Public – To be published on the Trust external website

Title: Clinical Escalation Procedure

Ref: CLIN-0017-003-v1

Status: Approved
Document type: Procedure
Overarching Policy: Safety and Risk Management Policy

Contents

1. Introduction

This procedure supports the trust strategic priorities as part of the next steps in Our Journey To Change (OJTC) and is aligned with the trust Safety and Risk Management Policy to ensure a standardised approach to clinical escalation across the Trust:

- Where there is an urgent need to get the right people together to support a shared understanding to make decisions about care, assessment, treatment, transition and or discharge.

- To support staff to engage in respectful, solution-focused conversations where appropriate feedback can be given and received. It is acknowledged that some conversations may be challenging, and it is important to facilitate them in a supportive and constructive way.

2. Purpose

This procedure helps clinical staff consistently escalate concerns and oversee challenges in patient care to prevent iatrogenic harm.

Following this procedure will help us to:

- Provide a clear structure of the process of clinical escalation, to support decision making at the appropriate level.
- Gather the right people to make timely decisions about care, assessment, treatment, transition, or discharge.
- Promote therapeutic benefits and mitigate harm, recognising there may be no harm-free options.
- Standardise clinical escalation across the Trust.
- Reduce health inequalities and foster diverse perspectives for better decision-making.
- Improve outcomes based on individual priorities.

The aim is to promote a culture that provides psychological safety and confidence in professional challenge to ensure better outcomes for people.

3. Who this procedure applies to

All staff working in clinical services.

It is the Senior Leaders within the team that plan and coordinate the clinical escalation procedure.

4. Related documents

This procedure describes what you need to do to implement the 4.4 section of the Safety and Risk Management Policy; which encompasses working together to understand the risk of harms. Collaborative working being essential to minimise risk of harm. This policy highlights how “risks cannot ever be eliminated and may change within moments or hours depending on multiple external factors. Care and safety plans at times may include decisions in which there are no risk-free options."

Where the reason for the clinical escalation is in relation to admission, transfer and discharge of a patient, refer to the Admission, Transfer and Discharge Policy.

The Safety and Risk Management Policy define working together to understand the risks of harm/s and is useful to read in conjunction with this procedure.

The Admissions, Transfer and Discharge Policy describe the minimum standards of practice to be followed to support people through their admission to hospital, any transitions or transfers between hospital services and subsequent discharge or transfer of care from inpatient services. It is useful to read in conjunction with this procedure.

The Transitions protocol Child & Adolescent to Adult Services or Primary Care describe the minimum standards of practice to be followed to support young people through their transitions from child & adolescent services to adult services. It is useful to read in conjunction of this policy.

5. Team level clinical escalation

If it is unlikely that clinical issues can be resolved at Team or Team-Plus level and there are immediate risks of harm occurring without intervening, to review and make a clear decision or plan, then use stop the line straightaway.

As part of usual care and treatment, Multi-disciplinary Team (MDT) discussions to support collaborative clinical decisions will be taking place routinely in the team / service.

The main forums for this are: MDT meeting, huddles, report out, leadership cells, assessment, care planning, formulation, reflective practice, supervision and advocacy involvement. This is not an exhaustive list as each team will have their own local MDT working arrangements.

5.1 Team Plus – Complex Needs Review

Any member of staff involved in a person's care and treatment can ask for a **complex needs review**. The relevant leadership team for that person's care and treatment will lead the planning of the meeting.

This is where there is a need to gain a different perspective and/ or external support. This may include senior clinical staff from other teams, consultation from subject matter experts (such as the personality and relational service, trust wide autism team, mental health legislation team, legal advice, forensic or learning disability specialists), external organisations from the Trust, commissioners to support decisions about care, treatment and/or discharge. This includes multiagency forums such as Multiagency Public Protection Arrangements (MAPPA), Child in Need, Child Protection Planning, Dynamic Risk Support and Local Area Emergency Protocols/Blue light, Care Education and Treatment Reviews.

The main forums for this are:

- Usual escalation routes to collective clinical, professional and operational leads
- Seeking a second opinion
- Martha's rule - where anyone who receives care from our Trust, as well as their family members, carers or advocates, can ask for an urgent review when there are concerns about urgent mental or physical deterioration)

If a suitable resolution is achieved, then the situation will return to business as usual.

Other Specialities may wish to review and adopt:-

- Mental Health Services for Older People MHSOP Complex Care Support Network (see Appendix 3) and
- Ridgeway Complex Case Panels (see Appendix 4).

