

Clinical Risk Assessment, Formulation & Management in Mental Health Services

Document Type:	Policy		
Secretariat Index Number:	PS08	Version No:	7.0
Document Owner:	Chief Nurse		
Directorate:	ASMH, CYPF, OPAC		
Team/Service:	Trustwide Mental Health Services		
Target Audience:	All mental health staff across all sites.		
Standards, legislation and key related documents:	CQC standards Reg 9: Person-centred care Reg 12: Safe Care and treatment Reg 13: Safeguarding service users from abuse and improper treatment		
This policy has been approved by:	Patient Safety Executive Team		
	Date Approved:	21 August 2024	Review Date: 21 August 2027
Are there any known financial implications linked to this policy:	Where a document has any financial implication on the Trust, the Local Counter Fraud Specialist (LCFS) has the authority to investigate and challenge this document with regards to current fraud and bribery legislation and to ensure appropriate counter fraud measures are in place.		
Does this policy require Counter Fraud approval:	Yes or No:	No	Date: N/A
Are there any known EDI impacts linked to this policy:	The author has carried out an E&DIA and there are no negative or unknown impacts. The E&DIA Form is attached to this document.		
Does this policy require Staff Side approval:	Yes or No:	No	Date: N/A

VERSION CONTROL SUMMARY

FORMAL RATIFICATION RECORD

Version	Date	Author	Details of Previous Version:	Oversight Group	Approval Group	Ratifying Committee	Date:
V7.0	May 2024	Directorate ADNQ – ASMH, CYPF, OPAC	Did not have the use of formulation embedded throughout.	N/A	PSE	Quality & Safety Committee	01/05/23

MINOR CHANGE RECORD

Version	Date	Author	Description of Change/s Made:	Authorising Executive	Date:
V7.0	August 2024	Associate Director of Nursing & Quality, ASMH	<p>Policy reformatted onto new template, references to RiO removed.</p> <p>4. p5. Training & Competency amended to reflect removal of mandatory Clinical Risk Assessment training from TNA and previous levels 1-3 of training.</p> <p>Section 5: process and content -</p> <p>5.2 p6. Positive risk taking clarified</p> <p>5.3.1 – p8. How we assess risk added</p> <p>5.3.2 – p10. personalised risk assessment added</p> <p>5.3.3 – p10. formulation section expanded</p> <p>5.3.8 - p13. Reviews updated to reflect use of S1</p> <p>5.6 – p16. Sexual safety added</p> <p>6. p19 Links to other documents updated</p> <p>Appendix 6 – formulation matrix added</p> <p>Appendix 7 – formulation example added</p> <p>Appendix 8 – competency assessment added</p>	XXX	01/05/23

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1.0 INTRODUCTION

- 1.1 Cambridgeshire and Peterborough NHS Foundation Trust (referred to in this document as CPFT or the Trust) is committed to the safety and wellbeing of service users, staff and all people visiting or working within the Trust.
- 1.2 Clinical Risk Assessment, Formulation and Management is part of the Trust's overall risk management strategy and is fundamental to maintaining safety. This policy outlines the principles of clinical risk assessment, formulation, and management of individual service users to be used within all local services.
- 1.3 This policy applies to all employees of the Trust where competency in the practice of clinical risk assessment, formulation, and management is required to fulfil their role.

2.0 OBJECTIVES and AIMS

- 2.1 To provide clinical teams with the support and guidance that will enable them to make well considered decisions with service users (and families and carers where appropriate) about the risk of potential harm for them and others.
- 2.2 To ensure that clinical teams understand the need to demonstrate the rationale and clinical judgement by which decisions were arrived at and how the potential risk of each harm was balanced in that decision making.

3.0 DUTIES, ROLES and RESPONSIBILITIES

- 3.1 **The Chief Executive** has overall responsibility for ensuring that appropriate and effective systems for clinical risk assessment, formulation, and management are in place. The Chief Executive must ensure that these systems enable the Trust to meet all relevant statutory requirements and that the Trust complies with best practice and any other relevant quality standards set by external bodies. The Chief Executive delegates responsibility for establishing required systems and monitoring processes to the Chief Nurse.
- 3.2 **Chief Nurse, Directors of Nursing/AHPs**, working with and supported by the Medical Director and the Director of Operations, are responsible for promoting a culture whereby the interrelationship between trauma informed care, personal recovery and wellbeing, and balancing risks of harm in support of that recovery are understood. The Chief Nurse also has joint responsibility with the Director of People and Business Development for ensuring there are effective arrangements for staff to be trained, supervised, and supported in the way they assess and formulate risk of harm, intervene to manage the risk, and demonstrate that process in the clinical record.
- 3.3 **Quality & Safety Executive** - This group is responsible for the development, approval, and review of this policy. It will provide guidance and direction to the clinical Directorates in relation to the processes and procedures to ensure effective implementation and monitoring.

- 3.4 **Directorate Senior Leadership Triumvirates** are required to assist the Chief Nurse in delivering this policy within their Directorates. They will:
- Ensure staff within their Directorate's comply with this policy and follow the appropriate procedures.
 - Ensure that staff are aware of any assessment tools that have been approved for use within the Trust.
 - Ensure that any tools, which have not been approved by the Trust, are presented to the Quality and Safety Executive for approval where appropriate.
 - Ensure that any assessment tools being used within the Trust and identified as having cost or copyright implications are appropriately resourced.
 - Provide for the release of clinical staff to attend mandatory training, as identified in the Trust's Mandatory Training Needs Analysis
- 3.5 **Service Managers/Modern Matrons/Ward Managers/Team Leaders** are responsible for the operational delivery of all services within their span of control, for ensuring that these all meet acceptable standards of quality and safety and for ensuring all associated risks are managed. As such, Service Managers/Modern Matrons/Ward Managers/Team Leaders are responsible for ensuring that their team is compliant with this policy and embraces its aims. Service Managers/ Modern Matrons/Ward Managers/Team Leaders are responsible for exercising local leadership in relation to patient safety, as well as the health and safety of staff and visitors. Service Managers/Modern Matrons/Ward Managers/Team Leaders are responsible for ensuring that:
- Staff are familiar with this policy.
 - Staff receive training, in accordance with the Trust training needs analysis, as well as Trust approved assessment tools.
 - Supervision processes include review of risk assessment, formulation, and management skills and practice.
 - Processes to monitor compliance with clinical risk assessment, formulation, and management procedures are implemented and contributed too.
- 3.6 **Clinical Staff** - All employees where competency in clinical risk assessment, formulation and management is required in their role are responsible for:
- Ensuring familiarity with this policy
 - Implementing the policy standards and procedure
 - Maintain their individual competence in clinical risk assessment and clinical risk management, through mandatory training, CPD and relevant core competencies set out within Directorates.
 - Attending Mandatory Training identified within the TNA for their role.

4.0 TRAINING and COMPETENCY

- 4.1 The Trust's Mandatory Training Needs Analysis (TNA) will include the timescales for frequency and identify the level of mandatory training clinical staff require in relation to their role and clinical risk assessment, formulation, and management.
- 4.2 The Trust provides clinical risk training as an e-learning package. Suicide Mitigation Training is also provided for clinical staff. Level 3 clinical risk training is not mandatory training however it is highly recommended for certain staff groups to participate in. This

will depend on their job role, service requirements and as part of their continuing professional development.

4.3 The Trust encourages experienced senior clinicians across all disciplines to participate where able in the training and education of junior professional colleagues, enhancing understanding and expanding one's knowledge base surrounding clinical risk issues within contemporary mental health practice. Competency Assessment may be completed as part of local induction where required.

4.4 Training will be further augmented by utilisation of a pool of appropriately skilled and prepared staff in use of specialist risk assessment tools, cascading new knowledge and skills to other individuals within their clinical roles.

4.5 The Compliance Dashboard will be prepared by the Head of Learning and Development monthly. This report is available on MI Reports.

4.6 **Staff support and supervision**

Staff who work with service users judged to represent a risk must be offered support and supervision. Managers should ensure staff receive regular supervision, in line with the Trust Scope for Growth Policy, and that there is a culture of openness, continuous learning and service improvement so that staff feel comfortable in bringing their concerns and feelings about patients presenting with risk to supervision and team meetings as well as care plan reviews.

