Rotherham Doncaster and South Humber NHS Foundation Trust

Engagement and Disengagement Policy (Mental Health)

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1. Policy Summary

1.1 What is this policy about?

This policy tells colleagues how to help people stay in contact with mental health services. It also tells colleagues what to do when a person misses an appointment, stops replying or does not want to continue with care. The policy applies to children, young people and adults who use mental health services and the Community Directorate.

1.2 Why might someone lose contact?

There may be many reasons. A person may have problems with transport, caring responsibilities, using a phone or computer, language, communication, physical health or mental health. They may not understand their care plan or may feel that the service does not meet their needs. Colleagues must listen and try to understand what is making contact difficult.

1.3 What must colleagues do?

- Involve the person in decisions about their care.
- Give information in a way the person can understand.
- Use suitable ways to make contact, such as telephone calls, text messages, letters or visits.
- Offer a different time, place or type of appointment when this may help.
- Record every contact attempt, decision and outcome in the electronic patient record.

1.4 What if there is a risk?

Colleagues must think about the safety of the person and other people. If there is an immediate or serious risk, colleagues must act quickly and ask a senior clinician or manager for advice. They may need to contact safeguarding services, the police or arrange a Mental Health Act assessment. Urgent cases should normally be reviewed within 24 hours. Routine or lower-risk cases should normally be reviewed within seven days if contact has not been restored.

1.5 Safeguarding children and adults

Colleagues must think about whether losing contact could put a child or an adult at risk. When a child or young person misses an appointment, colleagues should say that the child “was not brought”. Colleagues must try to contact the child or young person and their family or carers and check for safeguarding concerns. Information may need to be shared with other services to keep someone safe.

1.6 Can a person be discharged?

A person must not be discharged only because they have lost contact with the service. If colleagues cannot make meaningful contact, a multidisciplinary team must review the information and risks. A team manager must agree any discharge from secondary care. The person must receive written information, a care or crisis plan and clear details about how to get help or contact the service again. The GP and other relevant services must also be told when appropriate.

1.7 Who is responsible?

Managers must make sure colleagues know and follow this policy. Care coordinators, lead professionals and other clinical colleagues must raise concerns quickly and ask senior colleagues for help when needed. Clinical colleagues must complete the safeguarding training required for their role.

2. Introduction and aim

Disengagement means that a patient avoids or loses contact with services, either deliberately or unintentionally, over a period of time. The care team must use clinical judgement and the identified risks to decide when contact amounts to disengagement.

Disengagement may include:

- not attending a community appointment;
- not attending planned medicine administration or monitoring;
- not being at home for a pre-arranged visit;
- not attending agreed community activities;
- moving from their usual address without giving a new address; or
- not completing agreed tasks, such as scales, questionnaires or exercises between sessions.

A patient may disengage for reasons outside their control. These may include limited understanding of the care plan, difficulties with mental capacity, language or communication, sensory needs, daily living pressures, or poor communication from services. Other possible reasons include:

- Safeguarding, cuckooing, vulnerabilities to radicalisation and entrapment
- travel or transport issues
- childcare and caring responsibilities
- physical illness and mobility
- language spoken and understood
- nature of mental health difficulties e.g., negative symptoms, insight, fear, paranoia
- work and vocation commitments
- limited or no access to digital equipment or mobile phones
- culturally inappropriate course of treatment of care, which does not reflect or take into account the lifestyle, and beliefs of the individual.

Services may also contribute to disengagement. Examples include unclear appointment letters, not recognising the stigma linked to some services, long waits, inflexible appointment arrangements, or making it difficult for patients to contact the service.

Some patients stop engaging because they believe they have reached a point in recovery where they no longer need support. However, disengagement may sometimes create serious concerns about the health, safety or wellbeing of the patient or other people.

The report of the National Confidential Enquiry into Suicide and Homicide by people with a Mental Illness, found that “non-attendance and loss of contact with mental health services are frequent findings in enquiries into suicide and homicide”.

A person who has capacity, and whose mental health does not meet the legal test for detention under the Mental Health Act 1983, has the right to refuse treatment or services.

The Trust has a responsibility to ensure that it delivers safe and effective services and attempts to engage patients in treatment and care. It must also consider the complex mental health needs of its patients and the impact that disengagement from services may have on them and their families.

