Was Not Brought and No Engagement Policy (N-072)

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Policies should be accessed via the Trust intranet to ensure the current version is used

Contents

1. Introduction

The purpose of this document is to outline the roles and responsibilities of Humber Teaching NHS Foundation Trust staff in response to children, young people and adults at risk who are not brought to appointments and in addition where there are no access to home visits for appointments.

This policy provides guidance and support and is not intended to remove professional judgement. Individual practitioners remain accountable and as such need to be able to explain their decisions at all times.

Disengagement by a family/parent/child may be partial, intermittent, or persistent. It is important to be aware that this may be a signal of increased stress within a family and/or potential abuse or neglect of children and or adults at risk. It is important to identify early signs of disengagement so that any potential risk to a child young person or adult at risk can be assessed.

It is important to keep in mind that some parents/carers may be disengaging with healthcare for themselves or their own agenda; this may be a precursor to something more serious happening within the family.

Professionals need to consider their own role in how families are engaged with services whilst also remaining professionally curious to other factors and consider the risk in these situations.

When children, young people and vulnerable adults at risk are not brought to health appointments there are a number of issues that present a challenge to the service, and which has the potential to result in unaddressed need for the child(ren) young person or adults.

Many safeguarding reviews, both nationally and regionally, have featured failure to access health appointments or no access visits (NAV) as a precursor to serious child/adult abuse, neglect or death. The wellbeing of the person is often not known at the point of the missed appointment. Lord Laming (2003) recommended that following a missed appointment the responsibility for any assessment of the situation rests with the practitioner.

Professionals should consider the potential impact on the whole family that a failed contact or missed appointment could have. This is particularly relevant when mental health or problematic substance/alcohol misuse is featured. Always THINK FAMILY.

Section 11 of the Children Act 2004 places a statutory duty on health organisations to safeguard and promote the welfare of children and young people. An analysis of learning reviews identify disengagement with professionals as a factor for increased risk. Children and young people are reliant on their parent or carer to take them to their appointments, when they are not brought for health appointments, this may place a child's welfare in jeopardy.

Section 42 of the Care Act 2014 defines safeguarding as "Protecting an adult's right to live in safety, free from abuse and neglect". This applies to adults who have care and support needs (whether or not the local authority is meeting any of those needs) and is experiencing, or at risk of, abuse or neglect, and as a result of those care and support needs is unable to protect themselves from either the risk of or the experience of abuse or neglect.

2. Scope

This policy has been developed to guide staff by setting out clear processes to follow when a child, young person or adult is not brought for appointments with Humber Teaching NHS Foundation Trust services.

The purpose of this policy is to assist all staff within the Trust to be aware of their roles and responsibilities in safeguarding and promoting the welfare of children and adults who may be at risk from not being brought to appointments. The procedures and guidance within the policy will enable the Trust to fulfil its statutory duties as determined by the Children Act 1989 and 2004 and the Care Act 2014.

All staff should be aware that age, gender, cultural or religious beliefs, disabilities or social backgrounds may also impact on their ability to access help and support. Staff must give due consideration to these issues at all times when dealing with children, young people and their families, ensuring reasonable adjustments are in place.

This policy gives due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it.

3. Policy Statement

Safeguarding children and adults from harm is a core duty of Humber Teaching NHS Foundation Trust. This policy aims to assist the consideration and curiosity around potential safeguarding concerns where a child or adult dependent on others is not brought to an appointment, where an adult does not attend an appointment and where there are concerns for no access visits.

All staff have a duty for safeguarding children and adults at risk of abuse and/or neglect. This policy aims to ensure that there is a clear process for all staff working within Humber Teaching NHS Foundation Trust on how to apply safeguarding principles and procedures to the following situations:

- New referrals that do not attend/not brought to their first appointment.
- Patient known to our services but did not attend/ are not brought to a follow up appointment.
- No access visits where community staff are unable to make contact with, or gain access, to a person's place of residence.
- Appointments repeatedly cancelled by people in advance.
- Processes are in place to ensure early intervention and prevention when disengagement is a feature as this is the key to safeguarding adults / children.
- To ensure the recording and collection of timely information to enable analysis of incidents and identification of investigations.

4. Duties and Responsibilities

Chief Executive
The chief executive is required to ensure the organisation has systems and processes in place to implement this policy.

Executive Director of Nursing, Allied Health and Social Care Professionals
The Director of Nursing is responsible for the development and implementation of this policy. The Director of Nursing has overall responsibility for ensuring systems and processes are in place to maximise safeguarding for children and adults within the organisation.

Safeguarding Team
To provide advice and strategic oversight in relation to the safeguarding of children and adults including was not brought and non-engagement.

All staff
Humber Teaching NHS Foundation Trust shares a commitment to safeguard and promote the welfare of children and young people and for health this is underpinned by a statutory duty or duties.

It is the responsibility of all Humber Teaching NHS Foundation Trust staff to adhere to this policy to consider safeguarding where a child or adult is not brought, does not attend or there are no access visits.