5.0 PROCESS and CONTENT

5.1 **Principles of Working with Risk**

- Risk cannot be eliminated, but it can be rigorously assessed and managed or mitigated.
- A history of violence or risk to self/others is vitally important.
- An assessment of risk should identify key factors that indicate a pattern or that risk is increasing.
- Risk is dynamic and can be affected by circumstances that can change over the briefest of timeframes. Therefore, an assessment of risk needs to include a short-term as well as longitudinal perspective and frequent review.
- A formulation should be followed by a plan which specifically describes the current situation and details what could be done to mitigate the risk in future.
- Patient-identifying information may be shared:
 - with the patient's explicit consent; or
 - on a need-to-know basis when the recipient needs the information because they will be involved with the patient's care (where staff from more than one agency are involved, the patient needs to be told that some sharing of information is likely); or
 - if the need to protect the public outweighs the duty of confidentiality to the patient.
- Patients who present a risk to others may also be vulnerable to other forms of risk (e.g. self-harm, self-neglect, retaliation, or exploitation by others).

5.2 **Positive/Therapeutic Risk Taking**

Taking risks is a fundamental part of the human experience that supports personal growth; however, professionals can experience tension striving for a balance between the interests of the individual and societal pressures to control risk.

Positive risk taking is a process which starts with the identification of potential benefit or harm, whilst enabling patients to make decisions about their level of safety and to pursue goals. The desired outcome is to encourage and support people in positive risk taking to achieve personal change or growth.

Positive risk taking recognises that in addition to potentially negative characteristics, risk taking can have positive benefits for individuals, enabling them to do things which most people take for granted. In the right circumstances, risk can be beneficial, balancing necessary levels of protection with preserving reasonable levels of choice and control. Positive risk management does not mean trying to eliminate risk. It means managing risks to maximise people's choice and control over their lives.

Positive risk taking requires several things:

- Recognising a person's right to make their own decisions and to take risks in pursuit of their choices.
- Risk management being part of everyday practice, not a specialist job for 'someone else'.
- Working in equal partnership with people who use services, family carers and advocates, building trust and recognising different perspectives and opinions.
- Understanding and building on a person's strengths.
- Helping service users to learn from their experiences and understand the consequences of different actions.
- Being honest about potential risks and benefits.
- Making informed choices based on all the options available and accurate information.
- Developing an understanding of the responsibilities of each party.
- Empowering people to access opportunities and take worthwhile chances.
- Sometimes supporting short term risks for long term gain.
- Ensuring support is available to disabled and older people, particularly if things begin to go wrong for someone, and working out why.
- Developing person centred and transition planning for young people and adults which supports their involvement and that of their families in decision-making alongside practitioners.
- Ensuring all staff use the guidance, procedures and assessment tools adopted by their service, and receive appropriate support and supervision from their immediate line manager.

5.3 Approach to Clinical Risk Assessment and Harm Minimisation

Research carried out by the National Confidential Inquiry into Suicide (NCISH) (<https://sites.manchester.ac.uk/ncish/>) highlights a need to move away from using risk assessment tools that ask clinicians to predict risk in favour of a more collaborative and personalised approach. Their research into clinical risk in mental health services identified that 86% of people known to services who took their own lives had a long-term risk rating of low or none, identifying that risk assessment is not currently reflecting the dynamic changes in risk for people under our care.

The new consensus is that clinicians should be focusing on collaborative risk assessments involving the person and their wider support network, with the aim of co-producing person centred, individualised and meaningful risk mitigation plans that keep people safe. This

involves understanding risk through careful formulation based on personal, historical, and clinical presentation underpinned by effective and compassionate therapeutic relationships.

If tools are to be used, they are to support the risk assessment, formulation, and co-production of plans, and should not be used to predict future suicide or self-harm, or to determine who should or should not be treated or discharged.

5.3.1 **How to Assess Risk of Harm**

The Purpose of Assessing Risk

The purpose of any risk assessment is to support the service user in their recovery and support their wellbeing through minimising the risk of harm to themselves or others. It is important to understand risk assessment, formulation and management of clinical safety are not separate tasks. They are all part of the same collaborative process. By assessing someone's biological, psychological, and social needs we will start to formulate/develop understanding of the potential risk of harm and how best these can be managed, within a co-produced and personalised plan.

How we Assess Risk

To assess the risk of harm and think about how to minimise that harm whilst also supporting someone's wellbeing and recovery, we need to consider these questions:



We need to understand *why* the risk of harm exists for this person at the point of assessment and should increase the likelihood that any intervention will be effective both short and long term.

There are **four broad areas** of potential harm to consider.

These are:

- **Harm to self** can include self-harm, attempts to end own life, self-neglect or indirect / accidental harm to self.
- **Harm from others** can include being subject to physical harm, emotional and psychological harm, sexual harm, or exploitation of any type. It can also include harm from services and interventions (both intentional and unintentional).
- **Harm to others**, including physical, emotional, or sexual harm, exploitation, or neglect of those in their care.
- **Whenever a child or vulnerable adult is at risk, Safeguarding Think Family should be consulted for advice and consideration of a Safeguarding referral must be made.** All considerations must be documented within the care record. Please refer to the Safeguarding Adults Policy or the Safeguarding Children Policy for further guidance.

Other harms should always include consideration of risk to a person's physical health, as we know that people who experience mental health problems are much more likely to die prematurely from preventable physical health problems than the general population. Studies have also reported on avoidable mortality among children with intellectual disabilities. Staff should refer to the Physical Healthcare policy for Mental Health and Learning Disability Services and associated documents. We must also consider relational risks such as the breakdown in either care or support arrangements as well as loss of trust in others or services.

Other Considerations

A structured approach to the identification, assessment, formulation and management of risk and the review of incidents is essential as the total elimination of risk is unrealistic. It is vital that staff use the guidance, procedures and risk assessment / management tools that have been adopted by their service and seek clarification from their manager or supervisor if they are confused or unsure about what is expected of them.

Harm may arise because of our interventions, especially if they are not compatible with the person's aspirations and life goals. Examples would include adverse effects from medication which may impede the person's ability to live a full and meaningful life. Just as importantly, restrictive interventions such as therapeutic observations or restraint can be both traumatising and retraumatising. Not returning phone calls or turning up when we said we would, can create or perpetuate an experience of rejection.

In some cases, the decisions the service user wishes to take will develop into an advanced decision-making process and we will work with the service user to develop and adhere to advance decisions and statements.

Structured safety tools are an aid to clinical decision-making, not a substitute for it.

When there is a real and immediate risk to human life we must act. We need to be clear that our response is proportionate and related to these immediate risks, not disproportionately trying to protect the right to life at some point in the future. Our

responses should be developed through collective conversations with the person themselves if possible. It is important to include multidisciplinary contributions, family/carers and other support outside the team if needed.

When a team focuses on harm alone, it can lead to a disproportionate response; it is vital to consider the rights that the person has under the Human Rights Act. The two absolute rights that are most relevant are **the right to life and the right to not be tortured or treated in an inhuman or degrading way**. We should hold in mind the right to life does not 'outweigh' the right to be free of inhuman or degrading treatment. A team may need to access extra expert help if decisions were touching on this balance. Please refer to [EDI & Human Rights policy](#) for further information or contact the EDI team or Mental Health Law Manager.

The [Equality Act](#) protects people from discrimination. The Equality, Diversity, and Inclusion Team works across the organisation making sure we have robust processes in place to ensure we continually improve our compliance. The EDI team continues to take forward the equality agenda by ensuring equality legislation is embedded within the organisation. If you need further support please contact the Equality, Diversity, and Inclusion team [Equality, Diversity, and Inclusion | Intranet \(cpft.nhs.uk\)](#) email: edi@cpft.nhs.uk

5.3.2 Personalised Risk Assessment

Consideration needs to be given as to how the risk assessment is completed, a range of methods are available for example face to face, digital or telephone; the service user and the clinician need to be certain that the chosen method of completion is based on risk and need, ensures that all information is accurately shared and that it fully allows for a review of the potential harms.

Collaborative working is essential to minimise the risk of harm. Staff cannot control all situations where there is a risk of harm and accurate prediction of harmful events should not be assumed due to the fluid nature of risk factors. Whilst evidence shows that past behaviour remains a good indicator of future behaviour, this is not always the case. Therefore, historical, static, and dynamic factors should be considered alongside the current presentation and context in assessing the likelihood, imminence, severity, and target of any identified risks. This helps us to identify risk and need and to respond proportionately and reduces the risk of partial 'moment in time' assessments that may falsely reassure.

5.3.3 Formulation

All formulations need to be considered in the context of the person's relationships, wider networks and environmental factors.

