Cumbria Partnership
NHS Foundation Trust

Policy Title: Management of Direct and In-Direct Self Harm Policy (CPFT)

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Policy On A Page

SUMMARY & AIM

Provide support and guidance to practitioners in all teams in the management of care of people who self-harm. People who self-harm may be referred to or be on the caseload of all services provided by CPFT.

Therefore this policy is relevant to all teams and services. It needs to be recognised that all self-harm is an issue that needs to be considered by the whole of the health community in both primary and secondary care.

TARGET AUDIENCE:

The principles of good clinical risk assessment and management of self- harm described in this policy are relevant to all health and social care staff in all clinical areas working within CPFT.

TRAINING:

STORM for adult MH staff
Suicide Risk in Older Adults and people with dementia.
ASSIST

KEY REQUIREMENTS

The NICE guidelines recommends:

- People who self-harm should be treated with care, respect and privacy.
- Wherever possible be given the option of male or female worker.
- Offered treatment options
- All staff should be offered supervision in relation to self-harm
- Be offered a full medical and psychological assessment.
- Fully involve the service and where appropriate gain informed consent to involve carers and families.
- Staff should take steps to understand equality and diversity issues.
- Special measures should be undertaken when assessing older people who self-harm.
- CAMHS should provide consultation for the young person, their family, paediatric team, social services, and education staff.
- Service users should receive a comprehensive assessment of needs and risks.
- All staff that have contact in the emergency situation with service users should be adequately trained to assess mental capacity and to make decisions when care and treatment should be given without consent.
- Staff should understand when and how the MCA can be used to treat the physical consequences of SH.
- Staff working with people who self-harm should have easy access to legal advice about issues relating to capacity at all times.

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1. INTRODUCTION

The NICE (2004) guidelines on self-harm point out that self-harm is poorly understood by NHS staff and recommends that collaboration needs to take place between local health organisations in order to develop properly integrated services.

NICE have issued clinical guideline No. 16 – short term management of self-harm, followed by clinical guideline No. 133: longer-term management of self-harm (NICE 2011) and quality standard 34 (NICE June 2013). These guidelines form the basis of this clinical policy.

Cumbria Partnership NHS Foundation Trust is committed to providing the highest standard of collaborative care for Service Users and their Carers with mental health and substance misuse problems, believing safety is at the centre of good healthcare. The trust recognises the importance of clinical risk assessment for all Service Users and the effective risk management for those who may present an increased risk to themselves.

The trust is committed to supporting Service Users their Carers and clinical services by adopting a systematic and shared approach to risk assessment and management of Self Harm at individual practitioner, team and organisational levels. Embedding key principles and processes of generic risk assessment and management in relation to self-harm and specifically the service users recovery in day to day practice, enables staff to deliver empathetic support with effective objective assessment and management of the risk of Self Harm as part of the Care Programme Approach (CPA) so to achieve and sustain high quality healthcare.

2. DEFINITIONS

This policy uses the definition of self-harm:

“Any act which was intended to and may have resulted in actual or potential physical harm to the body”.

Self-harm

NICE (2004) - recommended terminology

- **Direct self-harm**
  Intentional act of **Self-injury** or **self- poisoning**

- **Indirect self-harm**
  A range of socially acceptable and unacceptable behaviours

NICE defines self-injury as:

“It’s an act done to oneself with the intention of helping oneself, rather than killing oneself. Paradoxically damage is done to the body to protect the integrity of the mind”

2.1 Self-Injury

Self-jury is distinct from other self-harm and suicidal behaviours. Like all self-harm, self-injury is a coping strategy to help deal with painful thoughts and feelings. Although characterised as direct self-harm causing immediate tissue damage, the injury is "usually" low-lethality (it is not life threatening). A person may use self-injury as a coping strategy occasionally, or frequently and repetitively. The intention is "usually" not one of suicide intent. However, there is a strong correlation with thoughts of suicide.

Cutting is the most common form of self-injury; but people also report;

- Scratching
- Biting
- Burning
- Hitting themselves
- Pulling hair

There are others form, that would need to be identified during the assessment.