5.1.1 Interface with Second Opinion Procedure including Martha's Rule and Clinical Escalation Procedure

- **Martha's Rule** is a national patient safety initiative. It empowers patients, families and carers to escalate concerns about an urgent deterioration. It provides a clear route for urgent review by a different clinical team, when concerns are not being addressed.
- A **second opinion** is a broader request for a clinical review by an independent person or team. This formal request and review process can be initiated by the patient, family or carer. It is not for instances of urgent deterioration.
- The **clinical escalation** procedure supports clinical staff to escalate urgent concerns. It is a way to bring the right people together to support a shared understanding and make decisions. Decisions could be about care, assessment, treatment, transition or discharge.

5.2 Stop the line

Any member of staff involved in a person's care and treatment can ask for a **Stop the line meeting**. The relevant leadership team for that person's care and treatment will lead the planning of the meeting to be held within 72 hours.

A "Stop the Line" meeting is a structured, rapid-response meeting used in a person's care to address urgent safety concerns or quality issues that require immediate attention.

It is a short, focused meeting convened immediately when a significant safety, quality, or operational concern is identified, allowing frontline staff and leadership to pause routine activities, assess the issue, and collaboratively determine corrective actions to prevent harm or escalation.

This could be if there are blocks, challenges in reaching a shared agreement between people or teams, and/or if there is a risk of harm, without intervening, to review and make a clear decision or plan. This includes Professional Challenge processes.

A professional challenge in safeguarding is to ensure effective inter-agency collaboration and maintaining a culture of open communication and constructive challenge. (For further information see the Safeguarding Policy).

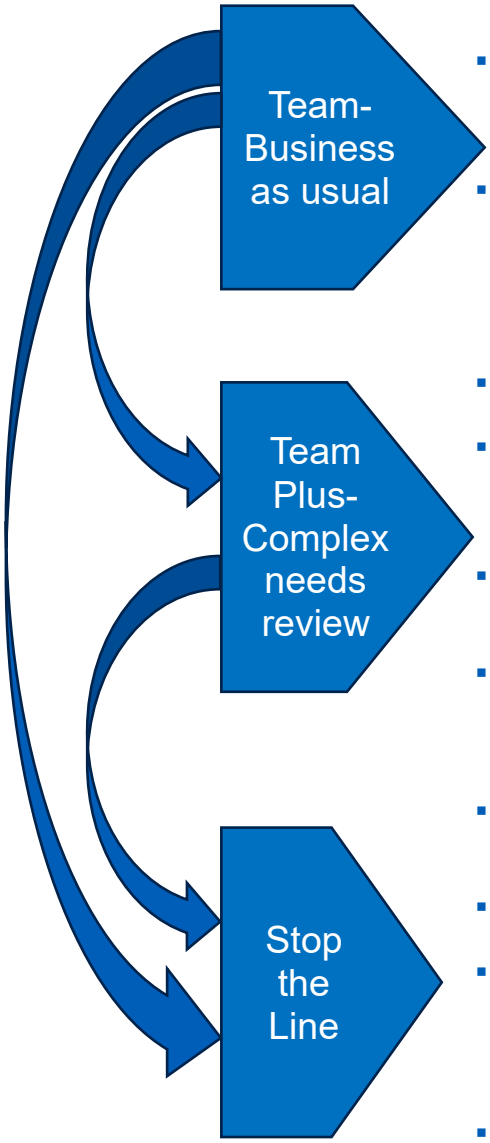
If a Stop the Line meeting is held, inform your General Manager and relevant Associate Director so this can be reported through quality governance.

It is imperative that an appropriate senior manager or director are present with the designated authority to help unblock the barriers and/or assist in reaching the required decision.

In the exceptional circumstance where there has already been one stop the line meeting and there are still difficulties reaching a decision/ outcome, to seek an independent chair to reach a decision, from another speciality or care group. The need for an independent chair would be dependent on the barriers, the purpose of the meeting and any decisions to be made.

6. Clinical escalation route

For each level, use the guidance in the preparation and facilitation table (6.1).



- This is part of usual care and treatment, utilising Multi-Disciplinary Team discussions, to support collaborative decision making with service users and carers.
- The main forums for this are; MDT meetings, huddles, report outs, assessment, care planning, formulation, reflective practice, supervision, advocacy involvement.

- This is where there is a need to gain a different perspective and external support.
- This may include; senior clinical staff from other teams, subject matter experts, external organisations from the Trust, case managers or commissioners, to support decisions about care, treatment and/or discharge.
- The main forums for this are; usual escalation routed to collective clinical, professional and operational leads, seeking a second opinion or Martha's rule.
- If a suitable resolution is achieved, then return to business as usual.