Considerations for safeguarding should be made by all staff working with children/adults. Where a staff member is unsure around threshold for a safeguarding referral, it is their responsibility to ensure a discussion is had with the Trust safeguarding team.

5. Definitions

- **Children -** Section 11 of the Children Act 2004 places a statutory duty on health organisations to safeguard and promote the welfare of children and young people. An analysis of learning reviews identify disengagement with professionals as a factor for increased risk. Children and young people are reliant on their parent or carer to take them to their appointments, when they are not brought for health appointments, this may place a child's welfare in jeopardy.

- **Adults** – Section 42 of the Care Act 2014 defines safeguarding as "Protecting an adult's right to live in safety, free from abuse and neglect". This applies to adults who have care and support needs (whether or not the local authority is meeting any of those needs) and is experiencing, or at risk of, abuse or neglect, and as a result of those care and support needs is unable to protect themselves from either the risk of or the experience of abuse or neglect.

- **Was Not Brought (WNB)** – is defined as any scheduled appointment to see an adult/child, who, without notifying the service, was not presented/was not brought for their appointment, this refers to any prearranged contact with an adult/child, whether it is at their home, community clinic, at a community team building, within a hospital setting, or any other type of contact arranged relating to the provision of this service. Where the situation relates to a child, or an adult with care and support needs (as defined in the Care Act 2014) please ensure that the terminology 'was not brought' is used.

- **Disguised Compliance** – involves a parent or carer giving the appearance of engagement, they may cancel appointments frequently at the last minute, or after a period of non-engagement may attend appointments to reduce professionals' concerns. Patterns of this behaviour should be discussed with your line manager and/or the safeguarding team.

- **No Access Visit (NAV)** – is an appointment made in advance, and when the health care professional attends their place of residence, or another setting within the community, at the pre-arranged time and place, they are not available, and no contact is made.

- **Disengagement** – is when an adult, family member, or carer does not respond to requests from health professionals. Disengagement is usually cumulative and may present in many ways.

6. Procedures Relating to the Policy

6.1. Appointments

During periods of non-engagement all appointments for routine health surveillance, immunisations and screening tests must continue to be sent. The team who are requesting the appointments and those they are referring to should consider why the patient is not attending as there may be some very practical solutions to facilitate attendance.

When arranging appointments and home visits, Humber Teaching NHS Foundation Trust (HTNFT) services are expected to consider all necessary steps to prevent or reduce the potential for nonattendance wherever possible. This will include:-

- offering choice and flexibility in relation to appointment times and location;
- offering clear, unambiguous, user friendly information in accessible formatting and in translations appropriate to local communities;
- employing the use of interpreters as necessary;
- ensuring a trauma informed approach to provision of services.

6.2. Communication Needs

Patients who need to access our services may have multiple pressures and demands, including communication issues such as literacy, language and learning disabilities, as well as mobility issues, poverty, discrimination and social exclusion. HTNFT recognises the importance of modelling services, which are accessible, relevant, user friendly, engaging, and respectful.

6.3. Safeguarding Children Procedures

Please see appendix 1 for deciding level of risk and next steps. Where there are safeguarding concerns, please ensure advice is sought from the Trust safeguarding team.

It is considered to be neglect when parents of children refuse or fail to co-operate with prescribed medical or therapeutic treatment that may result in a child suffering harm. In these cases, the clinician should think about the impact of this on the child and a referral considered to children's services. Be aware that parents may try to justify their decisions as being in the child's best interests and may well genuinely believe they are acting in the best interest of their child. Some reasons for this can be related to their religion, cultural expectations or beliefs or a disability of the child, including learning disability, and sometimes there is no obvious reason for this. These reasons or convictions may be strongly and genuinely maintained by a parent. However, such information and reasons given by the parent/carer do not change the legal duties of agencies to safeguard the child's best interests.

Following a child not brought for an appointment, the responsibility for any assessment of the situation rests with the practitioner to whom the child has been referred, in conjunction with the referrer (Laming 2003, CEMACH 2006).

Health professionals must be able to demonstrate that attempts to gain a parent's co-operation have been made. If after encouragement all attempts to work in partnership with parents have failed, consideration must be given to the potential consequences for the child. If the child's development or welfare is likely to be significantly impaired, a referral to Children's Services should be made. If the child is age 16/17 years, consider mental capacity around the attendance.

Children subject to child protection

For children known to be a subject of a child protection plan, any non-engagement should be reported as soon as possible to the family social worker. If the social worker is unavailable and the situation is urgent professionals must speak to the duty social worker or Team Manager. All actions should be documented in the child's records and the children's notes coded as 'was not brought' where possible or documented within the safeguarding section of the clinical records. Concerns should be discussed within multidisciplinary team meetings as appropriate to discuss the welfare and health of the child.