Key Features

- The inability to resist the impulse
- May have been building for hours or days
- Relief felt is short lived

2.2 Research and Findings

The national confidential inquiry into suicide and homicide report for 2016 to 2017 examined patients who died within 3 months of self-harm. During 2006-2016 there were 4,776 suicides in this group. The report also found self-harm to be increasingly common as an antecedent of suicide in mental health patients but may not be given sufficient weight at assessment. Protocols for managing self-harm patients who are under mental health care should highlight the short term risk.

Average age of starting is 12 but reportedly as young as 5. It is estimated that 4% of the population self- harms and it is one of the top five causes of acute medical admissions for adults (Wilhelm, 2000). Self-harm increases the risk of subsequent suicide. Approximately 1% of people who attend hospital following a self- harm attempt will die by suicide in the next 12 months and above 5% of episodes of self-harm are followed by completed suicide after 9 years (Owens et al, 2002).

The 5 year report of the National Confidential Inquiry into suicide and homicide by people with mental illness (2006) found that 68% of people who completed suicide had a history of self- harm. This is an increase in 4% since the last report.

2.3 Suicide

"Self-harm acts may or may not be associated with an intention to complete suicide. Suicide intent should be assessed and discussed as a separate but related issue

with the client. Sometimes self-harm may be a way of preventing and managing thoughts or urges relating to suicide. It should be assumed that any acts intending to but do not result in death are in any way failures, but the act and intentions always have a communicative message behind them"

It has been generally accepted that the words "deliberate" or "intentional" to pre fix self-harm and commit" to pre-fix suicide have a negative effect and are not acceptable to patients and in view of these words should be avoided by staff.

3. PURPOSE

The purpose of this policy is to provide a compassionate, flexible and reflective approach to the assessment and management of service users who self-harm.

3.1 Aims and objectives of assessment and treatment for clinicians when caring for individuals who self -harm

3.2 Risk Assessment

Risk management is a core component of mental health care and the Care Programme Approach. Effective care includes an awareness of a person's overall needs as well as an awareness of the degree of risk they may present to themselves or others (DOH 2009). Best practice involves making decisions based on knowledge of the research evidence, knowledge of the individual service user and their social context, knowledge of the service user's own experience, and clinical judgement.

3.3 Positive Risk Management

Positive risk-management means being aware that risk can never be completely eliminated. Therefore, management plans inevitably have to include decisions that carry some risk. This should be explicit in the decision-making process and should be discussed openly with the service user.
Positive risk management includes

- working with the service user to identify what is likely to work – and what is not;
- paying attention to the views of carers and others around the service user when finally deciding a plan of action;• weighing up the potential costs and benefits of choosing one action over another;
- being willing to take a decision that involves an element of risk because the potential positive benefits outweigh the risk;
- developing plans and actions that support the positive potentials and priorities stated by the service user, and minimising the risks to the service user or others;
- being clear to all involved about the potential benefits and the potential risks; and
- ensuring that the service user, carer and others who might be affected are fully informed of the decision, the reasons for it and the associated plans .Another way of thinking

Decisions about risk management involve improving the service user's quality of life and plans for recovery, while remaining aware of the safety needs of the service user, their carer and the public. Positive risk management as part of a carefully constructed plan is a desirable competence for all mental health practitioners, and will make risk management more effective (DOH 2009), Langan & Lindow 2004). Positive risk management can be developed by using a collaborative approach (Morgan 2004). Over-defensive practice is bad practice. Avoiding all possible risks is not good for the service user or society in the long term, and can be counterproductive, creating more problems than it solves.

Any risk-related decision is likely to be acceptable if;

- it conforms with relevant guidelines;
- it is based on the best information available;
- it is documented; and, the relevant people are informed, As long as a decision is based on the best evidence, information and clinical judgement available, it will be the best decision that can be made at the time.

3.4 The Comprehensive Risk Assessment Self Harm

All Service users who present with threat of or incidents of Self Harm should receive a full risk and mental state examination; the findings of risk assessment of self-harm should be documented.

Risk assessment is integral to deciding on the most appropriate level of risk management and intervention with a service user, whereby the assessor aims to make every effort to achieve harm minimization (see CPA policy). Best practice of risk assessment is a decision based on the knowledge of research evidence, knowledge of the individual Service User and their social context, the Service users own experience and clinical judgement information from other available sources such as case notes past and present, and carer and relative information / views.

Assessment of Self Harm should be conducted in conjunction with the risk domains of violence/risk to others, serious self-neglect, vulnerability and exploitation and substance misuse in line with the trust GRIST risk assessment tool.

