

Clinical Risk Assessment and Management in Mental Health Services

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Purpose of the Policy:	This policy outlines the principles of clinical risk assessment and management of individual service users to be used within all local services. It also describes the training that employees will undertake. It should be used by all staff involved in the assessment and management of clinical risk.

If developed in partnership with another agency, ratification details of the relevant agency	
Policy in-line with national guidelines:	

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Version Control Page

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5.1	April 2011	Carol Robertson, Senior Manager – Otters' Retreat.	Addition of Individual Client Risk Management Assessment Form for Otters Retreat to comply with NICE guidelines. Presented at March 2011 Patient Safety and Risk Management Committee and April 2011 Quality and Healthcare Governance Committee.

6.0	December 2013	Learning and Development Manager and Patient Safety Lead	Policy revised to incorporate changes in Mandatory Training requirements, changes in the Care Planning Process, Parental Mental Illness and Safeguarding Children and Risk process and the implementation of the Patient Electronic Records System RiO.
6.1	March 2015	Patient Safety & Complaints Lead	Addition of an identified risk to be indicated by an entry into RiO alert system (red triangle) using the most appropriate general category.
7	May 2019	Directorate Heads of Nursing – CYPF, CYPF	Review: <ul style="list-style-type: none"> • transitions and communicating with families sections added, DICES risk formulation included, adult and child safeguarding updated • process for risk assessment of young people on the waiting list added

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Other Quality Standards	Relevant NICE guidelines and quality standards

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1 Introduction

- 1.1 The Cambridgeshire and Peterborough NHS Foundation Trust (referred to in this document as CPFT or the Trust) is committed to the safety and well being of service users, staff and all people visiting or working within the Trust.
- 1.2 Clinical Risk Assessment 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 and management of individual service users to be used within all local services. It also describes the training that employees will undertake. It should be used by all staff involved in the assessment and management of clinical risk.
- 1.3 This policy should be read in conjunction with best practice guidance, including:
 - Best Practice in Managing Risk (Department of Health 2009)
 - Care Quality Commission (CQC) Fundamental Standards of Quality and Safety
- 1.4 As well as in conjunction with relevant national and local guidance, particularly in relation to:
 - The Mental Health Act
 - Care Planning Policy
 - Enhanced Observation and Engagement Policy
 - Prevention and management of violence and aggression, including relevant Trust policies – Positive and proactive care: The recognition, prevention and therapeutic management of violence and aggression, Managing Violence and Aggression against staff Policy
 - Clinical Record Keeping Policy
 - Adult Safeguarding Policy and Practice Guidance Procedure
 - Safeguarding Children Policy

2 Purpose

- 2.1 This policy outlines the framework to assist all staff, and in particular professional clinical staff, in the assessment and formulation of management strategies for new or existing service users in areas related to clinical risk.
- 2.2 In addition, it will have a particular focus on **four main areas of clinical risk: harm to others, suicide**, including self-harm, **self-neglect** and **harm from others**. It is recognised that service users are exposed to a range of other risks, for example risk of experiencing abuse, risk of disengaging from treatment, risks due to their physical health or from accidental harm e.g. falls. Care and treatment planning processes used within the Trust should aim to identify, assess and manage the full range of risks. For more information on risk assessment in relation to Physical Health, Falls and others. staff should refer to the relevant Trust policy.

- 2.3 This policy also provides guidance on the recording of risk assessments and management plans using the electronic patient record RiO and sets the standard for staff training and development (including refresher training).

3 Scope

- 3.1 This policy applies to all Trust staff and to all service users receiving mental health care and treatment from the Trust.
- 3.2 The principle of risk assessment covers all areas of mental health and is also applicable to the settings of learning disability and child health.
- 3.3 For the remainder of this policy, the term 'patient' and 'service user' means an individual receiving services from the Trust.

4 Definitions

4.1 Clinical Risk Assessment

- 4.1.1 Morgan (2001) defines risk as the likelihood of an event happening, with potentially harmful or beneficial outcomes, for self or others.
- 4.1.2 The Trust therefore accepts that risk assessment cannot accurately predict risk behaviours or harmful outcomes in all cases. Moreover it is accepted that there is a need for a balance to be struck between the rights of patients to lead their lives as independently as possible and to exercise choice, and the duty of care owed by professionals to help promote the health, safety and well being of patients and others.
- 4.1.3 Simplistic predictions of risk are rarely beneficial and a risk minimisation approach does not fit with a modern mental health service with an emphasis on recovery and of treating patients in community setting wherever possible.
- 4.1.4 Clinical risk assessment involves working collaboratively with the service user, and if appropriate their family, to build an understanding of the individual and/or environmental factors that can lead to an increase in risk. It is a continuous and dynamic process. Risk assessments should be structured, evidenced based, consistent across settings, and reviewed regularly as well as after significant events and prior to changes in care.

4.2 Clinical Risk Management

- 4.2.1 Clinical risk management involves developing plans or strategies aimed at preventing the identified risk from occurring, or if this is not possible, minimising the harm caused.
- 4.2.2 Clinical risk management is the process within the care planning process that ensures the risks and vulnerabilities of the service user are formulated and timely

interventions, that take the service user's and their families views into consideration (unless there are very clear, agreed reasons for families to not be involved), are planned to manage the identified clinical risk.

- 4.2.3 Risk management should be undertaken in a multidisciplinary context and be explicitly linked to the service user's care plan. (See Trust Care Planning Policy <http://www.cpft.nhs.uk/help/documents-that-guide-practice.htm>).

4.3 Risk Formulation

- 4.3.1 Risk formulation should, as far as possible, specify the factors likely to increase risk or dangerous behaviour, and those likely to decrease it. This formulation will include an understanding of what the potential risks are, how likely they are, when they might be present, what triggers, what indicators, how often and how serious they are. A risk formulation should account for the role of protective factors as well as risk factors. 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.