Patients referred to Adult Community Mental Health Services attend, in the main, on a voluntary basis. Exceptions to this are those individuals who are subject to Mental Health Act 1983 (MHA) Community Treatment Orders, other sections of the Mental Health Act, those who need to be treated under the Mental Capacity Act 2005 (MCA) and Treatment Orders directed by the courts.

In CAMHS, disengagement is often more complex than simple non-attendance. It may include:

- A young person refusing to attend sessions.
- Carers and or family members failing to bring the child to appointments.
- Inconsistent engagement with planned therapeutic tasks.
- Family not responding to contact attempts or repeated cancellations.
- Important contextual considerations include:
- The child's stage of development and ability to engage independently.
- Dynamics within the family or caregiving system (e.g. parental mental health, domestic abuse).
- Environmental barriers (e.g. transport, childcare for siblings, conflicting priorities).
- Cultural stigma, lack of trust in services, or misunderstanding of the role of CAMHS.

Non-attendance in these circumstances should not be viewed as service refusal without further exploration. Clinicians must consider whether disengagement could indicate unmet need, disguised compliance, or safeguarding risks.

3. Procedure

3.1 Engagement

Clinical teams and practitioners must make every reasonable effort to engage patients who need services. The actions below support good engagement.

3.1.1 Care planning and treatment:

- involve patients in decisions and develop care plans with them;
- give clear information in a way the patient can understand and use;
- explain and discuss the reasons for clinical decisions;
- if a patient does not engage, try to understand why and record the reasons in the clinical record;
- consider different interventions, locations, times or ways of providing the service;
- understand what matters to the patient and what they understand about their situation and choices;

- discuss the available care and treatment options, including the benefits, possible side effects and likely effects of accepting or declining them;
- make sure care plans support joint working with social care and other providers and explain how to obtain help in a crisis; and
- discuss and plan for possible disengagement before treatment starts, recognising that some patients may disengage and re-engage several times before completing treatment.

3.1.2 Accessibility:

- services should appreciate that there may be barriers preventing patients from accessing services such as transport difficulty, lack of digital access and carer responsibilities which should be explored
- children may be reliant on parents and or carers to bring them to appointments which may create barriers. Options to increase accessibility such as offering school-based appointments or digital appointments should be considered. Parental barriers to children attending appointments such as parental poor mental health, substance misuse or safeguarding concerns should be explored

3.1.3 Involving carers and families:

- for patients in secondary services communication involving the support network of family or carers is extremely important. For patients receiving taking therapies or primary care interventions only, they will likely have lower levels of risk and may have different confidentiality expectations. However, family and carer involvement should always be encouraged where appropriate
- ensuring families and carers are supported can help promote the engagement of patients with services
- colleagues need to make contact with families and carers as early as possible in the treatment process, so that their concerns and the information they have can be shared
- if the patient does not consent to their involvement, family or carers should still be provided an opportunity for their views and concerns to be listened to and considered within the care planning process. The family or carers' own choices and circumstances in caring must be considered. They may find it more comfortable to discuss this with the health professional in a separate meeting

3.1.4 Managing service transitions:

- anticipate that withdrawal and ending of treatments or services, and transition from one service to another, may evoke strong emotions and reactions in people using mental health services. Such changes, especially discharge, are discussed and planned carefully beforehand with the service user and are structured and phased
- when referring a service user for an assessment in other services (including for psychological treatment), they are supported during the referral period and arrangements for support are agreed beforehand with them

3.2 Disengagement

For this policy, patients who disengage are grouped as follows:

- patients referred to, but not yet assessed by services
- patients in receipt of services who subsequently disengage

- patients referred to primary care and talking therapy services

Colleagues must follow the part of this policy that best fits the patient's circumstances. If this is unclear, they must discuss the case with the multidisciplinary team, team manager or clinical lead and agree which pathway to use.

When a patient disengages, colleagues must follow the relevant steps below and record every action and outcome in the electronic patient record (EPR).

3.2.1 Re-engagement

If a patient is discharged because they have disengaged, colleagues must agree a care plan at discharge. The plan must explain how the patient can contact mental health services again. In most cases, the patient should not need a new primary care referral. The MDT section explains the minimum information the care plan must contain.

3.3 Methods of communication

Colleagues must use communication methods that meet the patient's needs. Depending on the circumstances, this may include:

- telephone calls
- text messages (including text reminders for appointments)
- letters
- cold call home visits and ad-hoc visits that are planned to common places of attendance, religious venues, places of frequent visiting
- communication with family, carers or support networks.