- If it is unlikely that clinical issues can be resolved at a team or team plus level, a "stop the line" meeting can be used to review and make a clear decision of plan.
- This would be useful when things feel "stuck" or there are immediate risks of harm occurring.
- It is imperative that the appropriate senior clinical and/or operational staff are present, with the designated authority to facilitate the discussion, to overcome any barriers and assist in making the required decision. This is to ensure a timely decision is achieved.
- If a Stop the Line meeting is held, please inform your General Manager so this can be reported through quality governance.

Examples are given below of the type of day-to-day MDT decision making and clinical escalations where the team may involve wider professionals or services and when an urgent decision is to be made using a "Stop the Line" meeting.

Team – Business as Usual

Example 1:

A patient who is detained under the Mental Health Act has requested leave. Family have concerns about this, as do some of the Multidisciplinary Team (MDT). The team would utilise an MDT meeting to discuss collaborative decision making, alongside the Responsible Clinician and involve the patient and family.

Example 2:

A patient needs to be transitioned to another team but there are complexities and some uncertainty from the receiving team. Therefore, it is agreed to for a period of co-working, to prevent delay to patient care.

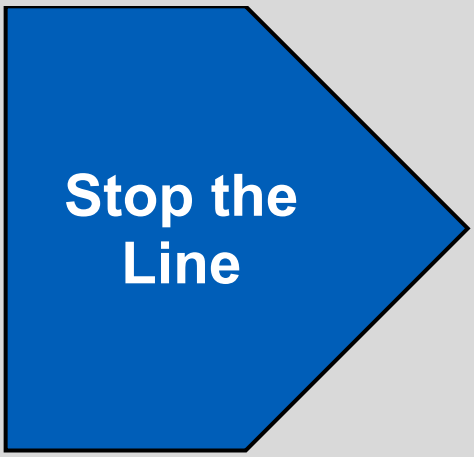
Team Plus – Complex needs review

Example 1:

There may be a dispute around Section 117 aftercare. At this point we may involve several other parties including legal support, advice from local authority and commissioners in the Integrated Care Board (ICB) to gain a different perspective and find an appropriate resolution and decision.

Example 2:

A patient has been discussed within the teams' huddles on a regular basis however, there continues to be disagreement in relation to whether to transfer care to the GP, remain on caseload or refer to an alternative service. A complex needs review would support a different perspective, objectivity from external facilitator and the patient may wish to request a second opinion.



Example 1:

Patient is clinically ready for discharge from the inpatient setting, and the environment is causing iatrogenic harm in terms of escalation in risk to self and others. There is increased anxiety within the ward team and dissatisfaction from the patient and family in relation to the care received. The community team are concerned about their safety in the community. The presence of senior staff at this meeting is to aim to unblock some of the barriers and create urgency for change and progress in the patients care.

Example 2:

A patient is in long term seclusion and there is concern about their quality of life. They're waiting to transfer to another setting. There are anxieties about the person's risk of violence towards others following staff being assaulted.

6.1 Preparation and Facilitation Table

What to consider at each point
• What are the patients and carers perspective in terms of their needs, wishes, priorities and goals? • How are the patient and carer going to be involved in collective decision making about their care, treatment and future plans? • Why now? What are the barriers, difference in opinion, anxieties or sense of 'stuckness'? • What is the purpose and desired outcome of the meeting? • Can the issues, concerns or barriers to progress be addressed at a team or service level? • What has already been considered through an MDT forum or external subject matter expert involvement?

Preparation
The Leadership team to: • Clarify the purpose and desired outcome of the meeting. • Identify level of urgency in organising the time and date for the meeting. • Identify who needs to be involved to reach an agreed plan and outcome (within, and external to the main MDT) • Identify who is best placed to be a facilitator of the meeting e.g. The Responsible Clinician, clinical or operational leader in the team or a more senior lead in the care group. The chair of the meeting would be dependent on the barriers, purpose of the meeting and decision to be made. • Preparation and collation of key relevant information to share prior to the meeting (including the patient/carer perspectives, main issues, understanding, what has been tried before and impact)

Facilitation
• Compassionate, containing, respectful and collective approach. • Introductions • Clarify purpose and desired outcome of the meeting. • Outline the expectations and structure of the meeting including time frame. • Identify a note taker. • A lead clinician/s to summarise the main issues, dilemmas, barriers to progress and the patient/carer perspective. • To invite people into the discussion in a timely manner.