- 4.3.2 Where staff have received DICES risk formulation and management training, the formulation should follow the format:

Describe the risks

Identify all the possible options

Choose your preferred option

Explain your choice

Share the decision with others.

4.4 Aims of Clinical Risk Assessment and Management

- 4.4.1 Clinical risk management is essential in order that:

- Service users, staff and others are safeguarded
- Wherever possible the service user and family (or identified others providing care and support), are involved in the planning and delivery of their care related to their personal level of risk
- Risks to the wellbeing of service users, staff and others are assessed and identified
- Indicators of possible increased risk, for example non-compliance with treatment or non-attendance at appointments are identified and addressed Information relating to risk management is appropriately documented and stored
- Risks to service users, staff and others are regularly reviewed
- Risks to service users, staff and others are communicated appropriately and in a timely fashion
- Care plans reflect and address assessed levels of risk
- Plans should be positive and not encourage defensive practice
- Shortfalls in services are identified and addressed.

5 Underpinning Values

- 5.1 The following should be considered when carrying out risk assessments and developing risk management plans:
- All individuals accessing services have the right to have any potential or actual risks assessed
 - Service users have the same rights as others, including, within the constraints of existing legal frameworks, the rights of self-determination and privacy
 - Whenever possible, service users and family/carers/identified others providing care and support, should be actively involved in defining potential risks and developing strategies to minimise risk
 - There is a need to balance the likelihood and severity of harm to self or to others against the likelihood of therapeutic gain and an enhanced quality of life
 - There is also a need to consider age, if the service user is under 18 or has a caring responsibility or role to children under 18 years, where their actions or behaviour may pose a risk of harm to children
 - It is recognised that it is not always possible to predict outcomes but the Trust has an expectation that all reasonable efforts are taken to minimise risk
- 5.2 All staff must recognise, and respond appropriately to any needs arising from a person's:
- race
 - religion
 - culture
 - age
 - sexual orientation and gender identity
 - disability
 - communication needs.
- 5.3 Risk assessments and their subsequent management plans are to be conducted in the best interest of individual patients, especially in areas where capacity to consent to care or treatment is diminished.
- 5.4 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/mcacode-practice-0509.pdf>).
- 5.5 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 in order to maximise privacy and dignity whilst keeping them safe.

- 5.6 Family, carers and/or other identified individuals providing care and support must be treated with respect, taking into account their relationship with the service user. Their knowledge of the situation and their actual and potential contribution to the service user's well being should be fully acknowledged and utilised.
- 5.7 The Children Act (1989) requires us to consider children's best interests. The welfare for children under 18 years is paramount
- 5.8 It must be recognised that all staff working with high risk situations may be subject to stress and have the right to receive appropriate support and supervision.
- 5.9 All staff can access ad hoc safeguarding supervision/advice when considering support needs or risk assessment for service users under 18, or where service users having caring responsibility for under 18s

6 Duties and Responsibilities

6.1 Chief Executive

The Chief Executive has overall responsibility for ensuring that appropriate and effective systems for clinical risk assessment 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 Director of Nursing and Quality.

6.2 Director of Nursing and Quality

The Director of Nursing and Quality, working with and supported by the Medical Director and the Director of Operations, is responsible for ensuring there are effective clinical governance systems in place within the Trust in regard to clinical risk assessment and management, and that relevant risk tools and their use within the Trust is agreed upon through the Quality and Compliance Executive. The Director of Nursing and Quality also has joint responsibility with the Director of People and Business Development for ensuring the provision of appropriate mandatory clinical risk assessment and management training and education.

6.3 Quality and Compliance 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.

6.4 Directorate General Managers, Heads of Nursing and Clinical Directors are required to assist the Director of Nursing and Quality 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 the 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 Compliance 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 available at <http://nww.cpft.training.nhs.uk/> or via hard copy through the Learning and Development Team. (See the Trust's Mandatory Training Policy <http://www.cpft.nhs.uk/help/documents-that-guide-practice.htm>)

6.4 Service Managers/Modern Matrons/Ward Managers and Team Leaders

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 controlled. 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, on clinical risk assessment and management as well as Trust approved risk assessment tools.
- Supervision processes include review of risk assessment and management skills and practice
- Processes to monitor compliance with clinical risk assessment and management procedures are implemented and contributed too.

6.5 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.
- Completing the Clinical Risk Mandatory Training programme as identified in the Trust's Mandatory Training Needs Analysis available at <http://nww.cpft.training.nhs.uk>.

7 Core Elements of Risk Assessment & Management

- 7.1 The safety and security of service users, their carers and relatives, employees and the general public is the fundamental principle guiding Clinical Risk Assessment and Management Practice.
- 7.2 In a safe service it needs to be acknowledged that any service user may present or experience risk to varying degrees. Therefore it is important that an initial risk screening of risk of harm to self, others, neglect/vulnerability and falls is undertaken on the day of admission or first contact with the Trust. The urgency of communication of the initial risk screen will depend on the clinical risks identified and should take place as soon as practically possible. The initial risk screen should be documented in writing, on the day of assessment, in the main case file; this will usually be on the core assessment risk screen held on the electronic patient record on RiO.
- 7.3 If the conducting of the initial risk screen identifies areas of concern a more in-depth risk assessment should be performed and **a clear reasoned formulation** (weighing up of the all the risks, protective factors and benefits, See Section 4.3) **of the person's risk developed and documented**. The date by which this will be completed should be agreed and stated at the time of completion of the initial risk screen and documented on the initial risk screen in RiO.
- 7.4 The presence of, or change in level of, an identified risk should also be indicated by an entry into the RiO alerts system (red triangle) using the most appropriate general category and additional comments.
- 7.5 **Strategies to reduce and manage the risk, including treatment measures to improve clinical state, should be identified and incorporated into the person's care plan.** One tool that can assist in the development of a comprehensive risk assessment is the RiO Risk Assessment (See Appendix 6). The RiO Risk Assessment prompts the gathering and consideration of relevant information. However, the RiO Risk Assessment does not in itself represent a formulation (weighing up of the all the risks, protective factors and benefits) of the risk or identify how any risk might be managed. In addition, and where possible, decision-making should involve the multi-disciplinary team and should demonstrate that best practice has been followed.
- 7.6 Risk assessment around service users under 18 years and for service users who have caring responsibility for under 18s must form part of overall risk assessment (see Keeping children safe tool in RiO), with appropriate use of alerts.
- 7.7 It is essential that the most difficult decisions around managing serious risk are made on the basis of collaborative information-sharing, discussion and agreement between the relevant, practitioners and agencies.