Health professionals should ensure that parents have understood the significance of withdrawing children from or refusing the service and the impact of this on the child's welfare. Consideration must be given to the parent's level of understanding, for example any learning disability, literacy, language, or communication difficulty. Remember to remain aware that parents and carers may have their own physical or mental health needs. Consideration should be given to the needs of the child and a parent's capacity to meet those needs and the environmental context of the child's situation. In some scenarios the child may well be a carer for their parent however, health professionals must take appropriate action to secure the child's welfare, regardless of the child's role as carer. Professionals should remain child focused even when the refusal or withdrawal relates to the parent's problems particularly when mental health, substance misuse or domestic violence is a feature.

6.4. Safeguarding Adult Procedures

Adults may also be reliant upon family members or carers in attending appointments where they have physical or mental impairment that affects their ability to access services. When an adult is not assisted to attend appointments, this may also raise the issue of neglect.

An adult may also decide not to attend an appointment, in such circumstances, the capacity of the adult should be considered to assess whether they have an understanding around the potential impact. Non-attendance and not wanting to engage with health appointments may raise concerns for self-neglect.

Following an adult not brought for an appointment, or an adult who does not attend, the responsibility for any assessment of the situation rests with the practitioner to whom the adult has been referred, in conjunction with the referrer.

Attempts must be made to support attendance with appointments. If the adult is dependent on a provider service for any appointment, this should also be followed up with the provider. Again, concerns for neglectful practice by a care provider should lead to consideration of a safeguarding concern being submitted. Where an adult lacks capacity to attend an appointment and there are concerns for neglect/self-neglect, this

will also require consideration for safeguarding referral in their best interest.

6.5. Vulnerable Adult Risk Meeting (VARM)

Where an adult with care and support needs has capacity around attendance/engagement and makes an informed decision to not attend/engage, where there is considered to be a significant risk of harm or death to the adult the vulnerable adult, the Vulnerable Adults Risk Management meeting process should be considered and discussed with the Trust safeguarding team. Details can be found here.

7. Professional Curiosity

Professional curiosity should always take place when an adult, family member, or carer, does not respond to requests from health professionals. There may be other multiple factors that contribute to a decision not to engage with professionals and or appointments. Professionals should be curious and remain vigilant to safeguarding concerns where: -

- Parent, family member or carer refusing for the child(ren) young person or vulnerable adult to be assessed;
- Repeated health appointments where a child, young person or adult is not brought;
- Attendance at urgent care centres, and emergency departments but not waiting to be seen/taking own discharge;
- Not being home for visits from professionals;
- Disregarding health appointments;
- Not allowing professionals into the home;
- Agreeing to take action but never do it;
- Hostile behaviour towards professionals;
- Manipulative behaviour resulting in no health care;
- Actively avoiding contact with professionals.

Factors to consider may be: -

- Symptom improvement may lead to reduced motivation or need to attend;
- Varying levels of engagement or satisfaction with the service;
- Missed appointments are more likely when time lapses between appointments;
- Families have other commitments and can forget or confuse appointments;
- Families may not be able to read or speak English;
- There may be wider accessibility issues around attendance;
- Fear of attending hospital due to negative/traumatic experiences;
- Child/adult with learning needs.

A key theme from safeguarding learning reviews or investigations is the use of the term ‘disengagement’ or ‘not engaging’ when in fact the person is unable to attend or engage for a reason. There should be further consideration in circumstances where there may be additional complicating factors that hinder or complicate successful engagement of services. Factors that should be taken into consideration include: -

- **Domestic abuse**
  A parent/carer or family member may be using control tactics to prevent service involvement. Where there have been any recent or historic concerns relating to domestic abuse, this should lead to further professional curiosity and relevant liaison with other services (Please refer to the Trust Domestic Violence and Abuse Policy).

- **Mental capacity**
  Is there a reason to suspect that the young person/parent/carer or adult may lack capacity to weigh up the risk associated with not having contact with the service? If so, a capacity assessment should be completed where possible. This may require liaison with other services who are involved in the young person/adult's care.

- **Transitional safeguarding**
  This refers to the process of a child aged 17 approaching their 18th birthday and transitioning to adult services. This can often be a very anxious period in a young person's life, there may be many complicating factors, fear and confusion associated with the transition or feeling rejected which may result in a young person declining services. A clear transition process should aim to start no later than 6 months prior to the young person's 18th birthday and include their wishes and feelings as part of this process. When disengagement occurs after transition, consideration should be made as to who has the best relationship with the young person and obtain their views in a trauma informed approach.

- **Trauma informed approach**
  Consider the professional/child(ren) young person or adult relationship and ability for successful engagement, have there been any difficulties in building up an effective or therapeutic relationship and would the child(ren) young person or adult respond more effectively to a different approach or professional? Consider what the service involvement means for the individual and previous experiences that are likely to have impacted upon their perception of the service.

8. Information Sharing / Record Keeping

Sharing of information amongst practitioners may be essential where there are concerns for an adult/child/young person who is not brought for an appointment or there is no access visit. Information sharing must be safe and proportionate as detailed in Information sharing Guidance for Practitioners & Managers (2018) https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice . Further information in respect of information sharing, safeguarding referrals and record keeping can be accessed through the Trust Safeguarding Adults Policy and Safeguarding Children Policy.