When assessing the risk of self-harm particular consideration should be given to the risk assessment of suicide and the evidence that previous and present acts of self-harm increase the risk of suicide, assessors should establish whether the intent of self-harm was to cope or carry out suicide.

Factors to assess and establish the intent of self-harm would be, ambivalence toward dying, relationship problems, debt, anniversaries, significant events and mental state in conjunction with the following factors being evident:

- Potential lethal method – attempted hanging
- Attempted to conceal – discovered
- Denying or trivializing serious attempt
- Procuring the means – purchased rope
- Detailed plan / tested out
- Recently made a will

- Written suicide note
- Sold or given away possessions

Risk assessment should form the following process:

- Assessment
- Develop Formulation
- Level risk
- Immediate safety plan/future safety planning
- Communication of plans
- Implementation of plans
- Evaluation of plans and planned reassessment

Establishing the level of self-harm risk would involve covering the following aspects of risk with the service user to help estimate each of these aspects:

- How likely it is that the event will occur.
- How soon it is expected to occur.
- How severe the outcome will be if it does occur.

Risk factors should be considered during the assessment process. A risk factor is a personal characteristic or circumstance that is linked to a negative event and that either causes or facilitates the event to occur. Risk factors have been categorised in a number of ways:

- **Actuarial:** Use statistical information about populations to help make decisions about who might be a risk dependant on whether they belong to an identified risk group. Higher risk groups may include: older, male, substance abuser, divorced, unemployed.
- **Clinical:** Is when clinical professionals use their experience and learning to assess the level of risk, e.g. suicide.
- **Static factors** are unchangeable e.g. history of child abuse or suicide attempts.
- **Dynamic factors** change over time e.g. alcohol misuse or attitudes to carers, these can be aspects of the service user or their environment; these factors are more amenable to change.
- **Dynamic factors** that are stable and change slowly are called **Stable** or **Chronic** risk factors.
- **Acute factors** or **Triggers** change rapidly.

When assessing the risk of self-harm the following areas need to be examined in detail in particularly the 48 hours leading up to the event followed by the previous 6-12 months:

- Risk factors
- History
- Ideation/Mental State (hopelessness & ambivalence toward harming self or suicide)

- Intent
- Planning
- Preparation

The assessor should attempt to obtain information from a variety of sources such as the Service User, GP/medical practitioners, family/carer, referrer, friends, care coordinator, medical reports/notes, MDT notes/reports, RIO, It is recognised that for service users not previously known to the service, information may be limited; however it is the responsibility of the assessor to make every effort to gain as much information as possible to aid effective risk assessment and management so to identify the support required.

All risk & Mental state examinations should be conducted jointly with the service user in a transparent manner, measurements, outcomes and formulations should be explicitly shared with the service user, carer/family (with consent). Service users opinions about the validity of assessments and formulation should be explored jointly so to inform care planning and further risk management.

Established risk levels can vary from low to high. E.g. **Low** may include having attempted or voicing self-harm in the past but a repeat of such behaviour is not thought likely between now and the next scheduled risk assessment, the service user is likely to cooperate well and contribute helpfully to risk management planning and they may respond to treatment; there's a sufficient number of protective factors (e.g. trusting relationship with staff, good response to treatment, supportive carer). To support ongoing desistance from self-harm.

High risk could be either planned or spontaneous which is very likely to cause serious harm, with few or no preventative factors to mitigate or reduce that risk and requires long term risk management, including planned supervision and close monitoring or organised treatment.

All assessment, formulation and care planning decisions should be discussed in a multi-disciplinary team when available (MDT), operating an open, democratic and transparent culture that embraces reflective practice, notes are to be recorded, and care planning is agreed jointly with the service user and their carers.

However if due to operational reasons or the time of assessment is out of hours and an MDT is unavailable, following a full risk and Mental state examination the outcome and proposed care planning decisions for an inpatient who has self-harmed should be discussed with the senior nurse on duty, and consultant on call if deemed necessary.