- 7.8 Positive clinical risk management as part of a carefully constructed plan is a required competence for all mental health and learning disability practitioners.
- 7.9 Clinical risk assessment and management are on-going, dynamic processes and will be under constant review as part of each interaction/intervention. However there are critical points at which a person's clinical risk assessment and management plan should be formally reviewed. These include, but are not limited to, the following circumstances:
- At first contact with the service. This includes first contact as a result of an assessment performed under the Mental Health Act
 - Prior to discharge or transfer of care from one treatment environment to another
 - Change in legal status
 - Significant change in life events
 - Significant change in clinical mental and or physical health condition
 - Following a serious event or incident involving a near miss or actual incident report being filed or where a patient fails to keep appointments or refuses treatment
 - Prior to discharge, and post discharge (7-days), from in-patient services. Prior to, and following return, from any leave from an in-patient setting.
 - Multi-disciplinary team review or any review of care provision e.g. CPA Review or nCPA Care Plan Review. The Trust Care Plan Policy states that a care plan should be reviewed as a minimum every 6-month unless clinically indicated otherwise (See care Planning Policy, <http://www.cpft.nhs.uk/help/documents-that-guide-practice.htm>).
 - Risk to children should be considered at admission and prior to discharge. This should include support needs as well as risk of harm as part of the Trust wide Think Family Approach
- 7.10 Clinical risk assessment should be based on the thorough collection of factual information and informed opinions, which can be validated in terms of reliability, from all available sources. Sources of information should include:
- Clinical interview and observation
 - Information from informants (these maybe relatives, carers, others providing significant support, and people from any agency involved in the person's care)
 - Documentary evidence available in care records
 - Psychological and if appropriate physiological tests
 - Prediction indicators derived from evidence based research.
- 7.11 Therefore, in certain cases, staff will not have full information and will have to make the best possible assessment based upon information available. As more information comes to light, and with the person better known, the risk assessment and care plan should be reviewed and updated. Staff should actively seek any additional information that could contribute to the understanding of a person's risk e.g. records from other CPFT teams or previous Trusts.

- 7.12 If the service user is likely to have or resume contact with children the risk assessment must include assessment of the potential risks to children.
- 7.13 Details of historical risk factors and history of risk behaviours, recent risk behaviours, severity frequency, pattern, effect and planned intent will be collated and integrated into the risk assessment formulation as well as the care plan.
- 7.14 An integrated treatment/care plan will identify the risks the service user presents through their behaviours, cognitions, physical state, and disability as well as in which situations and organizational contexts the risks present. The plan will identify all the actions/interventions that are to be implemented to address those risks, the goal/aim of those actions/interventions and who will act/intervene and when. The type of action/intervention will be congruent with the clinical risk identified and consistent in intensity with the level of clinical risk (See Section 6).
- 7.15 A record of the progress and outcomes of the intervention/care plan will be documented in the service user's contemporaneous progress sheets in the clinical record (Refer to Trust Clinical Record Keeping Policy).
- 7.16 Review and evaluation of the treatment/care plan and the evidence and rationale for any change should be made on the treatment/care plan (Refer to Trust Care Planning Policy).
- 7.17 A review will occur after any significant event or incident that changes an individual's personal circumstances (See Section 7.6)
- 7.18 Any changes to the level of identified risk should be recorded in the electronic patient record (RiO) core assessment risk screen and the risk formulation and treatment/care plan should be reviewed and up-dated to ensure that the type of action/intervention is congruent with the clinical risk identified and consistent in intensity with the level of clinical risk. This should be done as soon as practically possible. Urgency of communication and documentation will depend on the level of risk identified: as a minimum it is expected that in-patient written recording of changes to risk will take place before the end of the shift and community written recording on the same day. A verbal communication to others involved in the person's care will in the case of potential high risk take place immediately. This would include, but is not limited to, where it is known that the person has a potential weapon on their person or in their home.
- 7.19 Discussion of people's personal information with others (including families) is subject to the law of confidentiality. If people with capacity refuse to consent to the disclosure of their clinical information, there are only very limited circumstances in which a breach of confidence can be justified in the public interest.
- 7.20 Detailed guidance on disclosures made in the public interest is provided by the GMC <http://www.gmc->

[uk.org/guidance/ethical_guidance/confidentiality_36_39_the_public_interest.asp](http://www.nhs.uk/guidance/ethical_guidance/confidentiality_36_39_the_public_interest.asp)
 and the NHS Code of Practice on Confidentiality
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/200146/Confidentiality_-_NHS_Code_of_Practice.pdf
 Information sharing advice for safeguarding practitioners
<https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice>

- 7.21 For patients who do not have capacity, a decision has to be made in their best interests as to whether or not to share their confidential information with others.
- 7.22 The assessment of risk related to violence and self-harm should be based on a thorough review of information made available from a range of sources.
- 7.23 This should ideally include information about the individual's:
 - **Disorder**, exploring affect, cognition & perceptions as well as behaviour and mood level of the person.
 - **Background history** related to illness, personality, family background, age, culture, gender, and previous attempts at self-harm behaviour or acts of harm, to others, membership of a group known to have an increased risk of violence or suicide.
 - **Individual circumstances** often linked to environmental or current factors including immediate stresses, access to self-harm devices, weapons or victim. Environmental situation i.e. home, prison or hospital and the individuals' attitude or insight
- 7.23 All incidents of aggression, violence and self-harm behaviour must be documented in the patient's electronic record (RiO), clearly reported by staff and communicated to colleagues. The RiO entry should include recording of the Datix Incident number.