9. Dissemination and Implementation

This policy will be disseminated by the method described in the Policy for the Development and Management of Procedural Documents.

10. Monitoring and Compliance

Information regarding monitoring and compliance with this policy will be included in 6 monthly and annual performance reports from the Safeguarding Team to the Trust Quality & Patient Safety Group and the Trust Safeguarding Learning and Development Forum. This will include: -

- Any safeguarding reviews where child/adult at risk was not brought;
- Any safeguarding reviews where Humber Teaching NHS Foundation Trust services had no access visits;
- Any relevant audits undertaken.

11. References

- Children Act 1989
- ERSCP, HSCB and NYSCP Safeguarding Children Procedures
- Department for Digital, Culture Media and Sport (2018) Data Protection Act
- DfES (2006) What to do if you are worried a child is being abused
- Information sharing. Advice for practitioners providing safeguarding services to children, young people, parents and carers. March 2015 www.gov.uk
- National patient safety alert (2009); Preventing Harm to Children from Parents with Mental Health Needs
- NHS England Confidentiality Policy 2014 www.england.nhs.uk
- NSPCC 2019 Statistics briefing: Looked after Children
- The Victoria Climbié Inquiry Report (January 2003)
- What to do if you're worried a child is being abused; advice for practitioners (March 2015) www.gov.uk
- Working together to safeguard children: A guide to inter-agency working to safeguard children (March 2018) www.gov.uk
- The Care Act (2014)
- Mental Health Act (1983, 2007)
- Care Quality Commission essential standards (Outcome Seven – regulation 11: Safeguarding People who use services from Abuse)
- Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework. NHS England 2015
- CEMACH Why Children Die 2006
- Mental Capacity Act 2005

Appendix 1 - Risk Assessment

What to do when a child/adult is not brought or misses an appointment

Level of concern	LOW	MEDIUM	HIGH
What is the concern	Child(ren)/young person/adult was not brought or has missed/cancelled 1 or 2 appointments. Risk of harm to child or adult from missed appointment is unlikely.	Child(ren)/young person/adult was not brought or there are 2 or more missed/cancelled consecutive appointments or visits. Adult is deemed to have capacity around their care support needs but concerns for self-neglect May be some/low level impact for missed appointments but not deemed likely to result in significant harm	Child(ren)/young person/adult persistent pattern of not being brought/ non- attendance or non-engagement Adult lacks capacity around their care support needs and concerns for self neglect Impact of missing appointments will result in immediate/significant harm
Action - Review records	No known safeguarding Concerns for child/adult Child is in nursery/education	On-going medical, mental health condition or learning disability for Child(ren)/young person/adult Child is in nursery or education or other services **and/or** Known adult/parental mental ill-health, drug, alcohol misuse. Transition from child-adult services within 12 months Domestic abuse/coercive control but has not met MARAC threshold previously **And/or c**hild/adult remains under care of service provider (such as a residential care home)	Ongoing medical, mental health condition or learning disability for child(ren)/young person/adult Child not in nursery/education or known poor attendance **and/or** Known safeguarding concerns/ alerts **and/or** Known adult/parental mental ill-health, drug, alcohol misuse Domestic abuse risk has been discussed at MARAC within last 12 months Known Child Looked-after or subject to child-in-need (CIN) or child protection (CP) plan. Adult has care/support needs but support in place from care provider/informal carer
Consider	Service user/family have returned to country of origin Service user/carer/parent unable to read or English not first language Are there access issues impacting attendance		

	Trauma informed approach – is there an element of fear around the appointment? Capacity and understanding around the need for the appointment. Who has LPA? Reminder approach to appointments Consider others in household which may be impacting on appointment attendance (carer stress/domestic abuse/Transport)		
Action - Liaison	**Liaise with** parent/carer/family or provider to establish why child/adult was not brought Clarify contact details with GP Rearrange appointment as required including relevant communication as above	**Liaise with service user or Liaise with** parent/carer/family or provider to establish why child/adult was not brought or unable to visit home Confirm contact details & clarify the importance of engaging with appointments. Assess capacity/understanding of impact of missed appointment Clarify contact details with GP Rearrange appointment as required including relevant communication as above Liaison with other relevant services such as social worker. Consider who has best relationship with child/adult Seek advice from supervisor or discuss with safeguarding team	**Liaise with service user or Liaise with** parent/carer provider to establish why child/adult was not brought or did not allow access Confirm contact details & clarify the importance of engaging with appointments. Assess capacity/understanding of impact of missed appointment Clarify contact details with GP Rearrange appointment as required including relevant communication as above Liaison with other relevant services such as social worker Consider who has best relationship with child/adult. Seek advice from supervisor or discuss with safeguarding team
Action – Next steps	Arrange further appointment if indicated/still required. Arrange any necessary steps to assist with access and support. Document actions/discussion. Send standard letter to GP/referrer (appendix 3)	Arrange further appointment if indicated/still required. Arrange any necessary steps to assist with access and support Send standard letter to GP/referrer (appendix 3) and flag records If further was not brought; **Explore additional support**	Arrange further appointment if indicated/still required. Arrange any necessary steps to assist with access and support Send standard letter to GP/referrer (appendix 3) and flag records If further was not brought; **Inform** children's social care if