The key steps in a risk formulation involve professionals working with the service user to:

- As far as possible, specify the factors likely to increase risk or dangerous behaviour, and those likely to decrease it. This must include the behaviours in context, i.e., how relationships and environmental contexts are protective or increase risk.
- Include an understanding of what the potential risks are, how likely they are, when they might be present, how often and how serious they are.
- Identify triggers and risk indicators (early warning signs).
- Be clear on the factors that are protective in relation to each potential harm. No factors are completely protective or stable.

- Describe this formulation in words (a narrative), carefully separating out if necessary, where factors in one area (e.g. harm to others) are different from factors in any other area (e.g. harm to self).

Static factors: Factors which do not change. These include historical indicators for example a history of suicide attempts, violence, or childhood abuse. Although these factors will always be present, their relevance will vary across individuals and over time.

Dynamic factors: Factors which change over time. Examples of these are: relationships (likelihood of using relationships positively or being harmed in relationships); attitude and beliefs, alcohol or substance misuse, and social deprivation.

Using a risk formulation of the evidence will provide the crucial link between the assessment and management by informing the planning and implementation of the interventions while concisely summarising and communicating an individual's risk status.

5.3.4 Interventions to Reduce the Risk of Harm

It is important to appreciate that something that reduces one harm might increase the risk of another. For example, service users prevented from a behaviour we consider to be a risk, might take an alternative action with more serious consequences for them. We therefore need to balance ensuring the safety of the individual against over-intrusive interventions.

An important principle to consider is that service users have the right to make individual decisions or choices about their own recovery and how to minimise harm to ensure their wellbeing. This includes the right to make decisions that we may not agree with, and we should be trying, wherever possible, to reach a shared understanding with service users when judging potential risks of harm and how these should be managed. This involves shared decision making and supporting service users in their own decisions (not ours) to take positive risks when it is safe and appropriate for them to do so. By fully involving service users in risk assessment and management, we minimise the risk of unintended harm being caused.

Any decisions or actions taken in relation to care and treatment for or on behalf of patients without capacity to consent should be the least restrictive option in terms of impacting on one's individual basic human rights and freedom (2.11- 2.16 Code of Practice MCA 2005: <http://www.justice.gov.uk/downloads/protecting-the-vulnerable/mca/mcahttp://www.justice.gov.uk/downloads/protecting-the-vulnerable/mca/mca-code-practice-0509.pdfcode-practice-0509.pdf>).

Any intrusion into people's lives, or constraints imposed on their right to self-determination, must be both within the law, mindful of their human rights and at the minimum level necessary to maximise privacy and dignity whilst keeping them safe.

5.3.5 Documenting and Communicating Decisions

All service users will have their individual identified risks formulated into risk management/safety plans. This will be on the Trust's electronic record system in accordance with Trust procedures and practice. There may also be alerts placed on the electronic patient record system that highlight specific areas of risk for all clinicians to be aware of. The agreed risk management/Safety Plans will clearly identify which practitioner or service, relative or carer (where appropriate) is responsible for which agreed intervention, including how and when the intervention will be delivered and reviewed.

Developing and sharing the formulation and safety/care plans with the service user, involved clinical practitioners and significant others involved in the care of the service user significantly lowers the risk. Some aspects of this may need to be sensitively approached e.g. if there is a trauma history. What is shared needs to be necessary and justifiable.

During multidisciplinary/ multi agency reviews it is the lead practitioner's responsibility to ensure that the necessary elements of the assessment, formulation, and clinical management (safety) plans are communicated. However, each professional is responsible for assessing and communicating risks in a timely way that they have noted during their own work and ensuring this is integrated into a safety plan which is proportionate to risk.

5.3.6 **Communicating with Families/Carers**

We expect that, in most cases, the family and carers will have been involved in discussions while developing the formulation about risk of harm. It is also important to consider what formal information needs to be shared with carers and families through this process. In most cases this will be agreed with the service user, but in exceptional circumstances the duty to share will override the duty to maintain confidentiality (the Caldicott Principle '*The duty to share information can be as important as the duty to protect service user confidentiality*' is actively supported by the Trust). This must be reviewed on an individual basis by the multi-disciplinary team, considering and documenting the wishes of the service user and the reason why it is believed confidentiality should be breached. Wherever possible that reason should be shared with the service user.

Close relationships can be protective factors or can be risk factors. For some, this could involve discussing with the service user the full engagement of a friend, family, or carer in the assessment and management of risk, especially where these important relationships represent protective factors. The agreed sharing of plans and assessments could therefore be part of a positive and collaborative safety/wellbeing plan. There will be other circumstances where key relationships present significant current or historic risks. In these situations, staff will need to carefully consider the need to protect information about the service user.

Staff will therefore need to think carefully and deliberately on a case-to-case basis about how best to collaborate with the service user and involve family and carers in the assessment and management of risk for the service user, although it should be clear that at any time families can give information to the clinician without compromising the service user's privacy.

5.3.7 **Communicating and Working with Other Agencies**

Risk issues should be discussed with the service user, and the service user's consent to share this information should be obtained wherever possible. Service users should also be informed of the type of circumstances that will result in risk information being shared even if they withhold consent.

When risk factors have been identified, consideration needs to be given to who else needs to know. Information about risk factors should be shared on a need-to-know basis and agreed with the Consultant Psychiatrist and the Multidisciplinary Team. Where serious/significant risks have been identified, information must be shared with all agencies/people involved in the service user's care and other agencies or people whom these risks impact on. Where possible the service user's consent should be obtained before sharing this information. If this is not possible or the service user withholds consent, then a team discussion should take place to decide whether the risk outweighs the service

user's rights to confidentiality. This discussion and the decision must be recorded in the electronic progress notes.

5.3.8 **Reviews**

The factors affecting risk levels are often dynamic and so risk levels fluctuate. Therefore, assessing the risk of harm and managing those risks to minimise that risk of harm is a continuous, proactive process to be collaboratively undertaken by all involved in the person's care.

Service users should expect that the risks of clinically related harm will be assessed, formulated, and reviewed by staff with relevant training and that this will take place as often as necessary so that the identified risks can be managed effectively. Risk assessment happens at first presentation to mental health services and is held in mind at every contact. Formal review should take place when clinically indicated, e.g. when there is deterioration in mental state, risk changes, transitions between services, disengagement, discharge and with every formal review. Minimum standards for the frequency of review of risk assessments in the community will, at the very least, be annual but should take place whenever the situation changes. In inpatient services it would be envisaged that these reviews would be more frequent and related to the changing needs of patients.

Identified risks should be evident within the service user risk assessment. Subsequent risk incidents related to known risks should be indicated by an entry into the Risk Information tab on S1. New risks/changes to risk should trigger a review of the risk assessment.

5.4 **Specific Circumstances to Consider**

5.4.1 **Suicide Mitigation**

Good clinical risk assessment and management has a well-documented role in the prevention of suicide. All clinical practitioners should ensure they are familiar with contemporary information about risk factors and red flags associated with suicide for the communities they work with.

Recovery-focused practice in Mental Health Services emphasises the need for clinicians to work collaboratively with service-users to identify goals and aspirations, in a way that fosters hope and optimism and recognises an individual's desire to be listened to and respected. Although service-users may present to services at times of crisis and perceived hopelessness, it is important that all staff respond in a manner which promotes the possibility of recovery from the trauma of acute mental ill health and personal despair.

The principles harm minimisation applies to all people regardless of diagnosis, and we need to take an approach based on the individual. It is important not to be influenced by any labels (diagnosis or other) and instead to retain an individualised understanding of the person we are working with. Our role is to seek to understand the person's distress and work collaboratively with them to find ways to minimize that distress so that the harmful behaviours can reduce.

The Trust recognises that for some people, deliberate self-harm and/or suicidal thinking is present for long periods of time. Their lifetime risk of death or injury is higher than for other groups and the situations are often complex. Therefore, decision making should be inclusive and thoughtful and revisited regularly. When someone presents with a wide variety of suicidal and self-harm behaviours, these behaviours, thoughts, and feelings need

to be separately assessed and described following detailed discussion with the person and clinical record searches. It is important that clinicians understand and document the actual and intended lethality of different behaviours.

5.4.2 **Management of Behaviour that Challenges**

A significant clinical risk in mental health and learning disability services is the potential for violent, aggressive and/or behaviour that challenges (NICE, 2015). All clinical practitioners should ensure they are familiar with and knowledgeable about the content and principles of the Trust Reducing Restrictive Practice Policy as part of their clinical risk assessment and management knowledge and skills. In each service, clinicians with relevant clinical experience should support teams to think about formulation of risk and potential interventions in these situations.