8 Clinical Risk Assessment Guidance for Prison In-Reach

- 8.1 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 1 and 2.

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

- 9.1 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.
- 9.2 A guidance document has been created and attached as Appendix 3.

10 Transition Points

- 10.1 It is generally accepted that transition points in an individual's care can be times of increased risk. For example, when a patient is discharged from inpatient care to the community there will be a decrease in the protective factors associated with being in hospital and an increase in the potential risk factors associated with a move to less supervised accommodation in the community.
- 10.2 Transitions are often challenging and important points in peoples' lives. It can be potentially distressing for individuals and family members. All transitions must be managed sensitively to ensure effective collaboration and communication with the person concerned and the immediate teams/colleagues.
- 10.3 Transition points may include but are not limited to:
- Discharge from inpatient setting to the community.
 - Transfer from one level of security to another (e.g. from PICU ward to Acute inpatient ward).
 - Transfer from one Team to another.
 - Transfer from a Forensic Psychiatry Service to General Adult Psychiatry Service.
 - Release from Prison to the community.
 - Transfer from hospital to prison
 - Children services to Adults services
 - Adults services to older people's services
 - Transfer between wards
 - Where children are involved, communication with family units will be essential and risk assessed prior to the patient returning home
- 10.4 Risk Assessment, Safety Planning and Care Planning, must be considered at any of these transition points, to ensure that continuity of care is maintained and information is shared with Teams and Services who may be involved in providing care to the patient following transition.

11 Who should assess risk?

- 11.1 Managing risk is everybody's business. All staff, at all times, should be alert to hazards and the risk of harm. There are no circumstances under which a staff member should feel it to be legitimate or appropriate to ignore a risk. If not able to take steps to formally address a risk the matter should be reported to the appropriate person who, where in doubt, is one's line manager.
- 11.2 Formal, unsupervised, clinical risk assessments should only be undertaken by members of staff who are:
- Professionally qualified, and
 - Have undertaken post-qualifying training in clinical risk assessment (Clinical Risk Assessment Level 2 Training), and
 - Have been trained in the use of RiO

- 11.3 Qualified clinical staff (Band 5 and above), who do not meet the above criteria (for example, are not yet competent in the use of RiO) should only undertake formal risk assessments under the direct supervision of their manager or allocated professional lead/mentor who should 'sign off' any risk assessments undertaken.
- 11.4 Unregistered clinical staff (Bands 2, 3, & 4 for example Healthcare Assistants, STR Workers etc.) should record all risks noted in the RiO progress notes, and ensure that the appropriate Qualified Professional (usually the person co-ordinating a service users' care) or Manager is advised of any matters of concern on the same day. Any risk assessments undertaken by non-registered staff must be validated by registered staff.

12. The Management of Identified Risk

- 12.1 Effective management of risk requires the implementation of the most appropriate actions or strategies to reduce the identified risk.
- 12.2 **One important action/strategy in reducing risk is the implementation of treatment measures that can improve clinical state.**
- 12.3 Actions/strategies will need to be evaluated to measure their effectiveness in reducing the actual level of recognised risk.
- 12.4 It is acknowledged that sometimes it is necessary to take risks in order to achieve therapeutic gain with an assessed individual risk raised by the team. The decision-making rationale and treatment benefit should be clearly documented in the Service Users RiO Progress Notes.
- 12.5 Total risk avoidance has been known to lead to restrictive management, which can be damaging to the therapeutic relationship between the service and the individual concerned.
- 12.6 Multidisciplinary clinical decisions must be based on careful analysis of the identified risk issues highlighted in the initial screening and subsequent in-depth assessment process being used.
- 12.7 Risk assessments and risk management plans should be regularly reviewed with the service user and their multi-disciplinary team wherever possible (See Section 7.6 for minimum review standards). Part of this process should ideally examine the success or weaknesses of previous risk management strategies.
- 12.8 The management plan needs to be integrated into the overall CPA care plan or nCPA care plan for the individual. This will involve immediate risk issues identified, on-going management and future preventive measures required to monitor the level of risk.

- 12.9 Management plans should include a record of any known triggers of aggressive and / or violent conduct as well as self-injurious behaviour based on previous history linked to the individual's presenting clinical state.

13 Communication and Working with Other Agencies

- 13.1 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.
- 13.2 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 outweigh the service user's rights to confidentiality. This discussion and the decision must be recorded in the progress notes on RiO.

14 Communication and working with families

- 14.1 Staff must seek to collaborate with and involve the service user, their family and carers in the risk assessment process, risk management, and any safety planning unless there are clear reasons this is not possible or not clinically indicated (in which case these must be documented).
- 14.2 Staff will also need to carefully consider the role of family members and other close relationships in the well-being of service users. 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.
- 14.3 There will be other circumstances where key relationships actually present significant current or historic risks. In these situations, staff will need to carefully consider the need to protect information about the service user.
- 14.4 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 should be clear that at any time families can give information to the clinician without compromising the service user's privacy.

