Title: DISENGAGEMENT WITH COMMUNITY SERVICES IN RELATION TO CHILDREN	
Reference No: 1906 Version 2 Standard Operating Procedure (SOP)	
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Presented to: Care and Clinical Policies Group	**Date:** 20.04.16
Ratified by: as above	**Date:** 20.04.16
	Review date: 03.06.18
Relating to policies: Child Protection	

1. Purpose of this document:

This policy aims to:

Ensure all community staff who work with children and young people manage disengagement with services to ensure children are safeguarded and have access to health services.

2. Scope of this SOP:

2.1 Section 11 of The Children Act 2004, places a statutory duty on health organisations and their staff not only to safeguard but to promote the welfare of children and young people.

2.2 It is recognised that hundreds of children miss appointments in health settings and are not available at home to be seen by health staff. Parents/carers have a responsibility to ensure children receive health care, but not all parents have the capacity to facilitate this.

2.3 Serious Case Reviews, both locally and nationally, have frequently shown a history of Did Not Attend (DNA) appointments and No Access Visits (NAV) for Health care.

3. Competencies required:

These guidelines must be followed by all Torbay and South Devon NHS Foundation Trust staff that provide services to children and young people.

4. Procedure / Steps:

The management of disengagement with community services

4.1 These guidelines will support professionals to manage disengagement and ensure the child / young person is safeguarded.

4.2 **Definitions:**

Did Not Attend (DNA)
Repeated/persistent DNA- Did not attend appointments where the health needs of the child may be compromised. This may be with or without cancellation.
No Access Visit (NAV**) -** Not available at home to be seen for pre-arranged appointment.
Family Disengagement

Disengagement is when a child/young person or parent/carer does not respond to requests from Health Professionals.

Behaviours of disengagement are usually cumulative and may include:

- Disregarding health appointments;
- Not being registered with a GP;
- Not being at home for pre-arranged professional visits;
- Agreeing to take action but never carrying it out (false compliance);
- Hostile behaviour towards professionals;
- Manipulative behaviour resulting in no health care;
- Actively avoiding contact with professionals

4.3 **Procedure**

If a child or young person is not brought to an appointment, the practitioner should first of all check that the address is correct.

If the child/young person or family is already subject of concern or there are clinical implications of the child not attending appointment the case should be followed up within 48 hours by the practitioner. A referral to Children Services Social Care may be necessary. Advice should be sought from the Safeguarding Children Team

Consideration must be given to the parent's level of understanding i.e. any learning disability, literacy, language, and/or communication difficulty. Communication with parents/ carers should always be in a way that is appropriate to their needs.

Practitioners must take steps to ensure that parents are able to make an informed choice and be flexible in negotiating alternative means of offering health services. In non-urgent circumstances this may entail sending a letter to the parents/carers. (See Appendix 1 for a draft format of letter that may be sent.)

The practitioner must ensure that parents have understood the significance of the outstanding appointments and the implications of failure to uptake services for the child.

For No Access visits leave a written communication that you have called as arranged and record in case notes. Offer a follow-up appointment if appropriate.

The responsibility for any assessment of the situation rests with the practitioner.

Practitioners must take into account each individual child's circumstances and the likely implications of the failure to receive appropriate services. It is important to remember that babies and very young children are particularly vulnerable.

The practitioner must consider the needs of child and the parents/carers capacity to meet the child's needs and the environmental context of the child's situation.

The practitioner must identify whether intervention is required to secure the child's welfare. Advice can be sought from the Safeguarding Children Team via telephone or safeguarding supervision using signs of safety Appendix 3.

If a child does not attend for 2 consecutive appointments the original referrer must be informed. The original referrer should view the Did Not Attend letter and it is their responsibility as named referrer to follow up and refer to Children's services as necessary and inform other professionals who are working with the child e.g. Paediatrician, G.P. etc. and other agencies working with the family

Non-attendance and action taken should be documented in the child/young person's case notes.

4.4 Repeated / Persistent non engagement

A full, holistic assessment should be completed to assess the strengths and difficulties for the family and child, using signs of safety (appendix 3)
In situations where it is likely that the child and family will continue to disengage with the service the case must be discussed with other professionals working with the family and agreements recorded and actioned in case notes .

False or perceived compliance by the parent must be considered.

If services would normally be offered in a clinic, a primary care surgery or school, a home visit should be considered to enable access to the child. Staff should ensure a full risk assessment has been undertaken for lone visiting in line with Trust policy.

The child's G.P. must be informed if the family are persistently not attending appointments or disengaging from services.

A referral to Children's Services may be indicated (See DNA Appointment Flow Chart, Appendix 2)

Practitioners should discuss emerging concerns with the Named Nurse Safeguarding Children or Child Protection Supervisor.