		such as early help or children's social care if appropriate (depending on thresholds) and consent. Consider VARM/best interest meeting or r**efer** to local authority adult safeguarding. Document actions/discussion.	a Child Looked-after or subject to CIN or CP Plan. If deemed to lack capacity, arrange best interest meeting/discussion Refer to local authority safeguarding for child/adult Document actions/discussion
	Consider whether any further action is necessary eg **Consider** a wider discussion with other health professionals involved if known. Document discussion. **Contact** the family to confirm contact details & clarify the importance of engaging with appointments. **Re-refer back to service** if indicated/still required	**Discuss** with other health professionals involved if known. Document discussion. **Contact** the family to confirm contact details & clarify the importance of engaging with appointments. **Re-refer back to service** if indicated/still required. **Refer** to Early Help or Children's social care if appropriate (depending on thresholds). Use referral form to follow-up in writing if indicated. Document actions/discussion.	**Discuss** with other health professionals involved if known. Document discussion. **Contact** the family to confirm contact details & clarify the importance of engaging with appointments. **Consider** how to help engage the family eg home visit if appropriate. **Re-refer back to service** if indicated/still required. **Inform** children's social care if a Child Looked-after or subject to CIN or CP Plan. Use referral form to follow-up in writing if indicated. Document actions/discussion
Intended Outcome	Plan communicated with GP, family and other healthcare professionals involved	Family receive support to continue engagement with health. Plan communicated to all healthcare professionals and family	Multi-agency discussion and support to meet child's needs agreed with family and professionals and communicated out to all health care professionals and family

(Safeguarding Teams Hull CCG 7 East Riding CCG 2019. WNB/DNA Child and Family Engagement Guidance)

Appendix 2 - Parental Responsibility

Parental responsibility means the rights and responsibilities that parents have in law for their child, including the right to consent to medical treatment for them, up to the age of 18 in England.
Mothers and married fathers have parental responsibility. So do unmarried fathers of children, since 1 December 2003 in England and Wales, as long as the father is named on the child's birth certificate.

Unmarried fathers whose children's births were registered before these dates, or afterwards if they are not named on the child's birth certificate, do not automatically have parental responsibility. They can acquire parental responsibility by way of a Parental Responsibility Agreement with the child's mother or by getting a Parental Responsibility Order from the courts. Married step-parents and registered civil partners can acquire parental responsibility in the same ways. Parents do not lose parental responsibility if they divorce. If a child is taken into local authority care by way of a court order parents share parental responsibility with the local authority. If the child comes into local authority care with parental consent the local authority gains no parental responsibility – this remains fully with those who had parental responsibility prior to the child coming into care. Parents lose parental responsibility if a child is adopted. Parental responsibility can be restricted by court order.

Adoptive parents have parental responsibility, as do those appointed as a child's testamentary guardian, special guardian or those given a Residence Order or Child Arrangement Order. Local authorities have parental responsibility while a child is subject to a care order. You may need to get legal advice when in doubt about who has parental responsibility.

People without parental responsibility, but who have care of a child, may do what is reasonable in all the circumstances of the case to safeguard or promote the child's welfare. This may include step-parents, grandparents and child-minders. You can rely on their consent if they are authorised by the parents. But you should make sure that their decisions are in line with those of the parents, particularly in relation to contentious or important decisions.

Parental Responsibility Agreement [section 4, Children Act 1989]
This is a consensual arrangement made by the mother and the unmarried birth father acting together. It is a legal document and means that the parents have agreed to share parental
responsibility. A step-parent married to a birth parent may obtain parental responsibility in this way if all those with parental responsibility give consent to the agreement.

Parental Responsibility Order [section 4, Children Act 1989]
This is a court order that specifies that a named person has parental responsibility for a child. Parental responsibility is then shared between the holder and any birth parent who already has parental responsibility. An unmarried birth father can apply for parental responsibility this way. A married step parent can also apply for parental responsibility this way if it has not been possible to get all parties to consent to a parental responsibility agreement (see above).

Residence Order [section 8, Children Act 1989]
This is a court order that specifies the name of the person or persons with whom a child is to live. The named persons automatically acquire parental responsibility for the child and this is shared with anyone else who has parental responsibility for the child

(usually birth parents). The order lasts until the child reaches the age of 16 or 18 depending on the particular arrangement with the court.

Child Arrangements Order [Section 8 Children Act 1989 amended by Children and Families Act 2014]
This replaces the Residence Order and covers the same issues such as where and with whom a child should live and/or have contact with the person with parental responsibility. The local authority would not hold parental responsibility under a Residence Order or a Child Arrangements Order.