3.4 Patients referred to, but not yet assess by services

3.4.1 Urgent or emergency referral

In advance of a scheduled appointment attempts should be made to confirm appointment attendance

If the patient misses an initial appointment following referral, then the allocated assessor must:

- ensure that all the necessary information including risk factors are obtained from the referrer and others who may be involved in their care
- attempt to contact the patient at the point of their scheduled appointment to identify reasons for non-attendance
- agree an alternative appointment if possible
- attempt to contact any identified family members or carers where appropriate.
- consider undertaking a cold call home visit, if there is no answer, a calling card must be left asking the patient to contact the service
- where there are concerns regarding a real and immediate risk to life, or of significant harm to others, the assessor must consider informing the police, taking into account the "right care, right person" guidance (click here). Where possible this should be discussed with a team manager or senior clinician to inform right care right person approach
- if there is immediate significant risk to the patient or others, then a mental health act assessment should also be considered. It will often be appropriate to have tried to see the patient first prior to attempting any Mental Health Act assessment

but there may be circumstances such as concerns about patients absconding where a practitioner visit beforehand would be inappropriate. The Mental Health Act can also afford powers of entry under Section 135 if a patient is not allowing access to their property. The practitioner should consider calling the police if the patient can't be located. There may be recall powers that can be used such as Community Treatment Orders or Conditional Discharges

- check the patient record to identify any other agencies involved in the patients care and contact these agencies as appropriate
- no discharge decision should be made unless agreed in an MDT meeting as outlined in Section 3.8
- consider whether any steps need to be taken under safeguarding children or adults as set out in section 3.7
- unless contact is reestablished the case should be discussed in an MDT or with a senior team clinician within 24 hours of the missed appointment to agree appropriate actions and timescales for those actions

This list is not intended to be exhaustive and clinical judgement about appropriate action to take should also be used.

3.4.2 Routine referral

The referrer will determine the urgency of the referral and determine whether it is urgent or routine. If on triage there is disagreement about the urgency or immediacy of risk then the patient should be managed under the relevant part of this policy.

For routine patients where no immediate risks have been identified:

- attempt to contact the patient by telephone. All attempts to contact the patient must be documented in the clinical record with the time and outcome
- the record should include if indicated the plan for further contact and by whom
- check the record to identify any other people and agencies involved in the patients care. Contact should be made with these agencies and people in order to clarify reasons why the patient may not be engaging but also to inform discussions about any potential discharge
- if contact is unsuccessful there should be an MDT meeting as outlined in Section 3.8 to discuss potential next steps including whether the patient would be suitable for discharge
  consider whether any steps need to be taken under safeguarding children or adults as set out in section 3.7
- unless contact is reestablished the case should be discussed in an MDT or with a senior team clinician within 7 days of the missed appointment to agree appropriate actions and timescales for those actions

This list is not intended to be exhaustive and clinical judgement about appropriate action to take should also be used.

3.5 Patients who are already in receipt of secondary care services

For patients already receiving secondary care, the team must use the personalised risk assessment and formulation to decide what action is necessary and proportionate. Risk changes over time, and disengagement may show that risk is increasing.

3.5.1 No immediate risk to self and others identified

For patients where no immediate risk to self or others has been identified the team should take the following action:

Consultants, clinical leads or team managers would typically fulfil this role

- attempt to contact the patient by phone, or another appropriate method, to identify the reasons for non-attendance and to offer a further appointment. All attempts to contact the patient must be documented in the clinical record with the time and outcome
- the record should include if indicated the plan for further contact and by whom
- the option of an alternative venue and time most suited to the needs of the patient concerned should be offered
- contacting family, carers or known associates
- contacting other providers involved in the patients care including voluntary sector providers
- if contact is successful and there is a suspected or confirmed deterioration in the patients mental health, then the patient should be considered for transfer to a more appropriate community treatment team e.g. AOT (if the patient has a psychotic disorder) or Home Treatment Team
- if contact is successful and the patient is well and wishes to be discharged this should be managed in line with the discharge process
- consider whether any steps need to be taken under safeguarding concerns as set out in section 3.7
- if there continues to be no engagement then a there should be an MDT meeting as outlined in Section 3.8 to discuss potential next steps including discharge
- unless contact is reestablished the case should be discussed in an MDT or with a senior team clinician within 7 days of the missed appointment to agree appropriate actions and timescales for those actions

Taking into account the patient's personalised risk assessment and formulation the team should also consider the following actions:

- cold call home visits (if unsuccessful colleagues must leave a calling card asking the patient to make contact)
- consider support from Home Treatment (with a clear remit of clinical interventions for short term engagement) or Assertive Outreach (if the patient has a psychotic disorder) who may be able to offer a more flexible or intensive approach to engagement
- consider whether it is appropriate to undertake a Mental Health Act assessment. It will often be appropriate to have tried to see the patient first prior to attempting any Mental Health Act assessment but there may be circumstances such as concerns about patients absconding where a practitioner visit beforehand would be inappropriate. The Mental Health Act can also afford powers of entry under Section 135 if a patient is not allowing access to their property. The practitioner should consider calling the police if the patient can't be located. There may be recall powers that can be used such as Community Treatment Orders or Conditional Discharges

This list is not intended to be exhaustive and clinical judgement about appropriate action to take should also be used.

3.5.2 Immediate risk to self and others identified

For patients where there is an immediate risk to self or others identified the following steps should be taken:

- attempt to contact the patient by phone, or another appropriate method, to identify the reasons for non-attendance and to offer a further appointment. All attempts to contact the patient must be documented in the clinical record with the time and outcome
- the record should include if indicated the plan for further contact and by whom
- contacting family, carers or known associates
- contacting other providers involved in the patients care including voluntary sector providers
- where there are concerns regarding a real and immediate risk to life, or of significant harm to others, the assessor must consider informing the police taking into account the "right care, right person" guidance (click here). Where possible this should be discussed with a team manager or senior clinician to inform right care right person approach
- if there is immediate significant risk to the patient or others, then a Mental Health Act assessment should also be considered. It will often be appropriate to have tried to see the patient first prior to attempting any Mental Health Act assessment but there may be circumstances such as concerns about patients absconding where a practitioner visit beforehand would be inappropriate. The Mental Health Act can also afford powers of entry under Section 135 if a patient is not allowing access to their property. The practitioner should consider calling the police if the patient can't be located. There may be recall powers that can be used such as Community Treatment Orders or Conditional Discharges
- if contact is successful and there is a suspected or confirmed deterioration in the patients mental health, then the patient should be considered for additional support from the Home Treatment Team or referral to a more appropriate community treatment team e.g. AOT
- if contact is successful and the patient is well and wishes to be discharged this should be managed in line with the discharge process
- if contact is unsuccessful there should be an MDT meeting as outlined in Section 3.8 to discuss potential next steps including discharge
- consider whether any steps need to be taken under safeguarding concerns as set out in section 3.7
- unless contact is reestablished the case should be discussed in an MDT or with a senior team clinician within 24 hours of the missed appointment to agree appropriate actions and timescales for those actions

This list is not intended to be exhaustive and clinical judgement about appropriate action to take should also be used.

3.6 Primary care services (including talking therapies)

These are services where patients would either present themselves without immediate risk and only those people who are able to engage with a therapist or individual practitioner and GP alone.

Next of kin would very rarely be involved in a patients care due to the confidential nature of patients seeking therapy and would only be considered for involving when there is an immediate concern about risk.

3.6.1 During the first assessment and appointment:

- Allocated colleague contacts the patient by telephone at the time of appointment
- Text message sent to request to contact or advise of discharge (service dependent)
- If a request to contact is sent, there is a 2-week timescale to re-book an appointment
- If there are any risk or safeguarding concerns, then clinician to seek advice from their Clinical Lead or multi-disciplinary team before discharging. Cases requiring escalation should be done so within a week.
- Discharge letter sent to the patient and copied to the GP

This list is not intended to be exhaustive and clinical judgement about appropriate action to take should also be used.

3.6.2 During treatment:

- Allocated colleagues member contacts the patient by telephone at the time of appointment
- DNA text message and voicemail is sent to the patient requesting contact and the opportunity to opt back into the service. For Talking Therapies this is within 48 hours and if no contact a discharge letter is sent to the patient and GP. (Timescale for other primary care services differs)
- If there are any risk or safeguarding concerns, then clinician to seek advice from their Clinical Lead and or multi-disciplinary team before discharging. Cases requiring escalation should be done so within a week
- If a patient cancels an appointment, they will be given the option to rebook. If a patient cancels via a phone call, then admin will advise the clinician of the cancellation. The clinician is responsible for managing any risk concerns from cancellations. For psychological therapy intervention multiple missed appointments during treatment will be managed by clinicians and their supervisors, for example three missed appointments may indicate a need for discharge, as for therapy to be effective regular attendance and engagement is required. If there are repeated cancellations then please refer to the local working instruction.