- 14.5 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 has to 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).
- 14.6 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 on the basis of 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

15 Parental Mental Illness and Safeguarding Children – Understanding the Risks

- 15.1 Many parents or carers with mental health problems and mental illness are able to 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 as a whole. Staff working in mental health services receive training and advice (within the User guide) around making referrals for additional support (early help assessment). They can access further access advice, support and supervision via their managers and the safeguarding children team. Consent is required at Early Help level
- 15.2 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
- 15.3 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/liaise 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,

<https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice>

- 15.4 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.
- 15.5 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)
- 15.6 Royal College of Psychology Guidance states that - A referral must be made:
- a)** If service users express delusional beliefs involving their child and/
or
- b)** If service users might harm their child as part of a suicide plan.
- 15.7 A consultant psychiatrist should be directly involved in all clinical decision making for service users who may pose a risk to children
- <https://www.rcpsych.ac.uk/files/pdfversion/CR164.pdf>
- 15.8 See the Trust Safeguarding Children User Guide/intranet pages/contact the team on 01733 777961 or cpm-tr.CPFTsafeguardingchildren@nhs.net for further advice, supervision or support
- 15.9 CPFT has produced guidance for all staff who are in contact with children, parents or carers where there are concerns around adult mental health: *Safeguarding children who have a parent or carer with mental health problems/guidance for effective joint working*, August 2011. This guidance is informed by research, as well as the findings of local serious case reviews. These reviews have highlighted the importance in recognising that the onset of parental mental illness can present a risk to children even when there is no previous history of abuse or neglect.

15.10 Perinatal Mental Health

- 15.10.1 There are particular 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.
- 15.10.2 Please see NICE Guidance Ante-natal and post-natal mental health overview 2018 <http://pathways.nice.org.uk/pathways/antenatal-and-postnatal-mental-health>
- 15.10.3 Several local serious case reviews have highlighted the importance of understanding 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 (see the Trust safeguarding children User Guide/intranet pages/contact the team on 01733 777961 or cpm-tr.CPFTsafeguardingchildren@nhs.net for further advice /supervision /support.
- 15.10.4 Staff will be prompted to record details of children in relation to service users during the course of completing RIO 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.
- 15.10.5 The Safeguarding Children Team are also available to provide advice, support, and consultation.

16 Adult Safeguarding

- 16.1 Where the risks identified concern neglect or abuse of an "adult at risk" then an adult safeguarding referral should be made.
- 16.2 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)

- 16.3 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.

17 Use of Assessment Tools

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

- The risk screen embedded within the RiO Core Assessment
- The RiO Risk Assessment
- HCR20
- CAMHS under 4 risk assessment
- DICES risk assessment and formulation

- 17.2 Other risk assessments approved for use include:

- Falls Risk Screen Tool
- Falls Risk Assessment Tool
- 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

- 17.3 Please refer to the relevant policy for more information on these risk assessments.

- 17.2 There is a clear process for training of clinicians in the use of these tools either as part of:

- Core professional training programmes
- The Trust mandatory training programme
- Trust continuing professional development training programmes One to one coaching and instruction.

- 17.3 Other risk assessment tools maybe added following approval by the relevant Group (as identified within the Trust Governance Framework)

18 Education and Training Requirements

- 18.1 The Trust's Mandatory Training Needs Analysis (TNA) includes the timescales for frequency and identifies the level of mandatory training clinical staff require in relation to their role and clinical risk assessment and management. This is available on <http://nww.training.cpft.nhs.uk/> or through hard copy by contacting the Learning and Development Team. (See the Trust's Mandatory Training Policy <http://www.cpft.nhs.uk/help/documents-that-guide-practice.htm>).
- 18.2 The Trust's Mandatory Training Calendar/Prospectus shows dates and booking procedures. This can be viewed at <http://nww.training.cpft.nhs.uk/> or via hard copy by contacting the Learning and Development Team.
- 18.3 The Trust provides three levels of clinical risk training. These are Level 1 (foundation), Level 2 and Level 3. Level 1 clinical risk training is mandatory for all clinical staff. Level 2 clinical risk training is mandatory for all qualified 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.
- 18.4 **Clinical Risk Level 1** - This is mandatory and all clinical staff are required to complete during mandatory induction and to refresh every three years. It is delivered through an e-learning module. However, it is recognised that some clinical staff will have the knowledge and skills which exceed this training. Knowledge and skills of staff in clinical risk assessment can be assessed by their line manager and if following assessment a staff member is deemed competent an Exemption Notification Form can be completed by the staff member and line manager.
- 18.5 **Clinical Risk Level 2** – This is mandatory for all professionally qualified staff working in clinical areas. This training is classroom based and should be completed within the 6-months of appointment and up-dated on a 3-yearly basis.
- 18.6 However, it is recognised that some clinical staff will have the knowledge and skills which exceed this training. Knowledge and skills of staff in clinical risk assessment can be assessed by their line manager and if following assessment a staff member is deemed competent an Exemption Notification Form can be completed by the staff member and line manager.
- 18.7 **Clinical Risk Level 3** – this training is recommended for designated senior/experienced clinical staff who must hold a registered qualification and will be expected to complete the assessment of risk of violence using the Historical, Clinical, Risk – 20 (HCR-20 version 3) structured risk assessment tool and the risk assessment of suicide and self harm. This is a five-day classroom based training programme to be completed within 3 years of appointment and then 3 yearly refreshers.