5.4.3 **Therapeutic Observation and Engagement**

Supportive observation and engagement, over and above the lowest level of observations and engagement, whilst being a restrictive intervention, is a therapeutic intervention aimed at reducing factors which contribute to increased risk and promoting recovery. It should focus on engaging the person therapeutically and enabling them to address their difficulties constructively. It is important that staff balance the distressing effect and potential long-term harm of being on high level of observations and engagement (e.g. loss of skills, loss of autonomy) against the risk of immediate harm (e.g. serious self-harm or violence). As this will change over time, this balance will need to be continually assessed. [Therapeutic Observation & Engagement policy](#).

5.5 **Admission, Leave, and Discharge from Hospital or Transitions**

5.5.1 **Admission**

The first few days of admission should be recognised as a period of imminent danger. Careful risk assessment, formulation and safety planning is therefore needed. This should include discussions with service users, family, and carers, particularly when people have experienced recent illness onset or previous suicide attempts. Knowledge of recent life events or anniversaries experienced around admission should be incorporated into risk assessments.

It is important that the prescribing of therapeutic observations at the point of admission does not happen routinely, in order that, where they are prescribed, it indicates the individual has been assessed to present with specific risks requiring this level of intervention.

Careful planning and consideration are required prior to agreeing to and going on leave from the ward during inpatient admissions. Immediately prior to leave being taken, the person's mental state should be examined to ensure there are no concerns regarding leave taking place and recorded in the electronic pre-leave risk assessment at the earliest opportunity. (For clarity, the term 'leave' in this context refers to both Leave of Absence from Hospital (for detained patients and requiring a valid section 17 form) and time off the ward for an informal patient). Post-leave assessment should also be completed to determine any risks on return and whether a search is justified to minimise risk, based on risk assessment completed on admission, and any reviews indicating a change to risk.

Where periods of leave and/or discharge are being risk assessed, staff must always seek to involve families or carers in the process. The patient has a right to confidentiality, but this must be balanced against the possibility of risk to themselves and/or others. It might be a condition of leave that the relative or carer is involved in the safety planning, alternatively, in a situation where the patient refuses to allow a relative, or carer to be involved, this may indicate increased risk (see relevant policy on leave and from hospital).

Where a serious risk of harm to the physical or mental health of another person is identified (e.g. to a relative or carer living with the service user) careful consideration must be given to taking action to alleviate that risk. Such action may involve discussion with the person at risk or with the police or other appropriate authority. Each case will be considered based on its circumstances and will involve the balancing of the duty of confidentiality to the service user with the public interest in the protection of others. Such decisions are often difficult, and advice is available from the Safeguarding Team and through line management and clinical supervision structures.

5.5.2 Discharge

Careful planning is always required whenever anyone is discharged from hospital. Everyone should receive a follow up within 72 hours of discharge from hospital. Team responsible for completion of 72-hour follow-up must be agreed prior to discharge.

Crisis resolution home treatment (CRHTT) teams have an important role to play in helping to reduce the risk of harms during this period. An integral role of the CRHTT is to facilitate discharge from acute Inpatient wards for service-users who continue to experience distress, but no longer require continued hospitalisation. Intensive home treatment community support may be beneficial, including joint working with community locality and other relevant teams. CRHTT's have a responsibility to attend report out meetings and discharge meetings where appropriate. CRHTT's should have regular links with respective wards to identify patients that no longer require continued hospitalisation but may benefit from home treatment to safely transition from hospital to home. Clear communication between inpatient teams, CRHTTs/community teams is essential so each service can establish a clear role in the interventions that will be provided.

At the pre-discharge meeting a review will take place that will include comprehensive care plan discussion and a new risk management/safety plan will be agreed in collaboration with the service user (and including their family and carers where appropriate). The safety plan which includes management of risks will be communicated to all involved practitioners, the service user, and wherever appropriate, the family and/or carers.

The safety summary and safety plan must include the community living and support arrangements of the service user upon discharge or when granting any leave leading up to discharge. The assessment must include risks of harm to children if the service user may have or resume contact with children, especially if children have been implicated in any delusional or suicidal thinking.

5.6 Sexual Safety

People affected by mental ill health can be vulnerable, lack capacity to make sound decisions about relationships and may have experienced abuse in the past. They may also present as sexually disinhibited, which can be embarrassing, distressing and potentially

dangerous for the person exhibiting the behaviour as well as for those that may be exposed to it.

Staff will understand and discuss potential and actual sexual safety issues with patients and families in a sensitive way, including agreed actions to maintain sexual safety, in line with the [Trust Sexual Safety policy](#).

5.7 **Guidance for Prison In-Reach**

Managing risk in a prison environment a joint responsibility of our two partner agencies, therefore a guidance document has been created and available in Appendix 2 and 3.

5.8 **Clinical Risk Assessment for Children and Young People on the Waiting List**

Managing risk for children and young people on the CAMHs community services waiting list has been recognised as best practice following an initial risk assessment at point of referral. A guidance document has been created and attached as Appendix 4.

5.9 **Parental Mental Illness and Safeguarding Children – Understanding the Risks**

Many parents or carers with mental health problems and mental illness can parent effectively. Nevertheless, consideration must be given to the impact a parent's/carer's condition and symptoms may have on the child and what support the family may need. Staff working in mental health services receive training and advice around making referrals for additional support (early help assessment). They can access further advice, support and supervision via their managers and the safeguarding children team.

Some parents/carers with a severe mental illness do present a risk to their children and, where it is thought the child has experienced or is likely to experience significant harm as a result, the duty of care that a health professional owes to a child will take precedence over any obligation to the parent or other adult. **The welfare of the child is paramount.** If there is significant harm, then a referral can be made without consent. However, wherever possible, referrals should be completed with the service user's knowledge in a transparent way. Exceptions to this would be that doing so will increase the risk to the child at that time/ or facilitate the destruction of evidence.

Staff in adult mental health services must always consider the child's needs and the potential harm as a primary task of the assessment, clinical intervention, care plan and discharge process and as part of any multi-agency risk assessment process. Risks should also be considered for service users who are not parents/carers but are in contact with children – e.g., service users with younger siblings or grandchildren. The rule of optimism suggests that carers will have a positive influence in creating the safest circumstances for children. Staff should however be alert to the possibility of collusion and disguised compliance when undertaking risk assessments and designing safety plans and should liaise with GP/HV/School nurse/ children's social care and others involved in a child's care. Consent should be sought to share information/liase with other professionals. Staff should be transparent about what information they share and the reasons for wanting to share it.

If patients who are parents refuse to consent to share information, then advice should be sought from the safeguarding team, unless the child is at significant risk of harm,

A referral **must** be made to Children's Social Care if a service user expresses delusional beliefs involving their child and/or a service user makes threats to harm their child or might do so as part of a suicide plan.

Staff must **consider** a referral to Children's Social Care if the following are present:

- a history of severe mental illness self-harming behaviour and suicide attempts
- misuse of drugs, alcohol, medication
- obsessional compulsive behaviours involving the child.
- non-compliance with treatment, reluctance, or difficulty in engaging with necessary services.
- lack of insight into illness or impact on the child disorder designated 'untreatable', either totally or within timescales compatible with the child's best interests
- domestic violence and/or relationship difficulties
- unsupported and/or isolated parents
- a child is acting as a young carer for a parent or sibling.
- presence of thought disorder and psychotic symptoms (e.g. delusions)

5.10 Perinatal Mental Health

There are specific risks associated with the ante-natal and post-natal period. If your client is an expectant mother, or a father about to become a parent, you need to anticipate any risks that deterioration in their mental health may pose to the expected baby. If you think that an unborn or delivered baby is likely to experience significant harm, then you must make a referral to children's social care. As with other child protection concerns, it is also important you contact other professionals likely to be involved with the family including the health visitor, midwife, or GP.

It is important to understand a patient's 'relapse signature'. For example, if a patient has presented a risk to a child during a previous psychotic episode, then this must be considered a potential risk during a future relapse. It is important that all agencies involved understand how to recognise the early warning signs of a relapse and the specific risks to children that may result. When concerns arise, it is essential that all professionals involved with the family develop a shared understanding of the parental mental health issue and the specific risks this may pose to the children. Mental health staff have an important part to play in communicating these risks to other agencies.