This list is not intended to be exhaustive and clinical judgement about appropriate action to take should also be used.

*Please note that patients can re-refer themselves to Talking Therapies at any time, however, should a patient be continually referring themselves to the service and not engaging with their initial appointment offer, admin will seek advice from their Manager or Clinical Lead.

3.7 Cases where there are children or adult safeguarding concerns

At the start of any intervention or service offer, colleagues must explain their duty to safeguard children and adults at risk. This may require colleagues to share information with other agencies without the patient's consent. Colleagues must consider how non-attendance or disengagement may affect an adult's ability to parent or care for a child.

Disengagement may make a patient more vulnerable to abuse or exploitation. A safeguarding concern may also be stopping the patient from using services. Colleagues must remain professionally curious and consider whether a home visit is needed, as this may identify concerns such as cuckooing.

In addition to the actions listed in the relevant disengagement section colleagues should also consider:

- whether the disengagement could affect the parenting capacity and therefore place any child or children at risk or indeed create any other child safeguarding concern. The clinical colleague must discuss the case with their team manager, line manager, safeguarding supervisor or the safeguarding team as to what action should be taken
- determine whether the disengagement could affect the caring ability and put vulnerable adults at risk or whether there are any other adult safeguarding concerns. The clinical colleague must discuss the case with the team manager., line manager, safeguarding supervisor or the safeguarding team as to what action should be taken
- whether the disengagement itself may be being caused by a safeguarding issue affecting the patient
- whether disengagement may lead to an increased vulnerability which may give risk to safeguarding
- inform the referrer by telephone and in writing if the patient does not respond to re-engagement requests and the assessed impact that disengagement may have on their ability to parent or provide care to others
- inform any services known to be engaged with the children or vulnerable adults as part of any ongoing intervention e.g. health visitors, school nurses, GP's, other partner agencies, community support services, third sector organisations
- act in accordance with RDaSH safeguarding children policy
- act in accordance with RDaSH safeguarding adults policy

3.7.1 Where an adult is the patient:

In a small number of cases failures to attend or disengaging with services raises serious concerns relating to safeguarding children. In order to promote the safety and well-being of all children it is vital that failure of an adult to attend their appointment is considered factoring in the impact that compliance or lack of engagement will have on the adult's ability to provide good enough and consistent care to a child.

The overriding principles of the children act 1989 and 2004 place a clear and absolute requirement for all organisations and their services to have a clear emphasis on 'the importance of keeping the focus on the child and his or her safety and welfare, understanding the daily life experience of the child, seeing the child alone where appropriate and using information about the family's history and functioning to inform decision making'.

This awareness of the child's needs can help those services working with adults to recognise the potential impact of non-attendance or disengagement from services by adults and the impact this could have on the safety and well-being of a child or children whether they live with the child or have contact with a child or children. The clinical

decision tree is a key tool in this process and provides a tool where risk and impact can be considered.

If a carer has expressed concern about the risk to the patient or others, then a multidisciplinary case review should be held at the earliest possible opportunity to address these concerns. Wherever possible, given the permission of the patient, the carer should be invited.

3.7.2 Where a child is the patient:

For any children or young people who do not engage with their own scheduled appointment with child and adolescent mental health services (CAMHS), this must be considered as “was not brought” rather than “did not attend” and clinicians should be curious regarding lack of engagement, considering potential safeguarding factors. Clinicians should ensure they make all reasonable attempts to contact children and young people, and their families and or carers as appropriate as soon as they are aware of a “was not brough” situation to ascertain reasons for non-engagement. Further appointments should be offered at a location and time to suit the child or young person.

The process regarding contact and communication detailed in sections 3.5 and 3.6 should also apply to children and young people, with family and or carers and other agencies (such as schools) being contacted following any “was not brought” appointments to establish any safeguarding concerns related to the child or young person.

3.8 Multi-disciplinary team meeting (MDT) and discharge in secondary care

If the team cannot make meaningful contact with the patient, it must arrange a multidisciplinary team meeting (MDT) to review the risks and agree the plan for future care.

The available information and level of risk will decide how quickly the MDT must meet. The meeting must include at least a senior clinician or team manager and may include professionals from other agencies. Everyone involved must be able to contribute to the decision. Before the meeting, colleagues should seek relevant information from family members, carers, other services and agencies so the MDT can understand the patient’s current needs and risks.

