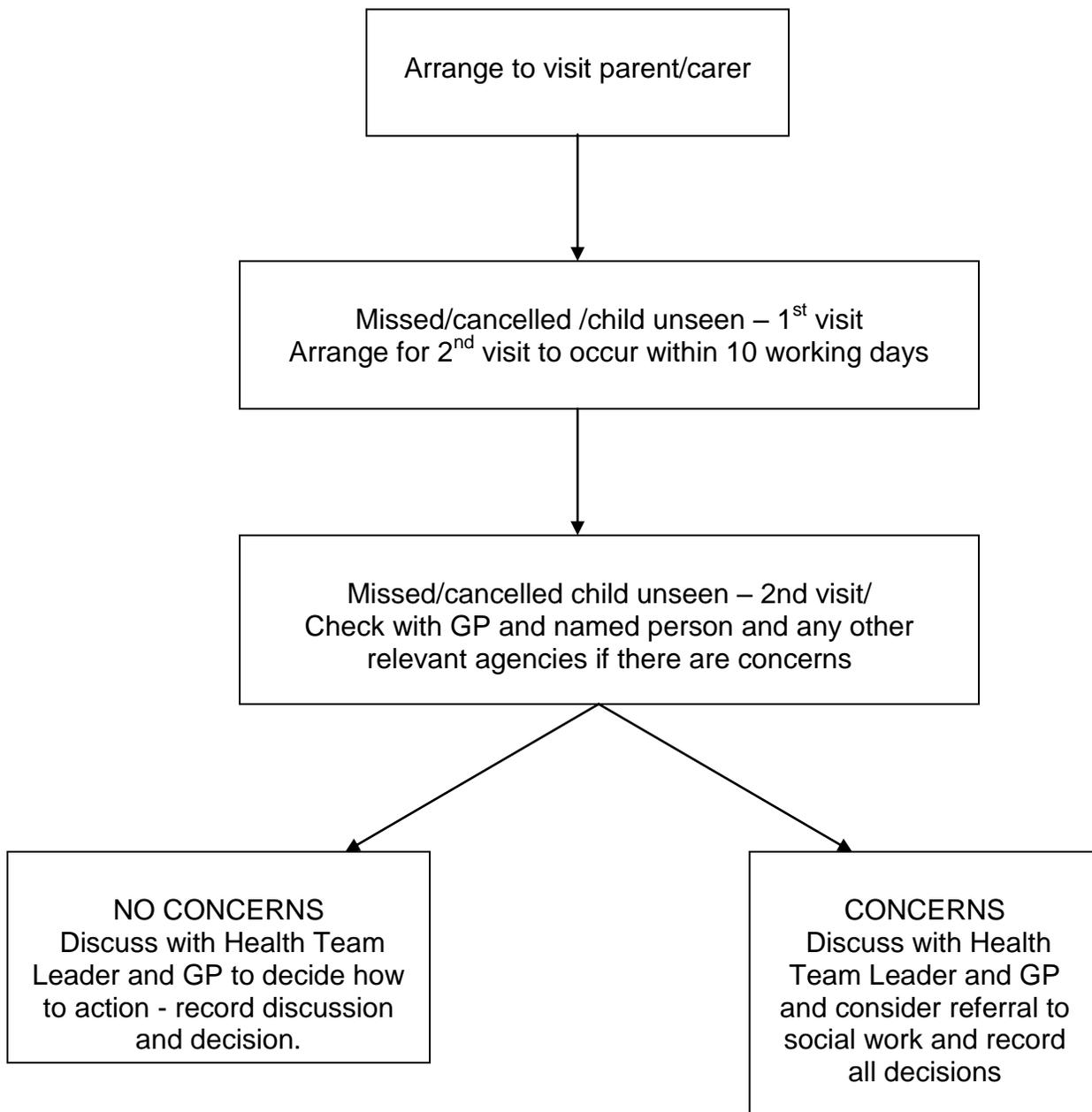
Appendix 1

Paediatric Clinic Nonattendance Pathway



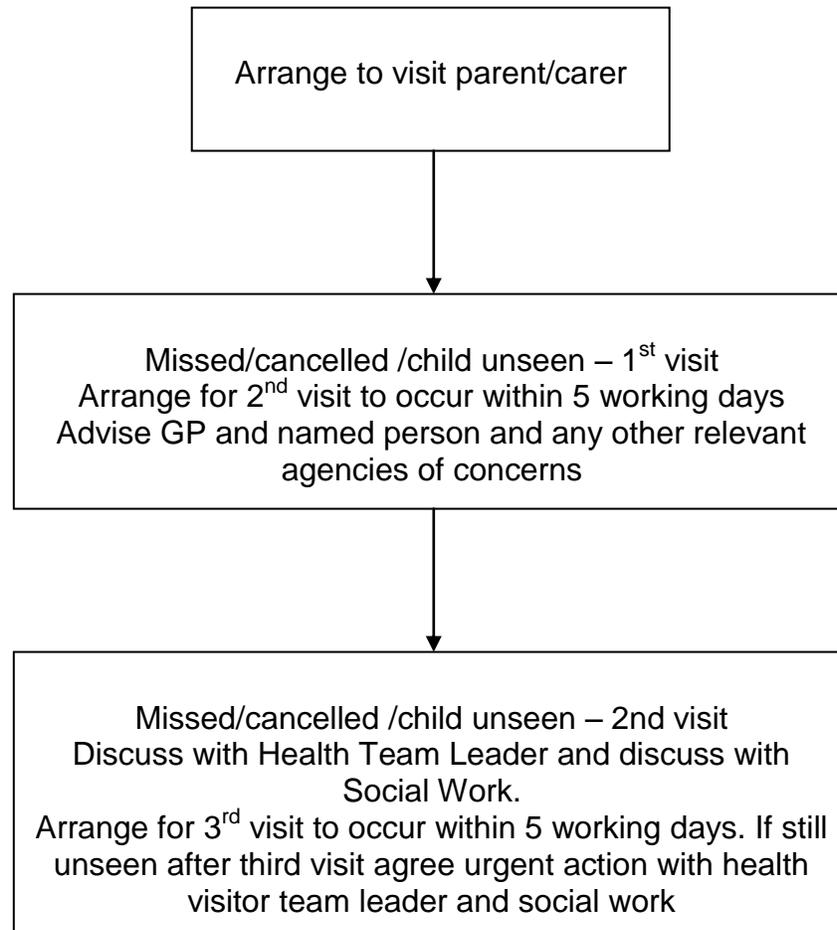
Appendix 2

THE UNSEEN CHILD – WHERE THERE ARE NO CONCERNS: HOME VISITS



Appendix 3

THE UNSEEN CHILD – WHERE THERE ARE CHILD WELLBEING/CHILD PROTECTION CONCERNS: HOME VISITS



Appendix 4

KEY CONTACTS

NHSGGC Child Protection Unit

NAME	TITLE	TELEPHONE NUMBER	EMAIL ADDRESS
Marie Valente	Head of Child Protection Development	0141 451 5617	marie.valente@ggc.scot.nhs.uk
Jean Herbison	Clinical Director	0141 451 6604	jean.herbison@ggc.scot.nhs.uk
Catherine Martin	Business Manager	0141 451 6550	Catherine.martin@ggc.scot.nhs.uk
Kerry Milligan	GPwSi child protection	0141 451 6605	kerrymilligan@nhs.net
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Verity Douglas	Child Protection Advisor	0797 175 5687	Verity.douglas@ggc.scot.nhs.uk
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The Head of Child Protection Development, Child Protection Advisors, GPwSi, Administrative staff and Clinical Director are available daytime hours, Monday – Friday, 9.00am – 5.00pm. The Clinical Director is available for clinical advice and intervention 24 hours when on call.

Appendix 5

SAMPLE

IN CONFIDENCE

Date
Your Ref
Our Ref

Enquiries to
Extension
Direct Line
Email

Dear

I have recently been unable to make contact with you in order to

.....

I now rearrange the visit for

.....

If this time does not suit you then please contact me to rearrange, my details are as follows

.....

.....

.....

Yours sincerely

Health Visitor/School Nurse

Appendix 6

SAMPLE

IN CONFIDENCE

Date
Your Ref
Our Ref

Enquiries to
Extension
Direct Line
Email

Dear

I have recently been unable to make contact with you in order to

.....

I now rearrange the visit for

.....

If this time does not suit you then please contact me to rearrange, my details are as follows

.....

.....

.....

If I do not hear from you I will need to inform other agencies of my concerns.

Yours sincerely

Health Visitor/School Nurse