Staff must record details of children in relation to service users during the course of completing their health records. If children are identified staff are expected to provide further detail, and, should any concerns arise, complete a 'Keeping Children Safe' Assessment. This tool will support staff to explore and consider any risks in more detail and help them to decide upon a response.

The Safeguarding Children Team are also available to provide advice, support, and consultation.

5.11 Adult Safeguarding

Where the risks identified concern neglect or abuse of an “adult at risk” then an adult safeguarding referral should be made.

An adult at risk is defined as an adult who:

- a. has needs for care and support (whether or not the authority is meeting any of those needs),
- b. is experiencing, or is at risk of, abuse or neglect, and
- c. as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it. (Care Act 2014)

The relevant categories of abuse are - Physical abuse, Domestic violence Sexual abuse, psychological abuse, financial or material abuse, Modern slavery, Discriminatory abuse, Organisational abuse, Neglect and acts of omission and Self-neglect.

NB self-neglect may not lead to a safeguarding enquiry unless attempts at care and treatment have not been successful and / or there is a significant risk to the person’s health and wellbeing. See Adult Safeguarding Policy and procedures.

5.12 Use of Tools

It should be noted assessment tools provide a means to systematically identify potential risk and protective factors. These should be used as an aid to formulation and risk management planning and are not a means of prediction.

Mental health assessment tools currently approved for use within the Trust are:

- The risk assessment embedded within SystemOne.
- HCR20
- CAMHS under 4 risk assessment
- DICES risk assessment and formulation

Other risk assessments approved for use include:

- SafeTool (suicide mitigation)
- Falls Risk Screen Tool
- Falls Risk Assessment Tool
- Multifactorial Risk Assessment
- Risk/Trigger Factors for Osteoporosis/Fracture
- People and handling Risk Assessment
- CAADA/DASH
- MUST
- Trust Physical Examination & Assessment Form
- Adult safeguarding risk framework
- Self-neglect assessment of need and risk
- Self-neglect risk indicator tool

Further assessment tools may be added following approval by the relevant Group (as identified within the Trust Governance Framework)

6.0 ASSOCIATED DOCUMENTS

6.1 This policy should be read in conjunction with relevant national and local guidance, particularly in relation to:

- The Mental Health Act
- The Mental Capacity Act
- Care Planning Policy
- Therapeutic Observation and Engagement Policy
- Restrictive Practice – Use of Force policy
- Clinical Record Keeping Policy
- Adult Safeguarding Policy and Practice Guidance Procedure
- Safeguarding Children Policy
- Sexual Safety Policy
- Mandatory Training Policy
- Guideline for the pharmacological management of acute behavioural disturbance in inpatient wards
- Guidelines for Administration of Medicines by Intramuscular Injection
- Seclusion and Segregation Policy
- Admission, Transfer and Discharge Policy
- Ligature Reduction Policy
- Transition Protocol: Young people moving from CAMHS to adult services in the community.
- Transfer of Patients Between Adults Mental Health and Older Peoples Mental Health Criteria.
- Physical Healthcare Policy
- Suicide Prevention Strategy
- PSIRF Policy

7.0 MONITORING COMPLIANCE

Document Section		Control	Check to be carried out	How often will the check be carried out	Responsible for carrying out the check	Results of check reported to	Frequency of reporting
Page	Section	WHAT?	HOW?	WHEN?	WHO?	WHERE?	WHEN?
	5	Presence of risk assessment	MI Report	Monthly	Team/Service Managers	Local / Directorate Governance meetings	Monthly
	5	Risk formulation / management plans	Supervision	Monthly	Supervisors	Ward/Team Managers	Monthly
	5	Quality of risk formulation /management plans	QAV	Annually	HoNS/ QMs	QSG Local Governance meetings	Annual

APPENDIX 1: CLINICAL RISK ASSESSMENT GUIDANCE FOR PRISON IN-REACH

Introduction

The main guidance document for CPFT staff is the “Harm Minimisation: Clinical Risk Assessment, Formulation, and Management in Mental Health Services Policy”. This addendum must be read in conjunction with that policy and the following HM Prison Service policy and guidance documents:

- PSO 2700 Suicide Prevention and Self-Harm Management (2007) – including annexes 1 to 8.
- Care of At-Risk Prisoners – ACCT Plan
- PSO 1700 Segregation of Prisoners (2005)
- PSO 2750 Violence Reduction (2007)

The purpose of this document is to guide CPFT staff to the relevant partner policies and to ensure that knowledge of them is kept up to date.

Managing risk in a prison environment is the joint responsibility of our two partner organisations and can only be effectively achieved if all staff are fully conversant with both sets of policies.

Induction of new staff

All new staff must be made familiar with the contents of the CPFT policy and the above HM Prison Service guidance by Team Leaders as part of their initial induction to the team. They must attend ACCT training as part of their induction and will be clear how and when to open an ACCT plan prior to commencing any clinical role.

All new staff will be given training in CPA risk assessment and management. All new staff will attend CPFT Risk Assessment Training.

Updating of existing staff

It is the responsibility of Team Leaders – supported by the Team Manager – to proactively check for updated HM Prison Service and CPFT guidance and policy change in this area. Monthly updates should be provided to all staff by Team Leaders via the weekly team meetings.

Risk assessment and management will form part of the clinical supervision process for all staff. Specific group supervision is available to support the implementation of the CPFT Risk Assessment Training (violence risk assessment, HCR-20, suicide risk assessment)

(CYPF DIRECTORATE)

INTRODUCTION

The majority of children, young people and families are referred to CAMHS through the Single Point of Access (SPA); referrals in Peterborough for the Neurodevelopmental service continue to go straight to the team. All referrals are triaged and risk assessed on the available information with the. Some cases may require further information before a decision can be made as to the appropriateness of the referral to CAMHS services.

For further information regarding the processes and risk information refer to Appendix 1.

Many children and young people referred to community CAMHS will wait to be seen for both assessment and treatment. It is important that there is a consistent and safe approach to managing the risk of these patients whilst they wait,

This document aims to set out the guidance for staff to follow at each of the key waits for the young person. These are:

- Waiting for first appointment
- Waiting for second appointment

WAITING FOR FIRST APPOINTMENT/CHOICE/ASSESSMENT

Once the referral has been passed to the teams for first appointment/choice/assessment the administrative team will send out a standard 18 week target letter to all young people and families which will include:

- The expectation that they will be seen within 18 weeks
- What to do and who to contact in a crisis situation
- What to do and who to contact if your situation gets worse
- What you can do in the meantime (self help/website etc.)

If it becomes clear at 16 weeks of a young person being on the waiting list that they will breach the 18-week target:

- Undertake a review of the clinical notes and re-prioritise if necessary and allocate an appointment (if able to)
- If risk is identified attempt to contact the family/young person
- If no risk is identified resend the self help letter and information
- if not possible to give an appointment arrange to review in 16 weeks time

This contact needs to be made by a clinician within the appropriate pathway.

WAITING FOR SECOND APPOINTMENT/PARTNERSHIP/TREATMENT

Once a young person has been seen for an assessment the risk may be changed depending upon what has been included within the risk screen which is completed for every person. If a young person needs to be seen due to increased risk, an urgent appointment is arranged. If following assessment there are no further risks identified, the young person is added to the waiting list. They will be given information on who/where to contact if they are in crisis and who/where to contact if the situation deteriorates. More targeted self-help information will also be discussed and given if agreed with the young person.

Whilst the young person is on the waiting list for a second appointment/partnership/treatment, they will receive a standard letter every 3 months to contain the following information:

- Make them aware that the service still has them on the waiting list.
- Ask the young person/family if they still wish to be seen.
- Who/where to contact if they are in crisis.
- Who/where to contact if the situation deteriorates.

This will ensure that there is continued engagement between the service and the young person/family, give them an opportunity to be discharged if they no longer need the service and provide them with details on what to do if things change. This also removes the need for case holding.

If a clinician feels that a young person/family will need more than just a letter they will need to bring the case to MDT for discussion and team agreement that more frequent/a different approach to contact is needed. This will be based on the clinical need of the young person/family and can only be with agreement of the MDT.

MONITORING AND GOVERNANCE

The monitoring of the 3 monthly letters will be via the waiting list spreadsheets where admin staff will check to see when young people/ families require the letter and send it out. They will update the spreadsheet to include the date the letter was sent out and any breaches will be monitored via the waiting list management group.

APPENDIX 3: CAMHS SINGLE POINT OF ACCESS POLICY FOR RISK RATING REFERRALS

The scope of this SOP is to describe the processes that the SPA team use to rate and manage risk within the SPA and when SPA transfer to other CAMHS teams.