- 18.8 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.
- 18.9 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.
- 18.10 All training attendance will be recorded on the Oracle Learning Management (OLM) database which is part of the Electronic Staff Record (ESR) system. Compliance procedures operate for all Trust mandatory training programmes. (See the Trust's Mandatory Training Policy)

19 Process for Monitoring Training Compliance

- 19.1 Monitoring of compliance with training requirements will be undertaken on a monthly basis by the Head of Learning and Development.
- 19.2 The Compliance Dashboard will be prepared by the Head of Learning and Development on a monthly basis. This report is sent directly to the Divisional managers for action at local level and the Executive Team for information and action to all senior managers. The impact of these actions will be monitored through the compliance dashboard. The Training Compliance Reporting Process is described in the Trust Mandatory Training Policy, <http://www.cpft.nhs.uk/help/documents-that-guide-practice.htm>

20 Process for Following up Those Who Fail to Attend Relevant Training Programmes

- 20.1 All classroom-based training requires each attendee to sign the participant's signature sheet. Non attendees will be identified through no signature on the signature sheet. The Learning and Development Team receive the completed signature sheet from the trainer and records attendees and non-attendees on OLM.
- 20.2 Non attendees and their managers will be notified of the non attendance and a new date will be given for attendance by the Learning and Development team. Should the employee fail to attend the new date, the Learning and Development team will repeat this procedure. If the employee fails to attend again (total 2 times) then the Learning and Development team will notify the Head of Learning and Development.
- 20.3 The Head of Learning and Development will contact the employee and their Manager requesting an explanation for non attendance and an assurance that the training will be completed within one month

- 20.4 If an employee persistently fails to attend mandatory training the Head of Learning and Development escalates this to the Divisional Clinical Director and General Manager for action. This may result in the general manager invoking the disciplinary framework under the Trust's Disciplinary Policy

21 Staff Support and Supervision

- 21.1 Staff who work with services users judged to represent a risk must be offered support and supervision. Managers should ensure staff receive regular supervision, in line with the Trust Supervision 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 high risk clients to supervision and team meetings as well as care plan reviews.

22 Monitoring Effectiveness of Implementation

- 22.1 The quality of clinical risk assessments will be monitored through a range of methods, including:
- Review of care records via the Quality Improvement Evaluation Tool (QuIET)
 - Ad hoc audits and reviews carried out at service level
 - Clinical supervision
 - Trust wide audit on a risk-based approach, as agreed by the Quality and Compliance Executive

23 Links to Other Documents

- Absent without Leave (AWOL) and Missing Patients Standard Operating Procedures
- Section 17 Policy Leave of Absence from Hospital
- Mandatory Training Policy
- Guideline for the pharmacological management of acute behavioural disturbance in inpatient wards
- Guidelines for Administration of Medicines by Intramuscular Injection
- Enhanced Observation and Engagement Policy
- Care Planning Policy
- Seclusion and Segregation Policy
- Clinical Record Keeping Policy
- Admission, Transfer and Discharge Policy
- Driving and Psychiatric Disorders Protocol
- Being Open and Duty of Candour Policy
- Ligature Reduction and Management Within Inpatient Settings Policy
- Manchester Ligature Points Assessment Tool
- 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 for Mental Health and Learning Disability services
- Management of Medical Emergencies Policy Incorporating Resuscitation and Do Not Attempt Resuscitation DNAR
- Management and Prevention Of Slips, Trips and Falls Policy
- Section 17 Policy Leave of Absence from Hospital
- Mental Capacity Act 2005 Practice Guidance for Staff Working in Health and Social Care
- Adult Safeguarding Policy and Practice Guidance Procedure
- Suicide Prevention Strategy (Trust)
- Safeguarding Children Policy
- Guidelines on the Prevention and Control of Violence and Code of Practice (Working Alone in Safety)
- Positive and Proactive care: The recognition, prevention and therapeutic management of violence and aggression policy
- Incident Management Policy Including Serious Incidents & Near Misses
- Working Together to safeguard children 2018
[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729914/Working Together to Safeguard Children-2018.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729914/Working_Together_to_Safeguard_Children-2018.pdf)

Relevant NICE Guidelines:

- Child maltreatment: when to suspect maltreatment in under 18s.
<https://www.nice.org.uk/Guidance/CG89> Clinical guideline [CG89] Published date: July 2009 Last updated: October 2017

24 References and Acknowledgements

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<http://publications.nice.org.uk/antenatal-and-postnatal-mental-health-cg45>

NHS Code of Practice on Confidentiality

([https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/200146/Confidentiality - NHS Code of Practice.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/200146/Confidentiality_-_NHS_Code_of_Practice.pdf))

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Staff may also refer to the document below for additional information. Please note that this document has a copyright and must not be reproduced without the permission of the copyright owner.

Manchester NHS Trust

http://www.healthcareworkforce.nhs.uk/index.php?option=com_docman&task=doc_view&gid=1610 (2009)

Guidance on disclosures made in the public interest is provided by the GMC

(http://www.gmc-uk.org/guidance/ethical_guidance/confidentiality_36_39_the_public_interest.asp)

APPENDIX 1

Clinical Risk Assessment Guidance for Prison In-Reach

Introduction

The main guidance document for CPFT staff is the “Clinical Risk Assessment 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.

