Rotherham Doncaster and South Humber NHS Foundation Trust

Engagement and Disengagement Policy

(Physical Health, Neurodiversity and Children's Services)

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1. Document summary

1.1 What is this policy about?

- This policy is about helping people to stay in contact with their health service and take part in their care.
- Sometimes a person may miss an appointment, may not be at home for a visit, or may stop using a service. This is called disengagement.
- When a child or young person misses an appointment because an adult did not bring them, staff should record this as “Was Not Brought”.

1.2 What should staff do?

- Staff should not make guesses about why a person has missed an appointment or stopped contact.
- Staff should try to speak with the person and find out what is making it hard for them to use the service. This might be transport, work, caring duties, communication needs, poor health, fear, problems at home or a bad experience of care.
- Staff should offer help in a way that meets the person’s needs. This may include a different appointment time or place, a telephone call, a text message, a letter or a home visit.
- Staff must record each contact attempt, any risks, the decisions made and what will happen next.

1.3 Keeping people safe

A missed appointment may mean that a person needs more help. Staff must check whether the person, a child, an adult at risk or another person may be unsafe.
If staff are worried, they must speak with their manager, a senior clinician or the safeguarding team and follow the Trust’s safeguarding procedures.

1.4 Ending care

A person should not be discharged only because they missed an appointment.
If staff cannot make contact, the team must look at the risks and decide what is safest. A senior clinician, manager or multidisciplinary team may need to be involved.

If care ends, the person must be told why, how they can get help again and what to do if their health or situation gets worse.

2. Introduction and aim

The Trust understands that people may decline treatment, miss appointments or stop using services for many reasons. Staff must listen to the person, understand what matters to them and identify any barriers that may make it harder for them to take part in care.

Disengagement means that a person avoids or loses contact with a service, either deliberately or because of circumstances outside their control. The relevant clinical team must use professional judgement, current information and the person’s known risks to decide when missed contact becomes a concern.

In adult services, signs may include missing appointments, medicine administration or monitoring; not being at home for an agreed visit; not attending agreed activities; moving without providing a new address; or not completing agreed tasks between sessions. In children's services, disengagement may include a child or young person refusing to attend, a parent or carer not bringing them, repeated cancellations, no response to contact, or inconsistent involvement in agreed care.

Staff must consider the full circumstances. These may include the person's age and development, ability to make decisions, communication needs, sensory needs, family circumstances, caring responsibilities, transport, work, physical health, digital access, cultural needs, previous experiences of services, fear, stigma, domestic abuse, exploitation, radicalisation, safeguarding concerns or poor communication by services. For children and young people, staff must also consider whether a parent or carer's health, substance use or other needs are affecting attendance.

A person may decide that they no longer need support. However, missed contact can also be a sign that their health, safety or wellbeing, or the safety of others, is at risk. Staff must respond in a way that is reasonable for the level of risk and must consider whether safeguarding action is needed.

Most people use Physical Health, Neurodiversity and Children's Services voluntarily. A person who can make the relevant decision has the right to refuse treatment or services unless there is a lawful basis for treatment or intervention. The Trust must still make reasonable attempts to offer safe and effective care, consider the person's wider needs, and explain the effect of disengagement on the person and their family.

This policy explains how staff must respond when a child, young person, adult, or older adult is not brought to an appointment, does not attend, cannot be seen at an agreed visit or disengages from services. Staff should explain early in the care process why attendance and engagement matter, what will happen after missed contact and how the service will work with the person, parent, carer or legal guardian to address barriers.

The policy applies to adults and older adults receiving Physical Health and Neurodiversity services; children and young people referred to or accepted by Trust services; children and young people entitled to universal services where routine contacts are planned; and people aged 0 to 25 with special educational needs and disabilities. It applies to all Trust staff and to agency, locum and bank staff working for the Trust.