Our referral form is clear that SPA referrals are for “non-crisis” referrals for community CAMHS.

SPA processes:

- At the point of referrals entering the SPA, the SPA Administrators to log all new referrals onto S1, using the risk rating given by the referrer.
- Once the referral (or any clinical information received by the SPA) has been scanned, uploaded, and logged on S1, the SPA administrators will place this in the “duty” section of the SPA Workflow.
- A SPA clinician will triage all referrals (and clinical information received by SPA) for risk. This is usually done within 4 hours of the referral being placed on S1.
- All referrals (and clinical information) will be risk rated as below. The function of the risk rating at this point serves the function of how SPA prioritise the screening of their referrals on their list. SPA duty clinicians follow the following risk triaging guidelines:

Urgent	Mention of eating disorder, significant weight loss (something that might indicate the YP might need to access the Eating Disorders Pathway)
	Mention of suicidal ideation, suicidal plans, history of suicidal behaviour
	Mention of severe and extensive deliberate self-harm or other risk behaviours (e.g.: use of aerosols, head banging)
	Mention of at-risk mental state: hearing voices (depending on age), delusional thoughts / ideas.
	Mention of being at risk to others (police and social care involvement)
	Mention of other underlying physical health diagnoses which will impact on risk
Moderate	Mention of mental state severely impacting on the YP functioning
	Mention of risk to self (some suicidal thoughts / ideas, but not current)
	Mention of the YP being started on psychotropic medication (eg: Propranolol, anti-depressants) by a non-psychiatrist
	Mention of the young person being LAC / unaccompanied minor
	Mention of Child Protection / safeguarding issues
Routine	All other referrals
On call	Mention of risk where it is felt that the YP cannot wait for 4 weeks and might need an on-call assessment (within the next 24 / 48 hours)
	<i>SPA duty clinician will usually screen and finalise this referral and liaise with on call workers in the local team.</i>

- The SPA duty clinician will then complete the SPA workflow and transfer from “duty” to “clinician triaged”.
- The SPA clinicians will organise the “clinician triaged” workflow and prioritise the referrals as “urgent”, “moderate” and “routine”.
- The SPA clinician will then screen the referral and the risk rating might change depending on the information that is found as part of the screening process. The process of screening might mean that we need to liaise with partner agencies (Early Help Hub, MASH, District Teams), other CAMHS teams (eg: CASUS, LADS), contacting the referrer for more information (GP, school etc) or contacting the parents/ guardians of the YP. There is an acknowledgment that this information gather can take some time and might need to wait for people to respond to letters that have been posted.

- While waiting for this information, the referral is moved from “clinician triaged” to “clinician liaison” in the SPA workflow. The SPA risk rating can be changed at this point but does not need to be changed.
- When a referral is ready to leave the SPA and be transferred to a CAMHS pathway team it will have a risk rating which communicates to the other team how the referral needs to be prioritised:

Risk Category	Evidence of:	SPA Process
<p>On call To be seen within 24/48 hours of referral</p>	<ul style="list-style-type: none"> • Significant risk to themselves (suicidal thoughts, plans, and intent to act on this, or recent attempt to hurt themselves / end their life) where they cannot wait for 4 weeks for a CAMHS assessment. • Significantly impaired or at-risk mental state: hearing voices, delusional ideas and impaired functioning where they cannot wait 4 weeks for a CAMHS assessment 	<ul style="list-style-type: none"> • ALL of these referrals will need a discussion with the local on call worker or team manager before SPA transfers the referral.
<p>Urgent To be seen within 4 weeks of referral</p>	<ul style="list-style-type: none"> • Suicidal ideation, suicidal plans, history of suicidal behaviour and previously undisclosed attempts • Severe and extensive deliberate self-harm or other risk behaviours (eg: use of aerosols, head banging) • At risk mental state: hearing voices (depending on age), delusional thoughts / ideas. • Family network struggling to cope and evidence of police / social care involvement 	<ul style="list-style-type: none"> • If there is no evidence of safety planning with the family / guardian; SPA clinicians to phone the family / guardian to discuss safety planning. To follow up the phone call, SPA will send a personalised safety plan letter. • If not able to get hold of the family / guardian by phone that day, but clear that the YP needs and URGENT Choice, SPA clinicians to post out safety letter.
	<ul style="list-style-type: none"> • Other issues or other underlying physical health diagnoses or medication which will impact on risk and mental state and cause of emotional distress. • Limited protective factors • Attempts to explore risks in detail by referrer / SPA clinicians, but the YP is unwilling / unable to disclose details, so the extent of the risk is largely unknown 	<ul style="list-style-type: none"> • If not able to get hold of the family / guardian by phone, and it is NOT clear that the YP needs an urgent choice then the SPA clinicians will send a “safety and more info” letter – asking the family to contact SPA for a phone consultation.

<p>Central and Cambridge Neurodevelopmental referrals</p>	<ul style="list-style-type: none"> • Diagnosis of a neurodevelopmental disorder (ADHD / ASD) • Risks as above 	<ul style="list-style-type: none"> • SPA clinician to send personalised safety letter. • Send through to Urgent / Moderate Choice
	<ul style="list-style-type: none"> • Transfer of a YP from another area who is on prescribed ADHD medication. 	<ul style="list-style-type: none"> • SPA to post out the template letter asking the referrer / parent / prescriber for more information, but the YP will transfer to the ADHD pathway
<p>Peterborough Neurodevelopmental referrals</p>	<ul style="list-style-type: none"> • Diagnosis of a neurodevelopmental disorder (ADHD / ASD / LD) • Risks as above 	<ul style="list-style-type: none"> • SPA to transfer to Peterborough Integrated Neuro team and let them know of risks.
<p>Eating Disorders</p>	<ul style="list-style-type: none"> • Weight for height of <80% • Recent rapid weight loss • Frequent purging behaviours • Physical compromise / medical risk due to eating difficulties 	<ul style="list-style-type: none"> • See EDS and SPA SOP • SPA clinician to liaise with the ED “duty” worker for risk rating (“urgent” or “routine”)
<p>Moderate To be seen within 8 weeks of referral</p>	<ul style="list-style-type: none"> • All LAC or unaccompanied minors (if not Urgent) • mental state severely impacting on the YP functioning. • moderate risk to self (some suicidal thoughts / ideas, but not current) • YP meeting CAMHS threshold and being started on psychotropic medication (eg: Propranolol, anti-depressants) by a non-psychiatrist. • Child Protection / safeguarding issues / CSE risk / frequent missing from home 	<ul style="list-style-type: none"> • Depending on issues, SPA clinicians to send safety letter if the concerns are relating to risk. • If low risk to self, and needs a Choice assessment, Choice admin will communicate with the family and referrers as per their normal processes. • If risk not imminent and need Neuro pathway intervention, then Neuro admin will communicate with family and referrers as per their normal processes.
<p>Routine To be seen within 18 weeks of referral</p>	<p>All other referrals who meet threshold for CAMHS</p>	<ul style="list-style-type: none"> • referral is passed to Choice admin or Neuro admin who will carry out their usual communication processes with the YP / family / guardian and referrer. • It is rare that a YP waiting for a Routine Choice would receive a safety letter, but it is possible. • If the YP waiting for a Choice has meds prescribed by a non-psychiatrist, a letter might go out reminding the prescriber of their responsibilities in monitoring meds and mental state of the YP as per NICE guidance. • SPA might write to the referrer or family / guardian to request physical health investigations (bloods etc) if necessary