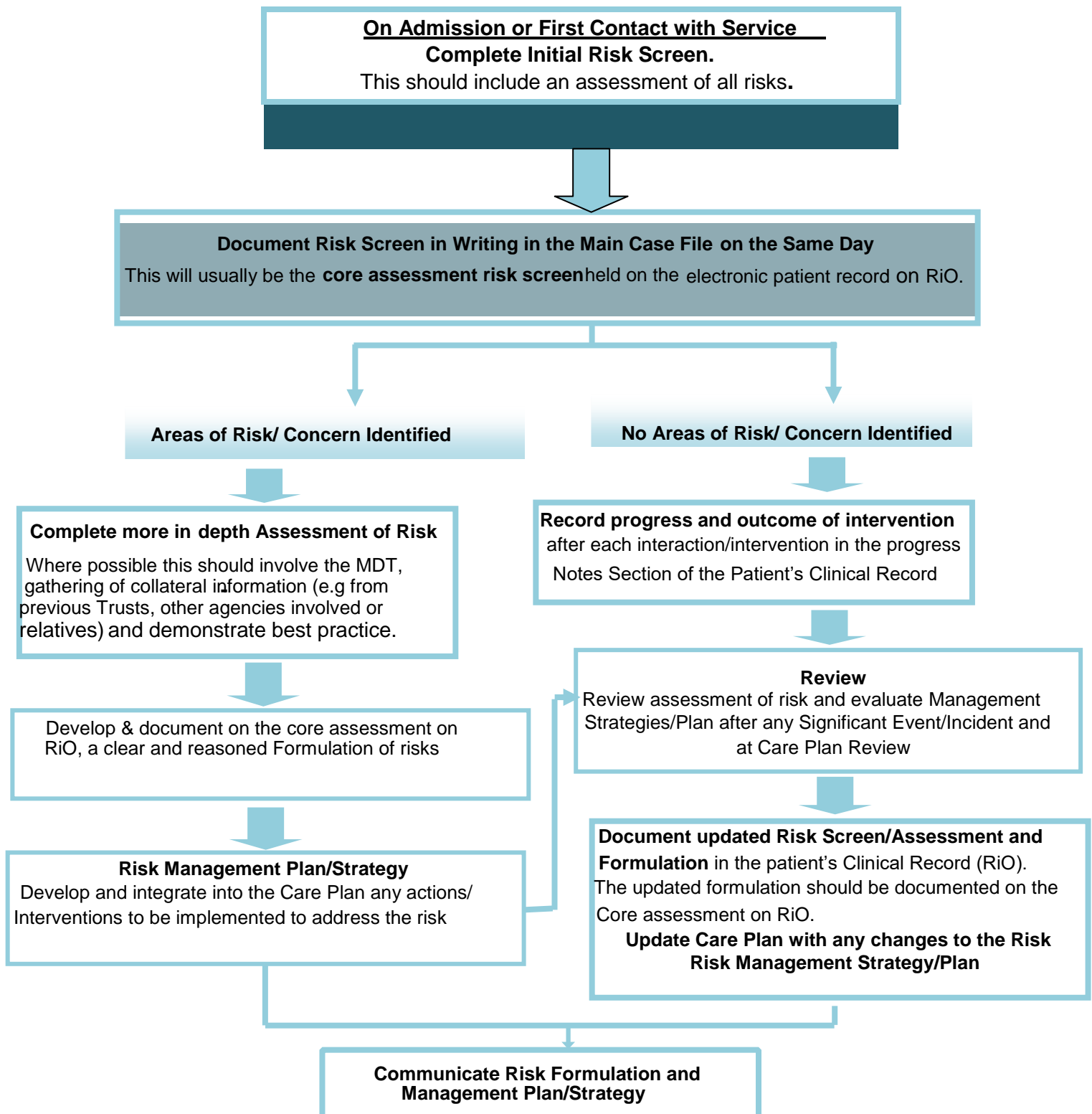
Updating of existing staff

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

APPENDIX 2

Summary of steps in the risk assessment and management process



APPENDIX 3

CHILDREN, YOUNG PEOPLE AND FAMILIES DIRECTORATE

Guidance for Risk Management of Young People on Waiting Lists

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 also 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 letter 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 4

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 RiO, 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 RiO, 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 RiO.
- 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 high 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 high 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 moderate 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
On call To be seen within 24/48 hours of referral	<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.

Urgent To be seen within 4 weeks of referral	<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 high-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.
Central and Cambridge Neurodevelopmental referrals	<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 be transferred to the ADHD pathway
Peterborough Neurodevelopmental referrals	<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.
Eating Disorders	<ul style="list-style-type: none"> • Weight for height of <80% • Recent rapid weight loss • Frequent purging behaviours 	<ul style="list-style-type: none"> • See EDS and SPA SOP

	<ul style="list-style-type: none"> Physical compromise / medical risk due to eating difficulties 	<ul style="list-style-type: none"> SPA clinician to liaise with the ED “duty” worker for risk rating (“urgent” or “routine”)
Moderate To be seen within 8 weeks of referral	<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 low risk and need Neuro pathway intervention, then Neuro admin will communicate with family and referrers as per their normal processes.
Routine To be seen within 18 weeks of referral	All other referrals who meet threshold for CAMHS	<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