In each case of non admitted, previously known or unknown Service User presenting who has self-harmed following assessment by a medical practitioners (e.g. in A&E) full risk and Mental state examination-one should be a conducted. It is recognised that not all Service Users who self-harm require hospital admission, at the point consideration should be given as whether any of the following interventions are required:

- ALIS/HTT referral

- Community Mental Health Team referral
- Signposting to voluntary organisation e.g. MIND, Samaritans contact details given
- Hospital Admission
- General Practitioner referral
- Carer or Family support (with consent)

3.5 The Comprehensive Mental state examination

NICE guidelines require that a health care professional conducts and records a comprehensive assessment of psychosocial needs for every service user who self-harms and presents to a health service. This assessment would normally include information upon the service users:

- Current problems
- Social situation (living arrangements, work, social isolation)
- Financial problems (debt)
- Family network
- Diversity (age, race, faith, gender, disability, sexual orientation)
- Physical ill health
- Personal relationships
- Recent life events, current difficulties or triggers that preceded self-harm
- Psychiatric history (diagnosis, previous treatments)
- Past history of self-harming behaviour (trends, patterns, relapse signature)
- Current Self harming behaviour and its implications to self or others
- Current Alcohol & substance misuse
- Coping resources and available support (protective factors what might help to reduce risk)
- Concern expressed by others
- Current mental state examination (psychiatric disorder, mood, psychosis, hopelessness, ambivalence about risk to self from self-harm; possible suicide)
- Enduring psychological characteristics associated with self-harm
- Function of behaviour
- Detailed account of the circumstances and motivation for the act
- Most appropriate aftercare
- Service users willingness and engagement with assessment & treatment
- Service user receiving abuse or the victimisation of others

3.6 A & E Staff contact Referral

Its recommend all people who have self-harmed should be offered a preliminary mental state examination at triage or the initial assessment in primary or community settings. The standard for a mental state examination should be completed within four hours of referral.

3.7 Comprehensive Risk Management of Self-Harm

Multidisciplinary and multiagency teams operating in an open, democratic and transparent culture that embraces reflective practice should develop risk management plans.

Risk management must always be based on awareness of the capacity for the service user's risk level to change over time, and recognition that each service user requires a consistent and individualised approach.

Risk management involves developing flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused. Risk management should take into account that risk can be both general and specific, and that good management can reduce and prevent harm.

Knowledge and understanding of mental health legislation is an important component of risk management. The assessment of capacity can become an important issue if the service user who refuses medical treatment for the physical injury of the self-harm. All registered Doctors should be able to assess capacity; in cases of self-harm this can be difficult as capacity may be temporarily impaired by the service users' mental state.

Following a full risk and Mental state Examination the GRIST risk formulation and management plan should be completed or updated identifying situations in which identified risks may occur, and the actions to be taken by practitioners and the service user in response to negative change, reassessment should be planned. This information should be communicated with all professionals involved and where consent is obtained to carers or family in the process of ongoing care or as a discharge.

4. SHARING DECISION MAKING WITH SERVICE USERS AND CARERS

Each stage along the process of developing a risk management plan should be based on discussions with the service user and those involved in their care. The service user should be given the opportunity to have a lead role in identifying risk from their own perspective and when it comes to devising plans to deal with difficult situations indicating the service users preference of the type of support given.

"Risk management can increase a user's awareness of their own behaviour and of how others view them. This can enable them to manage their lives and relationships more effectively". A user's view

5. DIVERSITY & RISK ASSESSMENT & MANAGEMENT OF SELF-HARM

All staff involved in risk management must be capable of demonstrating sensitivity and competence in relation to diversity in race, faith, age, gender, disability and sexual orientation.

6. TREATMENTS

6.1. Treatments for the physical consequences of self-harm

NICE guidelines for self-harm state healthcare staff should offer treatment for the physical consequences of self-harm, regardless of the Service Users willingness to accept Mental state examination assessment or psychiatric treatment.

Appropriate medical personnel should be alerted or accessed to provide medical assessment and treatment as deemed necessary, whether this is facilitated by PCAS, Accident & Emergency service, local GP, CHOC out of hours or on call medical cover.

In the treatment and management of people with self-inflicted injuries, clinicians should take full account of the distress and emotional disturbance experienced by people who self-harm additional to the injury itself, in particular, immediately following injury and at presentation for treatment.