Emergency Protection Order [sections 44-45, Children Act 1989]
A local authority may apply to a court for an emergency protection order which lasts a maximum of 8 days if they feel a child is at risk of significant harm. This enables a local authority to share parental responsibility with anyone else who already has parental responsibility.

Special Guardianship Order [section 14, Children Act 1989]
This court order gives the holder a more permanent arrangement, but it is not lifelong like an adoption order (see below). A carer secures parental responsibility for the child which enables them to make decisions for the child up to a child's 18th birthday. Birth parents who have parental responsibility retain residual parental responsibility, so the family link is maintained. There may be several persons sharing special guardianship.

Care Order [section 31 and section 38, Children Act 1989]
A local authority may apply to a court for a care order if they feel a child is at risk of significant harm. This enables a local authority to share parental responsibility with anyone else who already has parental responsibility. The local authority may make plans to provide accommodation for the child with alternative family carers or foster carers. Under Section 20 of the Children Act 1989 a child can be looked after by the local authority with the consent of the parent, in which case the local authority does not hold parental responsibility.

Placement Order [section 21, Adoption and Children Act 2002]
If a local authority regards that a child needs to be placed permanently with an alternative family, they may apply to the court for a placement order which then gives the local authority permission to place a child for adoption.

Adoption Order [section 46, Adoption and Children Act 2002]
The carer secures a lifelong relationship with a child throughout their lives when a child is adopted. The family line is legally changed so the child belongs to another family. The adopters acquire parental responsibility. Birth parents (and any other person) lose parental responsibility.
Anyone considering the adoption of a specific child who has not been placed with them by an adoption agency for the purposes of adoption (including step-parent adoption), must notify their local authority in writing at least 3 months before they to apply to court: this enables the local authority to commence necessary checks and interviews with the significant family members and ensure the child is being cared for appropriately.

What is a guardian?
A guardian is someone who has been named by a parent as someone who could look after a child in the event of the death of a parent. The named guardian would only have parental responsibly if all other persons with parental responsibility were deceased.

Appendix 3 - Standard Letter

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Dear (referrer name)

RE (patient details)

We have offered an appointment in respect of (patient details) on the XXXXX, unfortunately (**Patient/family details**) was not brought/cancelled/did not attend (**delete as necessary**) the appointment.

We have offered an appointment in respect of (**patient details**) on the XXXXX, unfortunately (**Patient/family details**) was not at home/did not allow access (**delete as necessary**) for the appointment.

We have attempted to contact the patient/family/care provider to find out the reasons for the cancelled appointment/non-attendance/no access visit (**delete as necessary**) although we have been unsuccessful.

From our review of information/records, we deem the impact of cancelled appointment/non-attendance/no access visit (**please delete as necessary**) to be of low/medium/high risk (**delete as necessary**) and therefore have taken the following action (**please delete as necessary**)

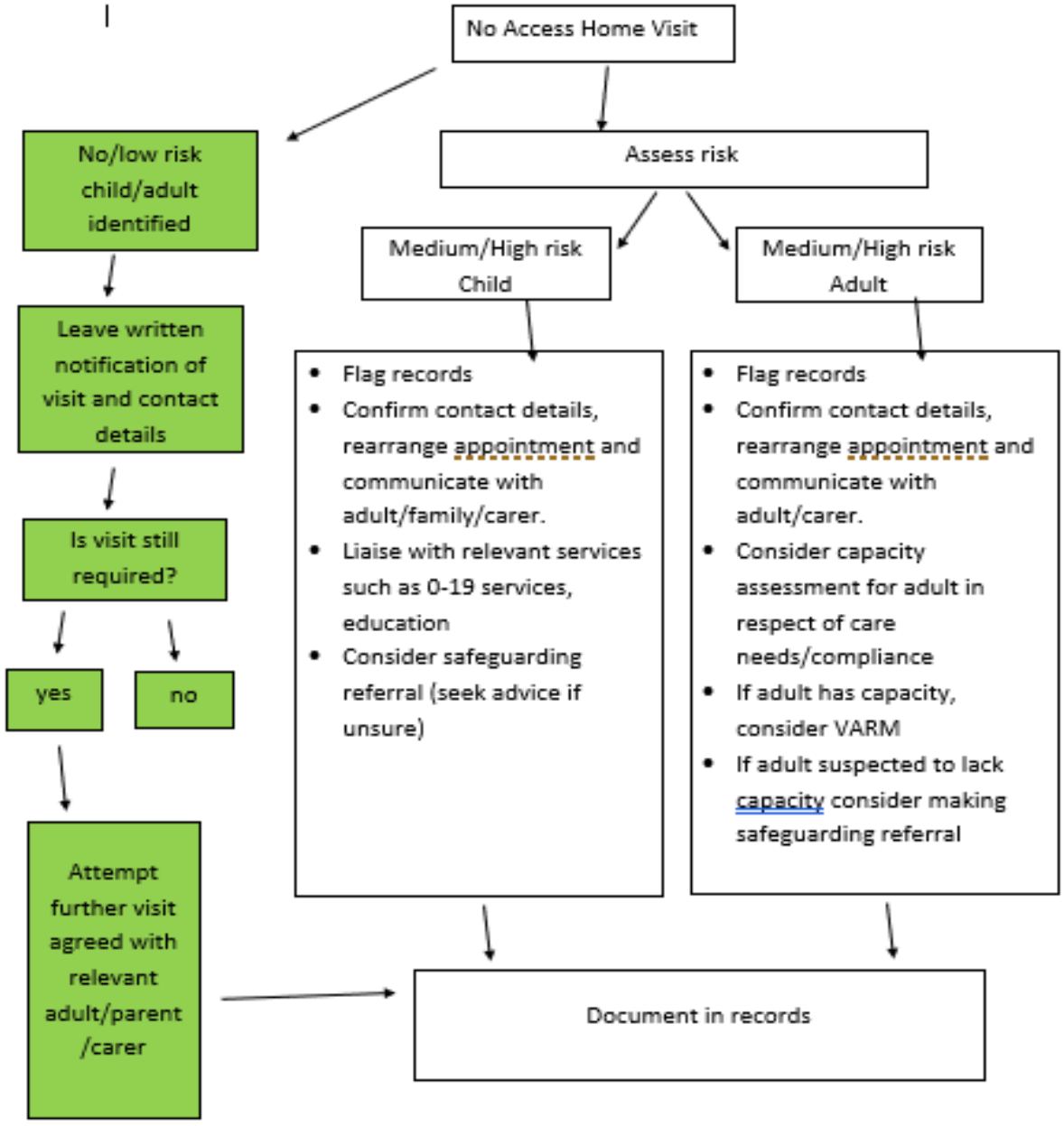
- Letter to family/patient and no further action at this time
- Safeguarding children referral
- Safeguarding adult referral
- Liaison with other service
- Arrange vulnerable adult risk meeting (VARM)