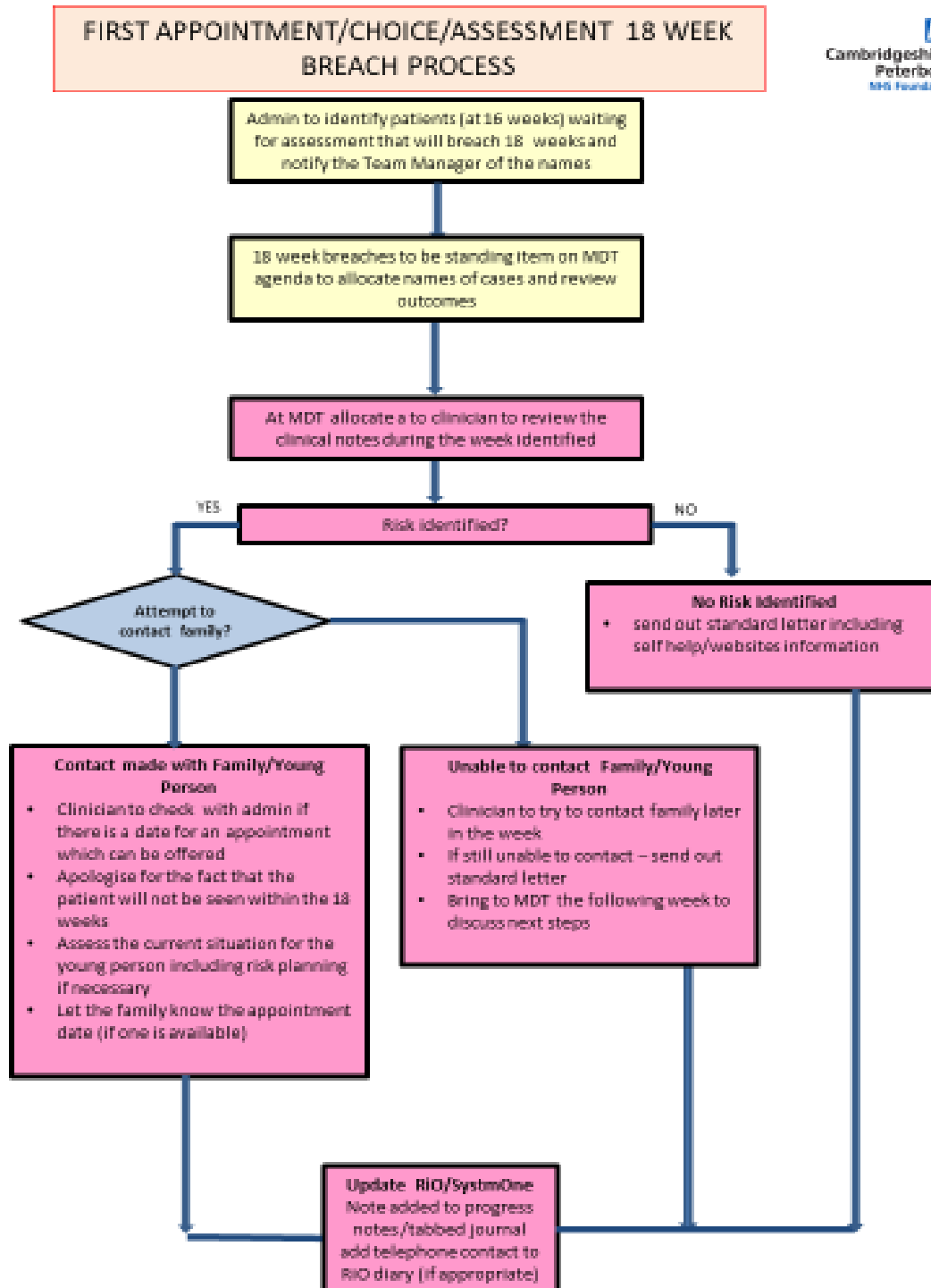
Expedite requests:

- The safety letter is clear about how families / guardians and professionals can request that a referral is expedited. This needs to be done in writing to SPA.
- Choice administrators send out a letter explaining that a Choice can be expedited by going back to the referrer for to put the concerns in writing to the SPA.
- There is an Expedite SOP. (the process is that SPA receive the request, SPA clinician reviews this and then passes this to the Team Manager of the team where the referral has been sent. The team manager will then make the decision about expediting and when the YP can be slotted in if necessary)

Additional information being received by SPA

- This will be placed in the “duty” section of the workflow and a SPA clinician will review the additional information received.
- SPA clinician will make a decision about the information and what needs to be done with this information and whether it will lead to an expedite of the assessment appointment.

APPENDIX 4: FIRST APPOINTMENT/CHOICE/ASSESSMENT 18-WEEK BREACH PROCESS



KEY	Admin	Clinical
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Version 3.0 21 03 19

APPENDIX 5: SECOND APPOINTMENT/PARTNERSHIP/TREATMENT 3-MONTHLY PROCESS

SECOND APPOINTMENT/PARTNERSHIP/TREATMENT 3 MONTHLY LETTER PROCESS

3 month clock will start from when patient is placed on waiting list

Admin to identify patients (at 10 weeks) waiting for second appointment (treatment) that will breach 3 months and notify the Team Manager of the names
 This does not include those patients who have had a first treatment and are waiting for a further intervention
 TO NOTE: this DOES include those patients in the Neuro pathway who have breached their medication review date please disregard the 3 month rule in these cases.

3 month breaches to be standing item on MDT agenda to review outcomes

Standard letter to be sent?

YES

NO

Standard 3 month letter to be sent to all patients identified

Case to be discussed at MDT for team agreement for a more frequent/different approach

Letter to be uploaded to system and date noted on waiting list spreadsheet

Following agreement at MDT
 • Clinician to contact young person/family
 • Clinician to arrange appointment with young person/family

Update RRO/SystemOne
 Note added to progress notes /tabbed journal

Update RRO/SystemOne
 Note added to progress notes /tabbed journal

KEY	Admin	Clinical
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Version 2.0 30 07 18

APPENDIX 6: FORMULATION MATRIX

	Biological	Psychological	Social
Presenting problem <i>(Details about the current problem. Symptoms, when it started, duration, co-morbidities)</i>			
Predisposing <i>(Pre-existing factors - environmental, family history, substance misuse, developmental history, etc)</i>	<ul style="list-style-type: none"> • Genetic • Birth trauma • Brain injury • Illness – psychiatric/physical • Medication • Drugs/alcohol • Pain 	<ul style="list-style-type: none"> • Personality • Modelling • Defences (unconscious) • Coping strategies (conscious) • Self-esteem • Body image • Cognition 	<ul style="list-style-type: none"> • Socio-economic status • Trauma
Precipitating <i>(Triggers – Stressful life events, loss, sexuality, mental or physical illness in family)</i>	<ul style="list-style-type: none"> • Medication • Trauma • Drugs/alcohol • Acute illness • Pain 	<ul style="list-style-type: none"> • Stage of life • Loss/grief • Treatment • Stressors 	<ul style="list-style-type: none"> • Work • Finances • Connections • Relationships
Perpetuating <i>(What is keeping it going? - Beliefs, interactions, patient or service actions)</i>	↓	↓	↓
Protective <i>(Strengths/resources – factors limiting severity)</i>	<ul style="list-style-type: none"> • Physical Health 	<ul style="list-style-type: none"> • Engagement • Insight • Adherence • Coping strategies • Intelligence 	<ul style="list-style-type: none"> • Relationships • Connections • Work

APPENDIX 7: FORMULATION EXAMPLE

	Biological	Psychological	Social
Presenting problem <i>(Details about the current problem. Symptoms, when it started, duration, co-morbidities)</i>	Poor appetite, not sleeping, lacking energy. Increased alcohol intake. Low motivation.	X describes feeling low in mood for 4 weeks and struggles with anxiety. Occasional suicidal thoughts (thinking about taking an overdose). Mum has recently died and there are now caring responsibilities for father.	Unable to see friends currently. Recent criticism of performance at work. Staying with father, only telephone contact with husband – missing him. Brother lives a long distance and unable to help practically.
Predisposing <i>(Pre-existing factors - environmental, family history, substance misuse, developmental history, etc)</i>	Use of alcohol.	Lacks self-confidence. Low self-esteem. Sensitive to criticism. Makes unfavourable comparisons with her brother.	
Precipitating <i>(Triggers – Stressful life events, loss, sexuality, mental or physical illness in family)</i>	Use of alcohol.	Loss of her mum. Caring for her father.	Stressful situation at work. Recent criticism of performance.
Perpetuating <i>(What is keeping it going? - Beliefs, interactions, patient or service actions)</i>	Impaired sleep. Caring responsibilities are stressful. Use of alcohol.	Sense of isolation. Limited support – missing husband. Limited contact with brother.	
Protective <i>(Strengths/resources – factors limiting severity)</i>	Generally good physical health.	Caring responsibility for father. Strong relationship with son. Engaging with the service and treatment.	Support from husband via phone. Support from brother via phone. Mostly enjoys her job.

APPENDIX 8: COMPETENCY ASSESSMENT

The Performance Rating Scale can be used to enable the practitioner and supervisor to rate the level of achievement in all areas of the competency framework. The grading, or scoring system, is to further discriminate levels of achievement.

