Failed Contact (including was not brought) Protocol for all Staff Working with Children and Young People in NHS Shropshire, Telford and Wrekin Integrated Care Board

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Document Amendment History

Version No.	Date	Brief Description
1	2015	Policy written as a new document.
2	2021	Protocol formulated
3	2022	Protocol update; grammatical changes
4	2022	Minor amendments due to change in

The formally approved version of this document is that held on the NHS Shropshire, Telford and Wrekin Integrated Care Board (ICB) website:

https://www.shropshiretelfordandwrekin.nhs.uk/

Printed copies or those saved electronically must be checked to ensure they match the current online version.

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1 Introduction

NHS Shropshire, Telford and Wrekin Integrated Care Board (STWICB) recognises the challenges that staff face when working with Children and Young People (CYP) and their families / carers who are deemed as “not-engaging” or appear to be actively “disengaging” with recommended health services. Examples of this include Was Not Brought (WNB) (previously referred to as Did Not Attend (DNA)) and practitioners being unable to contact or gain access to CYP and or families / carers.

1.2 The following protocol is to be used by staff when they are concerned that continued failed contact with a CYP under their care is / will be detrimental to their welfare – including their physical, mental and emotional well-being.

1.3 Whilst the protocol is intended to empower staff to use their professional judgement whilst ensuring that they are effectively able to manage cases of failed contact, it should not be used as a means of promoting a culture of “policing” or “harassment”.

2 Purpose

The aim of these guidelines is to:

2.1 Clearly outline the responsibilities of staff when persistent failed contact occurs with a CYP and their family / carer/s within the context of health, which if remains unaddressed would be detrimental to their welfare.

2.2 To provide staff with the appropriate guidance about what action they should take in the event of persistent failed contact with a CYP and their family / carer/s within the context of health, which if remained unaddressed would be detrimental to their welfare.

2.3 Ensure that any action taken in response to persistent episodes of failed contact is proportionate and in the best interests of the CYP.

3 Outline of Policy

These guidelines are intended to complement the Safeguarding Children policy and the non-attendance at appointments policy and individual service protocols of the ICB provider organisations.

The guidelines are intended for staff working in children’s services within NHS Shropshire, Telford and Wrekin ICB.

All CYP are entitled to receive health services to promote their health, wellbeing and development. Failed contact with health services can be partial, selective, intermittent and persistent in nature. It is recognized that the persistent non-engagement / disengagement of CYP with health services is significant when domestic abuse, serious neglect or physical abuse feature. On a national, regional and local level DNA, WNB and "no access" episodes as highlighted by CSPR's

and DHR's are regarded as a precursor for CYP who experience serious abuse or death.

3.1 Failed contact may encompass the following situations:

- CYP repeatedly fails to attend or persistently WNB to health appointments.
- It is reported (directly or indirectly) that the CYP is refusing to attend health appointments
- CYP and / or / family / carer/s are not at home for pre-arranged visits
- CYP is not seen at home visit
- CYP is missing and their whereabouts are unknown
- CYP and / or family / carer/s choose to actively disengage with services despite professionals deeming this as not being in the individual's best interest.

4 Legal and Policy Framework

- Information Sharing advice for Practitioners 2018 [1]
- Working Together To Safeguard Children 2020[2]
- Personal Safety & Lone Working Policy arrangements
- STW Safeguarding Adults Policy
- Mental Capacity Act Policy
- Fraser guidelines [3]
- NHS Shropshire, Telford and Wrekin ICB Safeguarding Children Policy

[1] HM Government Information sharing: advice for practitioners providing safeguarding services to children, young people, parents and carers (2018) www.education.gov.uk
[2] HM Government Working together to safeguard children- A guide to inter-agency working to safeguard and promote the welfare of children (December 2020) www.education.gov.uk
[3] Gillick v West Norfolk & Wisbech Area Health Authority (1985) UKHL 7. British and Irish Legal Information Institute (BAILII)

5 Key Responsibilities

Staff should consider follow up requirements on a case by case basis. This should take into account the following:

- The CYP's individual circumstances and the possible implications if they are not in receipt of the appropriate health services; for example the age of the CYP, in particular when a case concerns an infant aged <1 years of age, who is premature and is of a low birth weight, their current clinical need/s, any additional needs including learning disabilities, possible barriers to effective communication and is the CYP known to Children's Services (both historically and currently).
- Are there any identified safeguarding concerns in respect of the CYP and / or any family members within their household e.g. parents, carers, siblings etc.