We would welcome a further referral/discussion if you feel that the patient would still benefit from our service, and they are happy to have this service involvement.

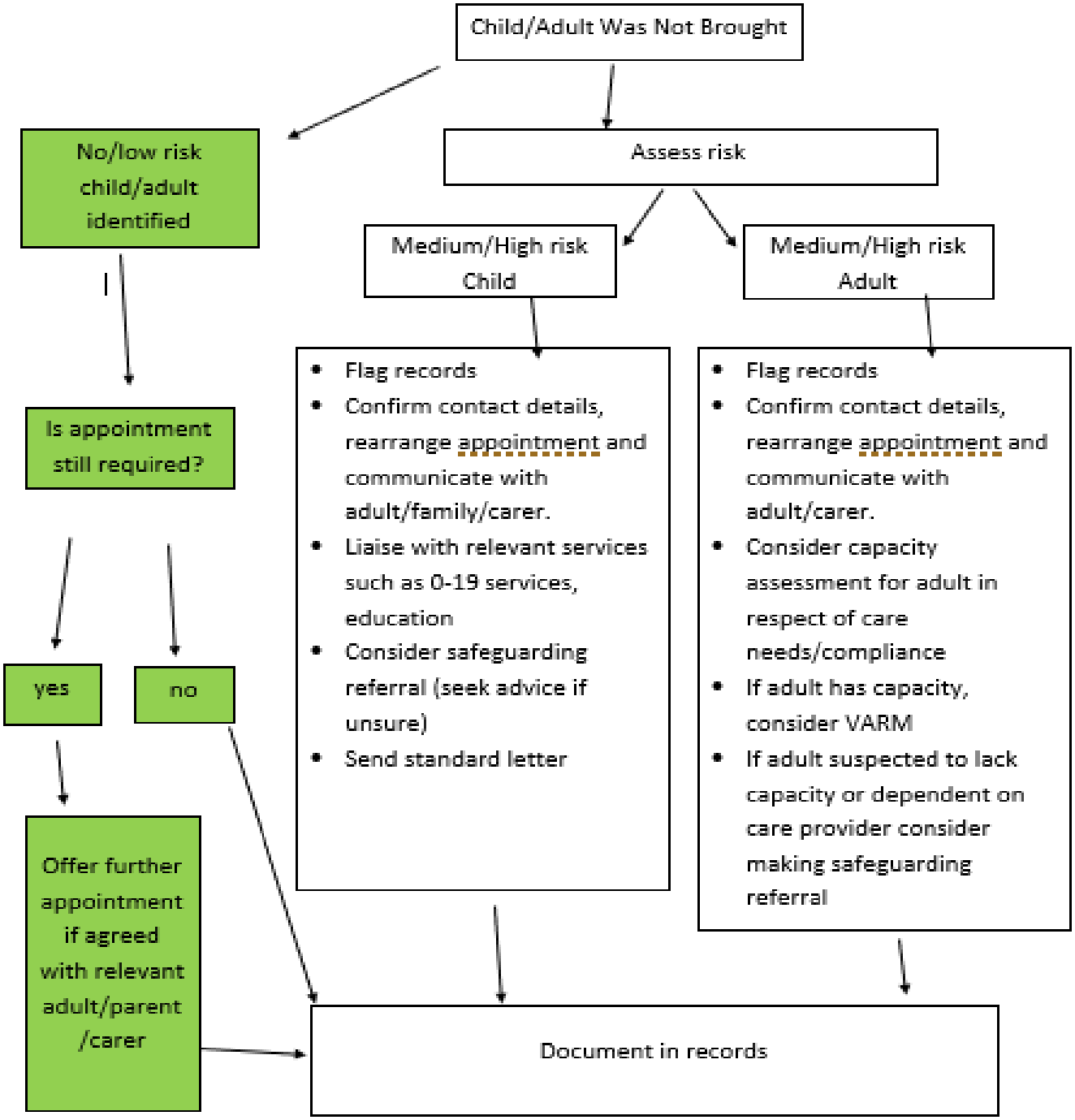
Yours sincerely

Team details

Appendix 4 - No Access Visit (NAV) Flowchart



Appendix 5 - Was Not Brought Flowchart



Appendix 6 - Document Control Sheet

This document control sheet, when presented to an approving committee must be completed in full to provide assurance to the approving committee.

Document Type	Policy		
Document Purpose	This policy provides guidance and support, outlining the roles and responsibilities of Humber Teaching NHS Foundation Trust staff in response to children, young people and adults at risk who are not brought to health appointments and in addition where there are no access to home visits for health appointments. The guidance included in this report reflects the wider safeguarding children partnership guidance.		
Consultation/ Peer Review:	Date:	Group / Individual	
list in right hand columns consultation groups and dates -	QPaS	16 March 2023	
	QPAS	April 2024	
Approving Body:	EMT	Date of Approval:	3 April 2023
Ratified at:	Trust Board	Date of Ratification:	31 May 2023
Training Needs Analysis: (please indicate training required and the timescale for providing assurance to the approving committee that this has been delivered)	No additional training required. This is already included in safeguarding training	Financial Resource Impact	N/A
Equality Impact Assessment undertaken?	Yes [x]	No [ ]	N/A [ ] Rationale:
Publication and Dissemination	Intranet [x]	Internet [ ]	Staff Email [ ]
Master version held by:	Author [x]	HealthAssure [ ]	
Implementation:	Describe implementation plans below - to be delivered by the Author:		
	This policy supports the existing response required to was not brought and non-engagement concerns. This will be referenced within safeguarding supervision sessions, future lunch and learn sessions and also be made available on the intranet.		
Monitoring and Compliance:	Safeguarding learning and development forum		

Document Change History:			
Version Number / Name of procedural document this supersedes	Type of Change i.e. Review / Legislation	Date	Details of Change and approving group or Executive Lead (if done outside of the formal revision process)