2.1 Definitions

- **Did Not Attend (DNA):** the person did not attend a planned appointment and did not cancel it or return required consent.
- **Was Not Brought (WNB):** a parent or carer did not bring a child or young person to a planned appointment.
- **No Access Visit (NAV):** the person was not available at home for a planned visit, or staff could not gain access.
- **Unseen child:** a child who is not receiving planned primary or community healthcare and has not been seen as expected.

- **Disengagement:** when a child, young person, adult, parent or carer does not respond to reasonable contact from health professionals or stops taking part in agreed care.
- **Opting out of the Health Visiting Service:** a family's informed decision not to receive the universal health visiting offer. The service must still check for risk and explain how the family can return.
- **Child and Adolescent Mental Health Services (CAMHS):** specialist mental health services for children and young people.

3. Procedure

3.1 Engagement

Clinical teams must make reasonable efforts to involve people in their care. Staff should make decisions with the person, explain information in a way they can understand, record why a person does not wish to engage, and consider different treatments, locations, times, or ways to provide care. Care plans should explain urgent support arrangements and support joint working with other services.

Staff must identify barriers such as transport, digital access, caring duties, communication needs, or reliance on another person to attend. For children and young people, options may include school-based or remote appointments where clinically suitable. Families and carers should be involved with the person's agreement. Even where consent to share information is not given, staff may listen to concerns and use them to inform risk assessment, without sharing confidential information in return.

Transitions and discharge can increase the risk of disengagement. Staff must plan them early, involve the person and relevant services, and use a phased approach where needed. Transitions between children's and adult services must follow NICE guideline NG43.

3.2 Disengagement

Disengagement may develop over time. Signs include missed appointments or visits, not returning calls or forms, repeatedly agreeing to actions that are not completed, refusing access, hostile contact, or avoiding professionals. Staff must not assume the reason. They should explore whether the person is making an informed choice, has had a poor experience, is afraid of judgement, faces cultural or practical barriers, or may be affected by neglect, exploitation, crime, or other safeguarding concerns.

The response will depend on whether the person has not yet been assessed, already receives secondary care, or uses primary care or talking therapy services. Staff must follow the most relevant pathway, discuss uncertainty with the multidisciplinary team, manager or clinical lead, and record every decision, risk assessment and contact attempt in the electronic patient record.

3.2.1 Re-engagement

When a person is discharged because they have disengaged, the discharge information must explain how they can return. Where available, teams should offer self-referral or patient-initiated follow-up, or explain how a GP, education provider or other professional can refer again.

3.3 Methods of communication

Staff must use communication methods that meet the person's needs. These may include telephone calls, text messages, letters, planned or unplanned home visits, and contact with family, carers or other support networks where appropriate. If the person prefers a family member to receive notifications, staff should agree and record this arrangement.

3.4 People referred to, but not yet assessed by services

3.4.1 Urgent or emergency referral: adult or older adult.

Where possible, staff should confirm attendance before the appointment. If the person misses the first appointment, the assessor must obtain available risk information from the referrer and other services, try to contact the person at the appointment time, offer another appointment, contact identified family or carers where appropriate, and check the record for other services involved. Staff must use clinical judgement and record all actions.

3.4.2 Routine referral: adult or older adult.

First try to contact the person by telephone. If there is no response, send a letter or text asking them to contact the service and offer a suitable time or place. Explain that they may be discharged if they do not respond within three weeks, how they can return later, and whether self-referral is available. Copy the letter to the referrer and GP.

If there are concerns about discharge, the allocated worker must discuss the case with the team leader, referrer and relevant services. Record the decision and reasons. Tell the GP, referrer and other relevant services in writing about any discharge.