6.2. Psychological treatment for Self-Harm

NICE clinical guidelines states services should consider offering 3 to 12 sessions of a psychological intervention specifically structured for people who self-harm, with the aim of reducing self-harm, in addition;

- The intervention should be tailored to individual need, and could include cognitive behaviour, psychodynamic or problem solving elements.
- Therapists should be trained and supervised in the therapy to people who self-harm.
- Therapists should also be to work collaboratively with the person to identify the problems causing distress or leading to self-harm.

7. HARM MINIMISATION APPROACHES

The objective is to provide support and advice for people who regularly self-harm; However, for people who self-poison; Do Not offer harm minimisation advice regarding self-poisoning –there are no safe limits, as even small ‘overdoses’ can kill.

When prescribing to people who are at risk of, have previously or live with someone at risk of self-poisoning always prescribe those drugs that are the least dangerous in overdose, prescribe as few as possible at one time, Drug therapies may include antidepressants, mood stabilisers and anxiolytics to alleviate the underlying symptoms (NICE, 2014).

- If the self-harm is a form of expression of anger for example; self-punishment, alternative methods of expression should be explored.
- If the self-harm is used; to provide relief from emotional distress, an individual harm minimisation plan should be developed in partnership with the service user.

- This plan may include the use of 1-1- therapeutic sessions, creative writing, CBT
- For people who repeatedly self- Injure there is a risk of infection if wounds are not treated and a risk of permanent scarring.
- Therefore advice and instruction on; self-management of superficial injuries (guidance should be sought from appropriately qualified professional), alongside information on threats to life.
- Information about how blood borne infections may be transmitted and how to avoid these should also be provided.
- Voluntary organisations may be able to offer support.
- A short booklet on self-harm for patients, carers and professionals can be downloaded from the Royal College of Psychiatrists website www.rcpsch.ac.uk

8. CARE PLANNING

A care plan for a person wishing to reduce or stop self-harming should include the following;

- Service users preferences for treatment as identified in the assessment
- Mechanisms to meet the dignity, privacy and safety of others (based on the care environment) have been considered
- Details of agreed specific therapeutic interventions to support the service user in the development of alternative coping strategies.
- Evidence that risks to the service user have been discussed, particularly in relation to hospital infections; this will include information being provided to the service user on infection control.
- Details of interventions to secure the physical well- being of the service user following an incident of self-harm. (This may include hands on physical restraint in the event of an emergency).

9. PATIENT EXPERIENCE

People who have self-harmed should be treated with compassion, care, respect. In addition, healthcare professionals should take full account of the likely distress associated with self-harm and or the ceasing of such behaviors.

Providing treatment and care for people who have self-harmed is emotionally demanding and requires a high level of communication skills. Therefore it is imperative that all staff working in this field have regular clinical supervision to allow them the opportunity to reflect on their practice.

Wherever possible, people who have self-harmed should be offered the choice of male or female worker. When this is not possible, the reasons should be explained and recorded in the patient records.

When caring for people who repeatedly self-harm in all discussions and decisions making about their treatment and subsequently care. Staff should ensure that the

person is provided with comprehensive information about different treatment options available (NTW 2018)

9.1 Consent

Staff often face difficult decisions about whether they should intervene to provide treatment and care to a person who has self-harmed and then refuses help. Not only are these decisions difficult but they provoke disagreements between staff who may interpret differently the legal framework that underpins them.

Consent may pertain to emergency treatment of self-harm (as defined by NICE 2004), or may pertain to longer term care options provided by services. Assessment of capacity and consent should be assessed at each point of contact with patients whom self-harm.

The concept of mental capacity is central to determining whether treatment and care can be given to a person who refuses it. The Mental Capacity Act (2005) gives clear definition of capacity and "best interests", how to measure and record decisions. Staff should refer to the Mental Capacity Act 2005 Code of practice for guidance.

A person may lack capacity to make decisions in question of either long-term mental disability or because of temporary factors such as; unconsciousness, confusion or the effects of fatigue, shock, pain, anxiety, anger, alcohol or drugs.

If a person has capacity to make the decision, then this decision must be respected; even if a refusal may risk permanent injury or death to that person.

Compulsory treatment can include medical and surgical treatment for the physical consequences of self-poising or self-injury if the self-poisoning or self-injury can be categorised as either the consequence of or a symptom of patients mental disorder, providing it can be shown (and recorded) that the person lacks capacity and that the treatment satisfies the conditions of best interests as defined by the Mental Capacity Act (2005).