	Level of achievement	Grade	Marking
Inexperienced practitioner in this field	Cannot perform this activity satisfactorily to participate in the clinical environment.	0	
	Can perform this activity but not without constant supervision and some assistance.	1	
↓ Competent practitioner	Can perform this activity satisfactorily but requires some assistance.	2	
	Can perform this activity satisfactorily with supervision but no assistance.	3	
	Can perform this activity satisfactorily without supervision.	4	
↓ Expert practitioner	Can perform this activity with initiative and adaptability to special problem situations.	5	
	Can perform this activity with initiative and adaptability to special problem situations and lead others.	6	

1 The engagement of the patient/service user		
No.	Competency	Level attained
1	Can demonstrate empathy and respect for the patient/service user.	
2	Can demonstrate knowledge of the principles of engaging a patient/service user including active listening skills.	
3	Can demonstrate a non-judgemental approach including being able to demonstrate the knowledge of triggers for crisis, factors which may increase the risk of repeat crisis and that the experience of crisis is a subjective experience.	
4	Can demonstrate they can establish trust with patients/service users in crisis.	
5	Can demonstrate they can identify the main issues for the patient/service user.	
6	Can demonstrate how they might de-escalate a patient/service user.	
2. Assessment of risk including self-harm		
No	Competency	Level attained
1	Can demonstrate knowledge of mental illness and different mental health problems in relation to risk to self and others.	
2	Can demonstrate knowledge of the principles, different factors and clinical indicators contributing to risk to self and others.	
3	Can demonstrate up to date knowledge of changing trends, risk indicators, and national guidance related to the assessment of risk to self and others.	
4	Can demonstrate knowledge of the use and effectiveness of risk assessment tools.	
5	Can demonstrate knowledge of the effectiveness of specific interventions for patients/service users who present with risk to self or others.	
6	Can explain the rationale for carrying out an assessment of risk as an integral part of the assessment process.	
7	Can demonstrate knowledge of local and national policies that might impact on the assessment of risk.	
3. Clinical competencies		

No	Competency	Level attained
1	Can combine theoretical knowledge with practical, clinical skills in assessing risk.	
2	Can demonstrate the ability to gather all necessary information to assist in the risk assessment and formulation process.	
3	Can make effective use of assessment tools.	
4	Can demonstrate the ability to arrive at a formulation of risk following assessment which incorporates the principles of positive risk taking	
5	Can formulate a comprehensive risk management plan to address areas of identified risk.	
6	Can demonstrate skills in reviewing existing care plans.	
4. Communication skills		
No	Competency	Level attained
1	Can demonstrate the ability to document the assessment, formulation and agreed management plan based on the assessed needs of the patient.	
2	Can demonstrate the ability to actively involve the patient/service user and where appropriate the patient's carers in agreeing the detail of a risk management plan.	
3	Can communicate the level and nature of risk identified to other relevant professionals involved in care.	
4	Can demonstrate the ability to communicate the formulation and management plan to the patient, carers, clinical team, and the wider MDT.	
5	Can co-ordinate the role of different members of the clinical team in managing clinical risk.	
5. Interventions		
No	Competency	Level attained
1	Can explain the rationale for providing a particular therapeutic response to an assessment.	

2	Can communicate and explain core aims and expected outcomes to other members of the wider clinical team.	
3	Actively participates in supervision relating to any therapeutic interventions they provide.	
6. Maintaining accurate records and documentation		
No	Competency	Level attained
1	Can demonstrate knowledge of the rationale for comprehensive record keeping and documentation.	
2	Can demonstrate knowledge of local policies, and guidelines on documentation and record keeping.	
3	Can produce accurate and comprehensive documentation of assessments, formulations, interventions, and outcomes.	

APPENDIX 9: EQUALITY AND DIVERSITY IMPACT ASSESSMENT

An Equality and Diversity Impact Assessment has been completed to assess the potential impact this policy might have upon protected groups or how it is likely to influence the Trust's ability to comply with the Public Sector Equality Duty.

The author of this document has considered any potential impacts. There are *no* specific adverse impacts for people with protected characteristics identified.

If you require this policy in a different format (e.g. larger print, Braille, different language or audio) please contact the Corporate Governance Team (corporategovernance@cpft.nhs.uk).

Who will be affected by the content of this document? (e.g. staff, patients, service users etc.)	Staff, patients/service users, family/carers
What are the desired outcomes of this document?	clinical teams will feel able to make well considered decisions with service users (and families and carers where appropriate) about the risk of potential harm for them and others.
What does this policy, function, process link to in terms of wider business plans and objectives?	

Evidence Considered:
<p>National Confidential Inquiry into Suicide https://sites.manchester.ac.uk/ncish/ Code of Practice MCA 2005:</p> <p>http://www.justice.gov.uk/downloads/protecting-the-vulnerable/mca/mcahttp://www.justice.gov.uk/downloads/protecting-the-vulnerable/mca/mca-code-practice-0509.pdfcode-practice-0509.pdf</p> <p>National Institute for Clinical Excellence</p> <p>Recommendations Self-harm: assessment, management and preventing recurrence Guidance NICE</p> <p>Royal College of Psychiatrists. Self-Harm and Suicide in Adults: Final Report of the Patient Safety Group (College Report CG229). RcPsych, 2020.</p>

When assessing potential impacts of this document on equality groups, the following has been demonstrated, in accordance with General Duty of the Equality Act 2010:

(Please tick the appropriate boxes)

<p>Age <i>Consider age ranges on old and younger people. This can include safeguarding, consent and child welfare.</i></p>	<input checked="" type="radio"/> Positive	<input type="radio"/> None	<input type="radio"/> Negative	<input type="radio"/> Comment
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Armed Forces Community	<input type="radio"/> Positive	<input checked="" type="radio"/> None	<input type="radio"/> Negative	<input type="radio"/> Comment
Disability <i>Consider any attitudinal, physical and social barriers.</i>	<input checked="" type="radio"/> Positive	<input type="radio"/> None	<input type="radio"/> Negative	<input type="radio"/> Comment
Carers <i>Consider part-time working, shift-patterns, general caring responsibilities.</i>	<input checked="" type="radio"/> Positive	<input type="radio"/> None	<input type="radio"/> Negative	<input type="radio"/> Comment
Gender Identify or Reassignment <i>Consider transgender and transsexual people. This can include issues such as privacy of data and harassment.</i>	<input type="radio"/> Positive	<input checked="" type="radio"/> None	<input type="radio"/> Negative	<input type="radio"/> Comment
Marriage and Civil Partnership	<input type="radio"/> Positive	<input checked="" type="radio"/> None	<input type="radio"/> Negative	<input type="radio"/> Comment
Pregnancy and Maternity <i>Consider working arrangements, part-time working, infant caring responsibilities.</i>	<input checked="" type="radio"/> Positive	<input type="radio"/> None	<input type="radio"/> Negative	<input type="radio"/> Comment
Race <i>Consider difference ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers.</i>	<input type="radio"/> Positive	<input checked="" type="radio"/> None	<input type="radio"/> Negative	<input type="radio"/> Comment
Religion or Belief <i>Consider people with different religions, beliefs or no belief</i>	<input type="radio"/> Positive	<input checked="" type="radio"/> None	<input type="radio"/> Negative	<input type="radio"/> Comment
Sex (Gender) <i>Consider men and women (potential to link to carers below).</i>	<input checked="" type="radio"/> Positive	<input type="radio"/> None	<input type="radio"/> Negative	<input type="radio"/> Comment
Sexual Orientation <i>Consider heterosexual people as well as lesbian, gay and bi-sexual people.</i>	<input type="radio"/> Positive	<input checked="" type="radio"/> None	<input type="radio"/> Negative	<input type="radio"/> Comment
Other <i>Consider and include the source of any evidence on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access.</i>	<input type="radio"/> Positive	<input checked="" type="radio"/> None	<input type="radio"/> Negative	<input type="radio"/> Comment

Engagement and involvement

Have you consulted or engaged stakeholders in testing and/or gathering evidence to support the content of this policy?

If so, with whom?

If not, why not?

If any box is marked as 'Negative', or 'Unknown', please escalate to the Equality and Diversity Team (EDI@cpft.nhs.uk) for further support and development of an action plan. Please then sign the box below:

Action Planning for Improvement:

	Action/s required to address gap:	Target Date	Executive Lead
Gaps and Challenges			
Monitoring, evaluating & reviewing			

Agreement by:	Signature:	Date:
Equality, Diversity and Inclusion Lead (if required)		
Chair of Approving Executive Led Group (Level 2)		
Document Author		