3.4.3 Children and young people who are not known to the service and have additional needs (see Flowchart 1 and Appendix D)

After an initial DNA or WNB, write to the GP within two working days. Do the same after two consecutive missed appointments. For an urgent referral or known or suspected risk, the care coordinator or allocated worker must try to contact the child or young person and their parent, carer or legal guardian within 24 hours.
If contact fails, agree a plan with the GP, referrer and relevant services; make assertive contact by telephone, text and home visit within two working days; record all actions; and discuss the case with the team leader or manager. If contact is still not made, review safeguarding and risk with all relevant services, including education and school nursing where appropriate. Offer a further appointment within three working days at a suitable time and place. Do not discharge until the team leader or manager and relevant services have reviewed and recorded the risks and an agreed plan has been shared with the referrer.

3.5 People who are already in receipt of secondary care services

3.5.1 Adults.

Use the person's current, personalised risk assessment, and formulation. Risk can change, and disengagement may show that risk is increasing.

3.5.1.1 No immediate risk to self and others identified
Try to contact the person, find out why they did not attend and offer another appointment. Record the time, method and outcome of each attempt and who will make further contact. Consider a home visit if this is reasonable for the known risks. If the person is well and wants discharge, follow the normal discharge process.

3.5.1.2 Immediate risk to self and others identified
Act promptly. Try to contact the person and record all attempts. Contact family, carers, known associates, and other care providers where appropriate. If there is a real and immediate threat to life or serious harm, consider police involvement in line with Right Care, Right Person and seek advice from a manager or senior clinician where possible. Consider safeguarding action. If contact is not restored, discuss the case with the multidisciplinary team or a senior clinician by the next working day and agree actions and timescales.

3.5.2 Children:
Follow Flowchart 2. After the first DNA, WNB or NAV, leave or send contact details and a new appointment within 14 days. After the second event, ask the family to contact the practitioner, check the current address, and contact details, communication needs and involvement of other services. If there is no response within seven days, contact relevant professionals or family members who may know the child. Follow safeguarding procedures where concerns are identified. If there are no welfare concerns and no response, explain in writing that no further appointment will be sent until the next routine review under the core offer.

3.5.3 Children and Young people known to services with additional needs and who are suspected to be at risk of disengaging with services
Follow Flowchart 2. Keep the risk assessment, crisis plan and contingency plan up to date. Anyone involved in care must report a break, or likely break, in contact to the allocated worker or care coordinator. That professional must decide whether the child or young person is out of contact, taking account of their wishes, ability to make informed decisions, current risks and information from relevant services. Make reasonable contact attempts and record the concerns, evidence and outcomes.

3.5.3.1 Managing Families who wish to opt out of the Health Visiting Service
Follow Flowchart 3 at appendix D. Check for current risk. If none is identified and the family decides to opt out, confirm this in writing, provide contact details and explain that they can return at any time. No further routine appointments will be sent, but the child must remain on the caseload.

3.5.4 Transient Families
A transient family moves often between areas and changes health professionals. Frequent movement can harm continuity of care and may increase safeguarding risk. For this policy, a family is considered transient after three changes of address or school within 12 months.

3.5.5 Recognition of the Transient Family
Signs include repeated moves, no response to contact, fragmented information between services, temporary or no GP registration, repeated missed appointments and frequent changes of professional.

3.5.5.1 Action to be taken by trust colleagues.

Add a high-priority SystmOne alert. Check records and contact relevant services, social care and Early Help to identify involvement or safeguarding concerns. Share concerns with the lead practitioner, discuss the family in safeguarding supervision and seek advice from the safeguarding team if the child cannot be found. If there are no identified safeguarding concerns, keep the child on the caseload and review records every six months.

3.5.5.2 Action for health visitors and school nurses

Tell the named health visitor or school nurse and discuss the family with the health team. The professional responsible at the last known address remains responsible until a new address is confirmed. When responsibility transfers, give a verbal handover and send the records securely; written information does not replace direct professional contact. A named health visitor or school nurse must remain responsible while the family is transient in the area, notify the GP practice and work with safeguarding partners to find the family if they have moved.