Treatment and care should take into account patients' needs and preferences. People who self-harm should have the opportunity to make informed decisions about their care and treatment, in partnership with health and social care professionals. If patients do not have the capacity to make decisions, health and social care professionals should follow the guidance in the code of practice that accompanies the Mental Capacity Act.

10. RELATIVES/CARERS

People who self-harm should be enabled, if they wish, to be accompanied by a member of their family, friend or advocate during assessment and treatment.

Staff should also be ready to offer support and help to the relatives/carers of people who self-harmed as they may be also be experiencing high levels of distress and anxiety.

Staff should recognize and incorporate into the care the vital role carers and relatives can play in formulation, maintaining safety and promoting recovery.

11. TRAINING AND SUPPORT

Clinical staff who have contact with people who self-harm in any setting should be provided with appropriate training to equip them to understand and care for people who have self-harmed.

Dealing with those that self-harm is often stressful and distressing. Consequently, staff need appropriate supervision and support arrangements.

Staff also need to consider:

- Addictive/compulsive nature and be prepared to discuss this with the patient.
- Understand that patients who self-harm may very quickly become distressed or volatile during consultations and be able to support and manage these types of encounters.
- Staff members and services involved with people who self-harm need to adopt, unambiguous care plans that are negotiated collaboratively with the patient and carer where appropriate to ensure maximum involvement and ownership. Complex case discussions and multi-disciplinary across agency working is therefore essential to support patients and ensure consistency.
- In the inpatient setting, engagement and observation of a patient may be required. It is important for staff to recognise that this is a therapeutic intervention that should involve the patient. It should not be carried out in a way that could be considered punitive.

People who self-harm should be involved in the planning and delivery of training for staff.

- Emergency departments should make training available in the assessment of mental health needs and the preliminary management of mental health problems, for all healthcare staff working in that environment.

- Mental health services and emergency department services should jointly develop regular training programmes in the Mental state examination and early management of self-harm, to be undertaken by all healthcare professionals who may assess or treat people who have self-harmed.

National Service Framework for Mental Health- standard on suicide prevention are that “Training for staff in specialist mental health services and risk assessment management is a priority, and (should be) updated at least every three years.”

The Cumbria Partnership Training Strategy identifies Clinical Risk Assessment Training as mandatory across all services for qualified staff with the responsibility to undertake clinical risk assessment and the management of clinical risk. Staff should attend updates every 3 years. A programme of Clinical Risk Assessment training is coordinated by the Trust Learning network Training Department.

12. PROCESS FOR MONITORING COMPLIANCE

The process for monitoring compliance with the effectiveness of this policy is as follows:

Aspect being monitored	Monitoring Methodology	Reporting		
		Presented by	Committee	Frequency
Compliance with assessment and treatment of people who self-harm.	Supervision Incident report monitoring STORM audit Training compliance records.	Team Leads Quality and Safety Leads STORM facilitators	Network Governance	6 monthly

Wherever the above monitoring has identified deficiencies, the following must be in place:

- Action plan
- Progress of action plan monitored by the Network Governance minutes
- Risks will be considered for inclusion in the appropriate risk registers

13. REFERENCES & READING LIST

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Consultation on preventing suicide in England: A cross-government strategy to save lives.

Quality Standard QS34: Self-harm (NICE 3013)
https://www.nice.org.uk/guidance/qs34 Accessed: 08.01.19

14. ASSOCIATED DOCUMENTATION

- Delegation of Duties for Registered Nurses and Allied Health Professionals working Non-registered clinical support staff
- Clinical Supervision Policy
- Policy to Promote Privacy, Dignity and Respect
- Policy and Procedure for Managing Informal Service users Non-Compliance
- Policy and Procedures for Physical Examination and Care of Service Users
- Consent Policy
- Policy on Observations and engagement
- Information Sharing (Disclosure) Policy
- Confidentiality Policy
- MHA Guidelines for Informal Leave Arrangement
- Guidelines for Consent to Treatment Part IV MHA 1893
- Joint Operational Protocol Section 136 MHA 1983
- Joint Operational Protocol for Policy Assistance
- MHA Section 5(2) Doctors 72 Hour Holding Power
- MHA Section 5(4) Nurses 6 Hour Holding Power

15. DUTIES (ROLES & RESPONSIBILITIES):

15.1 Chief Executive / Trust Board Responsibilities:

The Chief Executive and Trust Board jointly have overall responsibility for the strategic and operational management of the Trust, including ensuring that Trust policies comply with all legal, statutory and good practice requirements.