- Factors which may impact upon parents / carers capacity and ability to bring the CYP to health appointments including social issues, reduced socio-economic status, domestic abuse, substance misuse and mental and physical ill-health
- Reduced capacity of parents / carers in terms of their level of understanding which may be perpetuated by a learning disability, literacy issues, language barrier or communication difficulties.
- The wishes and feelings of the CYP and parents / carers.
- Consideration by practitioners that the failed contact may be as a result of an administrative error such as a change of address or contact details.
- Are the day, time, geographical location and clinical setting conducive to the individual CYP and their family / carers attending appointments as allocated?
- In the event that an alternative location is offered to negate the continued failed contact e.g. home visits, staff personal safety is prioritised and visits are undertaken in according with local policies and procedures including but not limited to “lone working”.
- Is there a pattern of failed contact with colleagues within other services such as social care and education?

NB If staff are concerned about any aspect of the key responsibilities identified within this protocol; please contact their line manager who can then seek further support and guidance from the designated safeguarding team within the ICB.

6 What to do in the event of persistent failed contact with a CYP

Practitioners should consider next steps in the event that a CYP has had 3x failed contacts (within context).

- Confirm home address and contact details are current, and up to date.
- Establish what actions have been taken to date to address the episodes of failed contact.
- If there are immediate safeguarding concerns, with the support of their line manager and if required the designated safeguarding team within the ICB contact Children’s Social Care with a view to submitting a safeguarding referral.
- In the event that a practitioner does not agree with or is not satisfied with the response from Children’s Social Care, they should escalate the case to the designated safeguarding team within the ICB.
- In the absence of any immediate clinical risk or safeguarding concerns, practitioners should offer further appointments / consider discharge in accordance with their individual service policies and protocols.
- Ascertain if other professionals are working with the CYP and if they are able to support health in managing their needs thus mitigating the risk posed by persistent failed contact.

- Inform the referrer into the service (where appropriate) of the failed contact and agree next steps.
- Liaise with the GP and consider whether an alert on the GP electronic records is required.
- Consider the most appropriate way of communicating the above with the CYP and family / carer/s

Staff should ensure that documentation completed is consistent with NHS Shropshire, Telford and Wrekin ICB records management policy and it is:

- Contemporaneous, clear, dated, timed and signed
- Includes all discussions, actions taken and outcomes recorded in the child or parent / carer record as appropriate.
- Records analysis, observations, conclusions and actions taken clearly, ensuring that any referral letters and the content of previous records have been considered.

If a CYP or parent / carer withdraws from Health Services staff should take the appropriate steps to ensure that all parties have understood the significance of this decision including any further action to be taken by health such as a referral into Children's Social Care.

7 CYP whose whereabouts is unknown

- Clarify when and where the CYP was last seen and by whom (including this person's relationship to the CYP).
- Ascertain if the child has attended local Out of Hours / Minor Injuries Unit (Research from Serious Case Reviews highlights that such attendances can be warning signs of parenting difficulties or abuse)**.**
- If not already informed, contact the Police immediately to advise as above.
- If the CYP is currently open to Children's Social Care e.g. subject to a current Section 47 enquiry or Child Protection Plan, deemed as a Child In Need or a Looked After Child, staff should liaise with the Allocated Social Worker or Emergency Duty Team (if outside of usual working hours Mon – Fri 09:00 – 17:00) at the earliest opportunity.
- Consider which other health services need to be informed of the missing episode e.g. Health Visitor, School Nurse, Family Nurse Partnership, GP.
- Ensure that the designated safeguarding team are informed of the CYP as needed and in the event that a Looked After Child (LAC) is missing the designated LAC nurses are informed.
- Ensure that there is an active alert on the CYP's records including any directives for professionals to follow in the event that the CYP presents to them in their setting.

8 Useful Links

- Analysis of Serious Case Reviews; 2014 - 2017: Research report analysing 368 SCRs with findings for professionals working with children and families Department for Education.

https://www.gov.uk/government/publications/analysis-of-serious-case-reviews-2014-to-2017

- Triennial of Serious Case Reviews; 2019

https://seriouscasereviews.rip.org.uk/wp-content/uploads/2019_triennial_analysis_of_serious_case_reviews_local_safeguarding_partnerships_Mar2020.pdf

- Rethinking 'Did Not Attend' – https://youtu.be/dAdNL6d4