4.5 Managing disengagement for Children who are subject to a Child Protection plan

The practitioner must inform the child's Social Worker of any missed appointments. Should the Social Worker be unavailable then the Duty Social Child Care team must be informed.

Confirm the discussion with the Social Worker in writing within forty-eight hours.

Record missed appointments and action taken in the child's records and on the significant life event form, if used.

4.6 Managing Disengagement

In order to safeguard and protect the welfare of children and young people, professionals should be aware of the risks and damaging impact disengagement from health care can pose.

This also applies in the cases where the service user is a parent, particularly where mental health and problematic substance misuse is concerned.

Disengagement is a strong feature in Domestic Abuse and in the Neglect and Physical Abuse of children. Children have a right to health care and for adults to act in their best interest (UN Convention Rights of the Child 1989). Children may suffer significant harm in terms of their physical, mental health or development where disengagement exists.

Practitioners should consider whether there may be children in the home when working with adult service users, and the potential impact of adult disengagement on the child.

It is important to keep lines of communication with the family open as much as possible. This may include offering an alternative worker. However, practitioners must guard against collusion with the family.

A chronology of attempted contacts must be used for families where there is non-engagement using the significant events page as per record keeping guidance.

For any other records, follow relevant Record Keeping Guidelines.

All children / young people should be registered with a GP to ensure that their care is co-ordinated and information is drawn together to inform assessment. Parents must be encouraged to register the child with a GP. If the parents do not do so, the service must continue to attempt to work with the child whilst continually encouraging registration with a GP. Refusal to register with a GP must be discussed with the Named Nurse Safeguarding Children or Child Protection Supervisor.

Practitioners must analyse/ risk-assess situations where disengagement is a feature and discuss with the Named Nurse Safeguarding Children or Child Protection Supervisor.

Further information on engagement or concerns should be sought from other professionals working with the family.

Other relevant professionals / agencies must be informed of disengagement of a family.

Practitioners must consider convening a Multi-agency meeting to share information and agree a way forward.

Cases of disengagement where there are concerns for a child's welfare must be discussed with the Named Nurse Safeguarding Children or a Child Protection Supervisor. From this discussion an action plan will be agreed which may include a referral to Children Services.

Practitioners must record all disengagement with services in the appropriate records. They must record their analysis of the risk, observations, and conclusions and actions taken clearly, ensuring that copies of letters and referral forms is kept.

5. Training and Supervision

No additional training is required to work with this guideline

6. Monitoring and Auditing

No formal audit will be undertaken to monitor conformance with this guideline. Disengagement will be discussed with the safeguarding supervisor or Named Nurse.

7. References

Children Act 2004 (2004) London, The Stationery Office

Department for Education & Skills (2008) Information Sharing: Guidance for practitioners and managers. London: DfES www.dcsf.gov.uk

HM Government (2013) Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, London: The Department for children, schools and families

Last accessed 04.04.16

8. Equality and Diversity

This document complies with the South Devon Healthcare Foundation Trust and Torbay and Southern Devon Health and Care NHS Trust Equality and Diversity statements.

9. Further Information

CHILD PROTECTION
CHILDREN AND YOUNG PEOPLE WHO WERE NOT BROUGHT TO OUTPATIENTDS APPOINTMENTS.
PATIENT ACCESS POLICY

Best Practice Information.

Forms/Recording Documentation

10. Appendices

Appendix 1

Draft Letter to Family

Professionals Address:

Addressee:

Date

Dear

Re:

Our records show that the following appointments have been made for your child and it appears that they have not been attended.

1 Date ……. With …… Purpose

2 Date ……. With …… Purpose

3 Date ……. With…… Purpose

Health appointments for your child aim to ensure their health and wellbeing both now and for their future development. They also provide you with an opportunity to discuss any concerns around their health which you may have.

As a Health Service we aim to provide your child with the best possible service. We would be happy to discuss a way forward with you and identify a mutually convenient time and place that would enable you to attend future appointments for your child.

If this information is incorrect or you have not received the appointments, please accept my apologies.