15.2 Executive Director Responsibilities:

All policies have a designated Executive Director and it is their responsibility to be involved in the development and sign off of the policies, this should ensure that Trust policies meet statutory legislation and guidance where appropriate. They must ensure the policies are kept up to date by the relevant author and approved at the appropriate committee.

15.3 Managers Responsibilities:

All ward managers, medical staff, nurse consultants, Allied Health Professional (AHP); Team Manager is responsible for ensuring that the policies and procedures are adhered to within their area of accountability.

15.4 Staff Responsibilities:

All staff within the scope of the policies and procedures are responsible for the implementation of the policy within their own area of accountability.

15.5 TMVA Committee Responsibilities:

The Chair of the TMVA committee will ensure the policy approval is documented in the final section of the Checklist for Policy Changes. The committee will agree the approval of the final draft of the policy.

16. ABBREVIATIONS / DEFINITION OF TERMS USED

ABBREVIATION	DEFINITION
AHP	Allied Health Professional
CBT	Cognitive Behavioural Therapy
CHOC	Cumbria Health on Call
CPFT	Cumbria Partnership NHS Foundation Trust
DOH	Department of Health
GRIST	Galatean Risk Screening Tool
MH	Mental Health
MHA	Mental Health Act
MLL	Memory and Later Life
NCUH	North Cumbria University Hospitals NHS Trust
NICE	National Institute of Clinical Evidence
NTW	Northumberland, Tyne & Wear

TERM USED	DEFINITION
	See section 2 for definitions

DOCUMENT CONTROL

Equality Impact Assessment Date	
Sub-Committee & Approval Date	TMVA – 14/01/2019

History of previous published versions of this document:

Version	Ratified Date	Review Date	Date Published	Disposal Date
POL/001/015	Dec 2015	Dec 2018	Dec 2018	Dec 2018

Statement of changes made from version 1.0

Version	Date	Section & Description
1.1	January 2019	• Updated definition introduced self-injury • Added patient and carer experience • Added capacity and consent
1.2	01/03/2019	PMG Amendments: • Policy on a page, Summary and aim – amended 1st paragraph to replace 'od' with 'of' • Section 10, first sentence – removed 'allowed' and replaced with 'enable' • Section 12 – author to confirm if the reporting committee is the **Mental Health** Network Governance Quality Improvement and update bullet number 2 below the table • Formatting amendments
1.3	13/03/2019	• Section 12 Reporting Committee Acute Care Quality Improvement

List of Stakeholders who have reviewed the document

Name	Job Title	Date
Sian Turnbull	Ward manager	7/01/19
Margaret Quinn	Ward manager	7/01/19
Jackie Rigby	Quality and safety manager acute and urgent	7/01/19
Paula McDonald	Ward manager	7/01/19
Aaron Vaughan	Ward manager	7/01/19
Julie Taylor	Senior quality and safety manager MLL	7/01/19
Angela Mcallister	Senior quality and safety manager CMHART and First Step	7/01/19
Laura Baker	Ward manager	7/01/19
Rebecca Mahoney	Ward manager	7/01/19
Clare Torn	Urgent Network manager	7/01/19
Rachel Warwick	ALIS/HTT team lead	7/01/19
Amanda Barwick	ALIS team lead	7/01/19
Chris Rice	ALIS/HTT team lead	7/01/19
Andrea Mcgarvie	Clinical lead ALIS	7/01/19

Name	Job Title	Date
Stuart Beatson	Associate Medical Director MH	7/01/19
Barbara Slater	HTT team lead	7/01/19
David Rawlinson	Associate medical director north	7/01/19
Dr Miriam Naheed	Associate medical director south	7/01/19
CAMHS		7/01/19
Denise Hemming	Quality safety lead for LD	7/01/19
Richard Thwaites	Clinical Director First Step	7/01/19
Andrea Greenwood	General Manager MH	7/01/19
Doug Maisey	Clinical Director Urgent Care	7/01/19
TMVA Committee members		14/1/19
Suicide prevention committee members (includes all CPFT care groups and NCUH members)		15/1/19