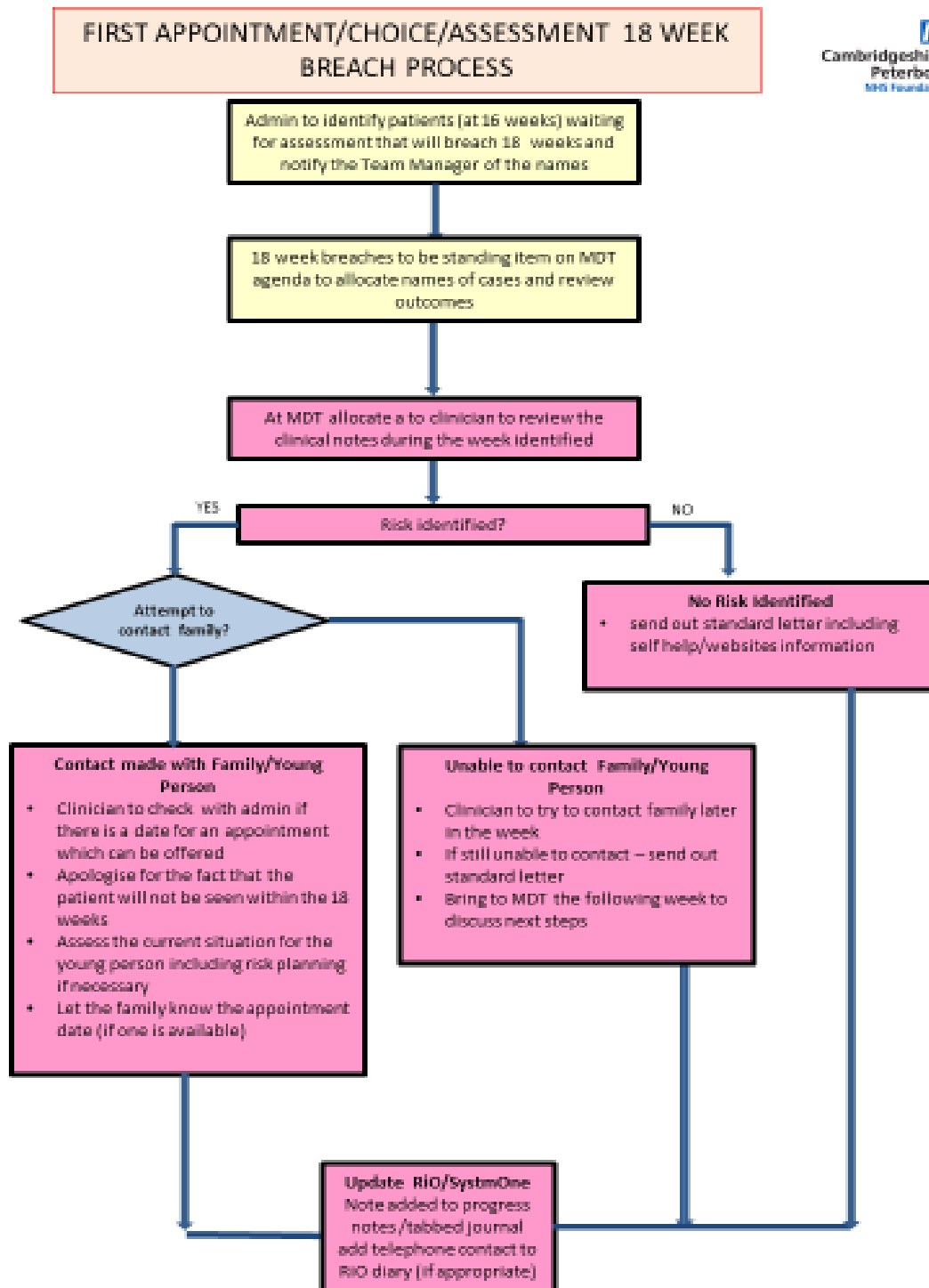
Expedite requests:

- 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 5



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APPENDIX 6

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

YES

Standard letter
to be sent?

NO

Standard 3 month letter to be sent to all
patients identified

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

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

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

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

KEY

Admin

Clinical

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APPENDIX 7

It is imperative that the manager responsible for signing off the Mandatory Training Exemption Notification is satisfied with the evidence provided and any responses to questions are at foundation level standard.

Mandatory Training Exemption Notification

The assessment of clinical risk is integral to the Care Programme Approach process and in particular the management of patient safety.

To qualify for an opt out from this programme Clinicians must be able to demonstrate competence in the following areas:

- Knowledge of the common principles and practice surrounding clinical risk assessment and management of violence,
- Knowledge about the individual responsibility workers have for communicating risk within their work setting whilst maintaining appropriate confidentiality.

Demonstrate the ability to reflect upon their current work practices in relation to assessment and management of risk

(PLEASE COMPLETE IN FULL AND PRINT)

Staff Member's Name Applying for Exemption: _____

Assignment Number: _____

Ward / Department / Team & Location: _____

Assessing Line Manager's Name: _____

Clinical Risk – Foundation Level

The Manager is responsible for assessing competence against the three broad areas above. Evidence may be presented in the form of;

- clinical notes
- completed CPA document
- tribunal reports
- completed Mental Health Act assessments
- other relevant documentation demonstrating an ability to assess and manage risk.

Questions should be posed around the relevant Trust policies;

- is the staff member aware of the policies?
- can they demonstrate an understanding of those policies?

Mandatory Training Exemption Notification

The assessment of clinical risk is integral to the Care Programme Approach process and in particular the management of patient safety.

I _____ the assessing line manager can confirm competence has been established for _____ in order that _____ they are exempted from the **clinical risk foundation level training**.

Date: _____

Their competence has been established using the guidance notes above. The completed form which should state unequivocal competence should be signed by the Manager and the staff member and returned to **The Learning and Development Team, Victoria House, Capital Park, Fulbourn, Cambridge CB21 5XB** – you should retain a copy for their personal file.

APPENDIX 8

Clinical Risk – Level 2

Mandatory Training Exemption Notification

The assessment of clinical risk is integral to the Care Programme Approach process and in particular the management of patient safety.

To qualify for an opt out from this programme Clinicians must be able to demonstrate competence in the following areas:

- Knowledge and understanding of the risk factors associated with violence and aggression and suicide in adult psychiatric
- Knowledge and understanding of the contemporary perspectives associated with suicide.
- Knowledge and understanding of risk formulation, risk management planning and risk communication.

(PLEASE COMPLETE IN FULL AND PRINT) Staff

Member's Name Applying for Exemption:

Assignment Number: _____

Ward / Department / Team & Location:

Assessing Line Manager's Name: _____

The Manager is responsible for assessing competence against the four broad areas above. Evidence may be presented in the form of; clinical notes

- completed CPA document
- tribunal reports
- completed Mental Health Act assessments other relevant
- documentation demonstrating an ability to assess and manage risk.
-

Questions should be posed around the relevant Trust

- policies; is the staff member aware of the policies?
- can they demonstrate an understanding of those policies?

It is imperative that the manager responsible for signing off the Mandatory Training Exemption Notification is satisfied with the evidence provided and any responses to questions are at level 2 standard.

I _____ the assessing line
manager can confirm competence has been established for _____

_____ in order that they
are exempted from the **clinical risk level 2 training**.

Date: _____

Their competence has been established using the guidance notes above. The completed form which should state unequivocal competence should be signed by the Manager and the staff member and returned to **The Learning and Development Team, Victoria House, Capital Park, Fulbourn, Cambridge CB21 5XB** – you should retain a copy for their personal file.