3.5.5.3 Action to be taken if the transient family move away from the area

If a transient family moves during an episode of care, staff must notify social care where this is required by the identified risk or safeguarding plan and must transfer relevant information safely to the receiving service.

3.6 Primary care services

Because these services are confidential, next of kin should normally only be contacted where there is an immediate risk concern or another clear lawful and proportionate reason.

3.6.1 During the first assessment and appointment:

At the appointment time, the allocated member of staff should telephone the person. Send a text asking them to contact the service or advising of discharge, according to the service pathway. Where contact is requested, allow two weeks to rebook. Before discharge, discuss any risk or safeguarding concerns with the clinical lead or multidisciplinary team and complete any required escalation within one week. Send the discharge letter to the person and copy it to the GP.

3.6.2 During treatment:

At the missed appointment time, telephone the person and send the service's DNA text or voicemail, offering a way to return. The clinician must review risks linked to repeated cancellations or missed contact. Discuss risk or safeguarding concerns with the clinical lead or multidisciplinary team before discharge and complete any required escalation within one week.

3.7 Cases where there are children or adult safeguarding concerns

At the start of care, staff must explain that they have a duty to safeguard children and adults at risk and may need to share relevant information. When a person disengages, consider whether this affects their ability to care for a child or adult, whether abuse or exploitation is preventing access, or whether loss of support increases vulnerability. Use professional curiosity and consider a home visit where safe and appropriate.

Discuss concerns with the manager, safeguarding supervisor or safeguarding team. Inform the referrer and relevant services where necessary, by telephone and in writing, and follow the Trust's safeguarding children and safeguarding adults policies.

3.7.1 Safeguarding children

3.7.1.1 Where an adult is the person:

Consider how the adult's disengagement may affect any child they live with, care for or have contact with. Keep the child's daily experience, safety and welfare central to decisions and use the clinical decision tool to assess risk and impact. If a carer raises concerns about risk, arrange a multidisciplinary review as soon as possible and involve the carer where the person agrees or information sharing is otherwise justified.

3.7.1.2 Where a child is the person:

Treat a child or young person's missed appointment as WNB rather than DNA. Contact the child or young person and their parent, carer or legal guardian promptly, explore why they were not brought and consider safeguarding concerns. Offer another appointment at a suitable time and place and contact relevant services, including education, where needed to understand risk.

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

If meaningful contact cannot be made, consider an MDT meeting as part of the risk assessment. Hold it as quickly as the known risks require. It must include a senior clinician or team manager and should include relevant services. Wherever possible, obtain current information from family, carers and other agencies before the meeting.

The MDT must consider whether continued outreach, a different team, another access route or discharge is safest. A missed appointment alone does not justify discharge. Consider both current risk and foreseeable risk after support ends, including safeguarding concerns. Any discharge must be agreed with the team manager, recorded with reasons and shared with the person, GP, referrer, relevant services and family or carers where appropriate.

Send the person written notice of discharge in a format they can understand. Include a contingency plan explaining how to return if their physical or neurodevelopmental health worsens, together with suitable community support information.

4. Responsibilities

4.1 All other clinical colleagues

Every member of the care team must tell the care coordinator or lead professional if they are concerned that a person may disengage. Staff must follow the relevant pathway, record contact attempts and decisions, and raise risk or safeguarding concerns without delay.

4.2 Lead professionals

Lead professionals must coordinate the response, make sure the steps in this policy are followed, keep the risk assessment and care plan up to date, and inform the team manager or nominated deputy when advice, escalation or an MDT decision is needed.

Service managers or team managers are responsible for making staff aware of the policy, checking that it is followed, supporting multidisciplinary decisions, addressing gaps in practice and monitoring completion of required risk management training.

4.3 Care Group Directors

Care Group Directors are responsible for keeping the policy under review, ensuring it reflects current practice and reporting implementation concerns through the Operational Management Meeting.