A decision to discharge for failing to keep appointments may not be deemed clinically appropriate, and therefore the MDT meeting should consider the appropriate course of action keeping the patients General Practitioner informed of any changes in care. Consideration should be given to whether patients would benefit from an Assertive Outreach approach where there are identified difficulties with engagement.

For those patients that are under Assertive Outreach services where there is continued disengagement it must be made clear that disengagement in of itself is not a reason to discharge a patient. Risks must be considered and if appropriate use of the Mental Health Act also considered.

The MDT may conclude that is appropriate to discharge a patient after the patient has been notified in writing of the plan to discharge but it should be noted that some patients

may struggle with letters due to language barriers and disabilities and so consideration needs to be given to whether this is appropriate.

The plan agreed by the MDT meeting must be shared with the GP, other relevant agencies and family or carers where appropriate.

The MDT must inform and support any decision to discharge, and the team manager must agree it. The decision must consider both the patient's current risk and any risk that can reasonably be expected to increase after discharge. The team must take reasonable steps to reduce these risks. If discharge is agreed, the team must tell the GP, relevant agencies and, where appropriate, family members or carers, and explain the reasons.

The patient must receive written notice of discharge and a crisis plan. As a minimum, the plan must explain how to contact services if their mental health gets worse. It should also include suitable community support. A patient discharged because of disengagement should usually be able to contact the team again without a new primary care referral, unless more than two years have passed or there are exceptional circumstances. This is different from discharge after planned treatment has ended, when a new primary care assessment may be appropriate.

Summary for MDT Meetings:

- The urgency at which an MDT meeting is held will depend on clinical information and risks as known at the time
- Risk assessment is dynamic and disengagement can indicate an increasing level of risk. Any decision to discharge someone from services and care plan should consider risks that could be reasonably predicted that may happen in the future
- Attempts should be made to obtain information from other people and agencies that can feed into the MDT discussion such as family, carers, known associates, other care providers and voluntary sector organisations.
- Consideration should be given to transferring the patient to another team such as AOT that may be able to engage the patient
- For patients already under AOT a failure to engage is not a reason alone to discharge the patient
- Where discharge is being planned for a patient, the MDT should consider if it is appropriate to notify the patient of this in writing and give them an opportunity to make contact
- Where a patient is disengaging this should always prompt consideration for any safeguarding concerns. These may be safeguarding concerns about the patient themselves, vulnerable adults or children.
- When a patient is discharged, they must be notified in writing and sent a care plan. Information should also be sent to the referrer, GP and other relevant agencies informing them of the discharge.

4 Responsibilities

4.1 Service managers or team managers are responsible for:

- make sure colleagues know and understand this policy;
- monitor whether colleagues follow the policy; and

- support multidisciplinary discussions so that assessments, decisions and plans are clear and shared.

4.2 Care coordinators and lead professionals

- follow the relevant steps in this policy and involve the team manager, or nominated deputy, when needed.

4.3 All other clinical colleagues

Every member of the care team must tell the care coordinator or lead professional if they are concerned that a patient may disengage from services.

5 Training implications

All colleagues must know the key requirements of this Trust policy. Services may share and reinforce these requirements through:

- all-user emails for urgent messages;
- one-to-one meetings and supervision;
- continuing professional development sessions;
- posters;
- practice development days;
- group supervision;
- special meetings;
- team meetings; and
- local induction.

All clinical colleagues must complete the safeguarding training required for their role. Colleagues should also follow the Safeguarding Adults Policy and the Safeguarding Children Policy.

6 Monitoring requirements

6.1 Management of patients who do not attend appointments

- How and who by: Dip sample of patients with recorded did not attend by matron and or service manager
- Reported to: Care group quality meeting.
- Frequency: Quarterly.

6.2 Management of patients who are discharged for reasons of disengagement

- How and who by: Dip sample of patients with recorded as discharge due to disengagement by matron and or service manager
- Reported to: Care group quality meeting.
- Frequency: Quarterly.

6.3 Number of patients who are discharged due to disengagement

- How and who by: Report on re-portal by MHA Manager
- Reported to: Quality Committee
- Frequency: Quarterly.

6.4 Number of patients who did not attend appointments

- How and who by: Report on re-portal by MHA Manager
- Reported to: Quality Committee
- Frequency: Quarterly.

7 Related documents and references

Safeguarding Children Policy
Safeguarding Adults Policy
Safeguarding