V1.0	*New policy*	*April-23*	*New policy (created to support and formalise expected staff responses to was not brought and non-engagement safeguarding concerns). Approved at EMT (3 April 2023) and ratified at Board (31 May 2023).*
V1.1	*Review*	*April 24*	*Minor amends*

Appendix 7 - Equality Impact Assessment (EIA)

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name: **Was not Brought and No Engagement Policy**
2. EIA Reviewer (name, job title, base and contact details) **Kerry Boughen**
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? **Policy**

Main Aims of the Document, Process or Service
To set out the requirements that must be met for approval, ratification and dissemination of all Humber Teaching FT policies.
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender re-assignment	Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	f) who have you consulted with g) what have they said h) what information or data have you used i) where are the gaps in your analysis j) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people, Young people, Children, Early years	Low	The policy applies to all patients regardless of age
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory, Physical, Learning, Mental Health (and including cancer, HIV, multiple sclerosis)	Low	The policy applies to all patients regardless of and disabilities
Sex	Men/Male, Women/Female	Low	The policy applies to all patients regardless of sex.
Married/Civil Partnership		Low	The policy applies to all patients regardless of marriage or civil partnerships
Pregnancy/ Maternity		Low	The policy applies to all patients regardless of any pregnancy
Race	Colour, Nationality, Ethnic/national origins	Low	The policy applies to all patients regardless of race
Religion or Belief	All Religions Including lack of religion or belief and	Low	The policy applies to all patients regardless of religion

	where belief includes any religious or philosophical belief		or beliefs
Sexual Orientation	Lesbian, Gay Men, Bisexual	Low	The policy applies to all patients regardless of sexual orientation
Gender Re-assignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Low	The policy applies to all patients regardless of gender

Summary

Please describe the main points/actions arising from your assessment that supports your decision above: The policy applies to all patients, there are no circumstances where any groups of patients wou7ld not be considered within this policy.	
EIA Reviewer: Rosie O'Connell	
Date completed: 28/03/2024	Signature: *Rosie O'Connell*