- **Listen to issues around raised and felt, with opportunity to hear from everyone present.**
- **Consider options and the relative benefits and disadvantages of these.**
- **Summarise decision making in terms of next steps, roles and responsibilities for these actions and any follow up meeting.**
- **Agree how to involve, respond to feedback and work collaboratively with the patient and carers in relation to the next steps.**
- **Document attendance, main themes and agreed actions in the Electronic Patient Record**

7. Definitions

Term	Definition
Iatrogenic Harm	Harm, illness or negative outcomes caused by treatments, interventions or advice provided by healthcare staff. The term covers mistakes e.g. wrong medication dose and unintended complications e.g. an adverse drug event like diarrhoea from anti-biotics. Not all iatrogenic harm is avoidable, but preventable harm is the focus of patient safety. (Refer to examples in section 6).
Complex	Refers to needs or situations that are layered and intricate, characterised by uncertainty and unpredictability. Outcomes emerge dynamically requiring flexible, adaptive and creative approaches. There is no guaranteed 'recipe for success' to follow every time.
Team Level	Good MDT-working includes a patient-centred, innovative approach and clear goals, excellent communication, defined roles with flexibility and mutual respect. Ensuring all professionals collaborate to provide high quality, holistic care. (Refer to examples in section 6).
Team-Plus Level	Proactively engaging support and perspective external to the good MDT-working in place. Recognising that in practice, where needs the patient presents with are of a such complexity that a more diverse response is required. Relying on the system around the MDT to provide constructive clinical challenge and facilitate problem-solving. (Refer to examples in section 6).
CCSN	Complex Care Support Network – available primarily in MHSOP services.
MAPPA	Multiagency Public Protection Arrangements

MDT	Multi-Disciplinary Team
ICB	Integrated Care Board
SBARD	**S**ituation, **B**ackground, **A**ssessment, **R**ecommendation and **D**ecision. A structured communication tool used for clear, concise, & focused information transfer primarily used during handovers and for escalating concerns.
RC	Responsible Clinician
IMHA	Independent Mental Health Advocate
AMD	Associate Medical Director
ADoT	Associate Director of Therapies
ADoNQ	Associate Director of Nursing and Quality
SCD	Specialty Clinical Director
GM	General Manager
OT	Occupational Therapy / Therapists
S&LT	Speech and Language Therapy / Therapists
PBS	Positive Behaviour Support
DBT	Dialectical Behaviour Therapy
MHA	Mental Health Act
EPR	Electronic Patient Record
5 P's Formulation	A psychological framework using 5 key areas to understand a person's difficulties: Presenting Problem, Predisposing Factors, Precipitating Factors, Perpetuating Factors and Protective Factors. The 6th 'P' often added to this is 'Plan'.
CC (cc'ing)	To 'carbon copy' i.e. copy to or include someone in messages, usually via email. Sometimes referred to as 'cc'ing'.

8. How this procedure will be implemented

The Procedure will be published on our Trust intranet and external website.

Line Managers will disseminate this procedure to all trust employees through a Line Management briefing.

8.1 Implementation action plan

Activity	Expected outcome	Timescale	Responsibility	Means of verification/ measurement
A series of presentations across both Care Group boards, including the following forums: Speciality Level Governance Meetings and Strategic Quality Standards Group and the care group equivalents. Organisational Learning Group and Executive Clinical Leaders Subgroup.	Staff will understand the procedure and will be able to implement accordingly.	Within 2 months of publication.	DTVF Care Group Director of Therapies; Trust-wide Deputy Professional Head of Social Work; Head of Clinical Strategy MHSOP; Head of Clinical Strategy ALD; Head of Clinical Strategy AMH	Log of meetings, including number of attendees.
Offer bespoke sessions to those teams/services that gave feedback during the consultation period.	Staff will understand the procedure and will be able to implement accordingly. Address questions and any concerns raised.	Within 2 months of publication.	DTVF Care Group Director of Therapies; Trust-wide Deputy Professional Head of Social Work; Head of Clinical Strategy MHSOP; Head of Clinical Strategy ALD; Head of Clinical Strategy AMH	Log of meetings, including number of attendees.
Following implementation, an evaluation of the use of Stop	To analyse the effectiveness from different	Within 12 months of publication.	DTVF Care Group Director of Therapies; Trust-wide Deputy	Evaluation.

the Line meetings will be conducted.	perspectives and nature of use.		Professional Head of Social Work; Head of Clinical Strategy MHSOP; Head of Clinical Strategy ALD; Head of Clinical Strategy AMH	

8.2 Training needs analysis

No training needs have been identified in relation to this procedure.