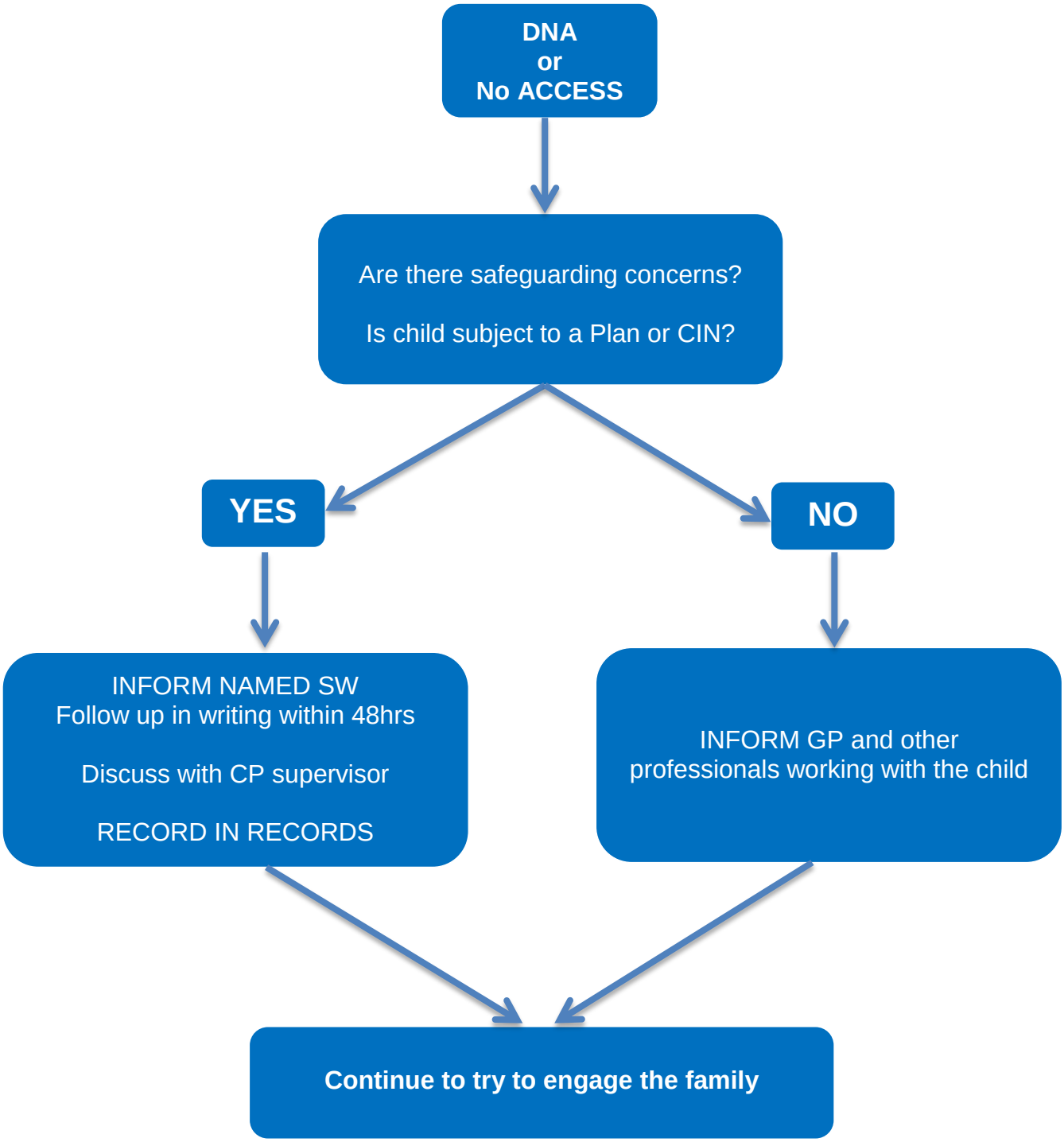
To arrange another appointment please contact this number

Tel: ……..…….
by Date: ……

Yours sincerely

Appendix 2

Management of Non Attendance or No Access



Appendix 3 **SIGNS OF SAFETY ASSESSMENT AND PLANNING FORM**

What are we worried about?	What's going well?	What needs to Happen?

SAFETY SCALE **0-10** **Rate the situation on a scale of 0 – 10, where 0 means things are so bad the family can no longer care for the children and 10 means that everything that needs to happen for the children to be safe in the family is happening.**		

5. Monitoring tool:

Standards:

Item	%	Exceptions

Equality Statement.
The Trust is committed to preventing discrimination, valuing diversity and achieving equality of opportunity. No person (staff, patient or public) will receive less favourable treatment on the grounds of the nine protected characteristics (as governed by the Equality Act 2010): Sexual Orientation; Gender; Age; Gender Reassignment; Pregnancy and Maternity; Disability; Religion or Belief; Race; Marriage and Civil Partnership. In addition to these nine, the Trust will not discriminate on the grounds of domestic circumstances, social-economic status, political affiliation or trade union membership.

The Trust is committed to ensuring all services, policies, projects and strategies undergo equality analysis. For more information about equality analysis and Equality Impact Assessments please refer to the Equality and Diversity Policy

References:

Appendix: *i.e. Flowchart, diagrams etc.*

Amendment History

Issue	Status	Date	Reason for Change	Authorised
1	New	20/11/13	New	Care & Clinical Policy Group
2	Revised	03/06/16	Revised	Care & Clinical Policy Group

The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

"The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves". (3)

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare

http://icare/Operations/mental_capacity_act/Pages/default.aspx

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.