4.4 Director for Nursing

As the nominated strategic lead is responsible for making sure relevant policies and procedures are implemented, compliance is monitored, clinical teams have suitable resources and training, required training is completed, and effective clinical supervision systems are in place.

5. Training

As a trust policy, all colleagues need to be aware of the key points that the policy covers. Colleagues can be made aware through a variety of means such as:

- all user emails for urgent messages
- one to one meetings supervision
- continuous professional or development sessions
- posters
- practice development days
- group supervision
- special meetings
- team meetings
- local induction

5.1 All clinical colleague groups receive safeguarding training as part of the safeguarding training offer For example, Manual Handling training

- Frequency: The policy links to safeguarding children training requirements
- Training delivered by: Named Nurses, Safeguarding Children
- Where are the records of attendance held: Electronic Staff Record system (ESR)

6. Monitoring Arrangements

6.1 Management of people who do not attend appointments

- How and who by: Dip sample of people with recorded did not attend by the Service Manager
- Reported to: Care group quality meeting
- Frequency: Quarterly

6.2 Management of people who are discharged for reasons of disengagement

- How and who by: Dip sample of people with recorded as discharge due to disengagement
- Reported to: Care group quality meeting
- Frequency: Quarterly

6.3 Number of people who are discharged due to disengagement

- How and who by: Report on reportal
- Reported to: Quality Committee
- Frequency: Quarterly

6.4 Number of people who did not attend appointments

- How and who by: Report on reportal
- Reported to: Quality Committee
- Frequency: Quarterly

7. Related documents and associated references

Safeguarding Children Policy
Safeguarding Adults Policy
Safeguarding
Clinical Risk Assessment and Management Policy
Engagement and Disengagement policy (Mental Health)
Healthcare Record Keeping Policy
Incident management Policy
Lone working Policy

To be read in conjunction with the Local Safeguarding Children Board (LSCB) multi-agency procedures in the geographical areas in which the trust provides services:

- Doncaster LSCB Procedures: https://dscp.org.uk/
- Rotherham LSCB Procedures: Homepage – Rotherham Safeguarding Children Partnership (rscp.org.uk)
- North Lincolnshire LSCB Procedures: http://www.northlincslscb.co.uk/
- NSPCC Was Not Brought: https://www.youtube.com/watch?v=dAdNL6d4Ipk

8. Appendices

8.1 Appendix A Guidelines and prompts for the decision-making process and assessing Risk

A child or young person who is not brought to an appointment may miss an important assessment, treatment or safeguarding opportunity. Staff must take each missed contact seriously and consider any other information that may increase risk. The prompts below support professional judgement; they are not a complete checklist and do not replace discussion with a supervisor, manager or safeguarding team. Staff should consider whether:

- a referral has been made to children's social care, or the child is supported through Early Help, a Child in Need plan or a Child Protection Plan
- staff have attended, or been invited to, a professionals' meeting or strategy meeting
- there are concerns about an unborn child
- the child is looked after, accommodated voluntarily or living in a private fostering arrangement
- the child or young person has a learning disability, physical disability, complex health need or other additional need that increases vulnerability
- the young person is a parent, has caring duties, or depends on an adult with complex mental health needs, substance misuse or a learning disability
- there are concerns about domestic abuse, neglect, exploitation, criminal activity or other harm within the household
- recent moves, missing information, repeated missed appointments or poor contact between services make it difficult to understand the child's current circumstances

Staff must record which factors were considered, the information used, the decision reached and any action taken. If the level of risk is unclear, staff must seek advice and must not close the case only because contact has been difficult.

8.2 Appendix B Checklist guidance: no access and or child not brought to appointment (x2)

Please refer to Checklist guidance: no access and or child not brought to appointment (x2)

8.3 Appendix C Flowchart 1

Please refer to Flowchart 1 young person not known to service

8.4 Appendix D Flowchart 2

Please refer to Flowchart 1 person known to service

8.5 Appendix E Flowchart 3

Please refer to Flowchart 3