9. How the implementation of this procedure will be monitored

Number	Auditable Standard/Key Performance Indicators	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	Evidence of timely escalation and multidisciplinary decision-making documented in patient records. Reduction in incidents of harm linked to delayed or absent escalation. Themes from complaints and patient experience feedback related to	**Frequency** = Monthly **Method** = Regular review of incident reports, complaints, and patient experience data by the Service Improvement Delivery Groups. Ongoing monitoring through routine supervision and case reviews by service managers. **Responsible** = Service Managers and Specialty Supercell's.	Findings and action plans will be reported to the relevant Directorate Governance Group. Oversight and implementation of those plans will be monitored through the Trust's Governance Framework. Any required service improvements will be tracked via the Quality and Assurance Committee.

	escalation practices.		

10. References

NG 197: Shared decision making.
CG 138: Patient experience in adult NHS services: improving the experience of care for people using adult NHS services.
NHS England Martha's Rule.
Home | Civility Saves Lives

11. Document control (external)

To be recorded on the policy register by Policy Coordinator

Required information type	Information
Date of approval	18 March 2026
Next review date	18 March 2029
This document replaces	N/A – new document
This document was approved by	Executive Clinical Leaders Sub-group
This document was approved	18 March 2026
This document was ratified by	n/a
This document was ratified	n/a
An equality analysis was completed on this policy on	18 August 2025
Document type	Public
FOI Clause (Private documents only)	n/a

Change record

Version	Date	Amendment details	Status
v1	18 Mar 2026	New document	Approved

Appendix 1 - Equality Impact Assessment Screening Form

Please note: The Equality Impact Assessment Policy and Equality Impact Assessment Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Trustwide
Title	Clinical Escalation Procedure
Type	Procedure
Geographical area covered	Trustwide
Aims and objectives	To ensure a standardised approach to clinical escalation across the Trust and foster diverse perspectives for better decision-making. Gather the right people to make timely decisions about care, assessment, treatment, transition, or discharge. Reduce health inequalities and improve outcomes based on individual priorities.
Start date of Equality Analysis Screening	15/08/25
End date of Equality Analysis Screening	18/08/25

Section 2	Impacts
Who does the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	All clinical staff working in the Trust.
Will the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups? Are there any Human Rights implications?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men and women) **NO** • **Gender reassignment** (Transgender and gender identity) **NO** • **Sexual Orientation** (Lesbian, Gay, Bisexual, Heterosexual, Pansexual and Asexual etc.) **NO** • **Age** (includes, young people, older people – people of all ages) **NO** • **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women / people who are breastfeeding, women / people accessing perinatal services, women / people on maternity leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Armed Forces** (includes serving armed forces personnel, reservists, veterans and their families) **NO** • **Human Rights Implications NO** (Human Rights - easy read)
Describe any negative impacts / Human Rights Implications	
Describe any positive impacts / Human Rights Implications	By ensuring that the multi-disciplinary team can work together effectively when caring for the people with the most complex needs, we are ensuring a personalised approach to care planning.

Section 3	Research and involvement
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	This procedure has been developed in response to feedback from our services that clearer standards are needed to guide the care of people with complex needs.
Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	No
If you answered Yes above, describe the engagement and involvement that has taken place	
If you answered No above, describe future plans that you may have to engage and involve people from different groups	We will be consulting Trustwide with our staff to ensure it meets their needs.

Section 4	Training needs
As part of this equality impact assessment have any training needs/service needs been identified?	No
Describe any training needs for Trust staff	N/A
Describe any training needs for patients	N/A
Describe any training needs for contractors or other outside agencies	N/A

Check the information you have provided and ensure additional evidence can be provided if asked.

Appendix 2 – Approval checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

Title of document being reviewed:	Yes / No / Not applicable	Comments
1. Title		
Is the title clear and unambiguous?	Y	
Is it clear whether the document is a guideline, policy, protocol or standard?	Y	
2. Rationale		
Are reasons for development of the document stated?	Y	
3. Development Process		
Are people involved in the development identified?	Y	
Has relevant expertise has been sought/used?	Y	
Is there evidence of consultation with stakeholders and users?	Y	
Have any related documents or documents that are impacted by this change been identified and updated?	Y	
4. Content		
Is the objective of the document clear?	Y	
Is the target population clear and unambiguous?	Y	
Are the intended outcomes described?	Y	
Are the statements clear and unambiguous?	Y	
5. Evidence Base		
Is the type of evidence to support the document identified explicitly?	Y	
Are key references cited?	N/A	

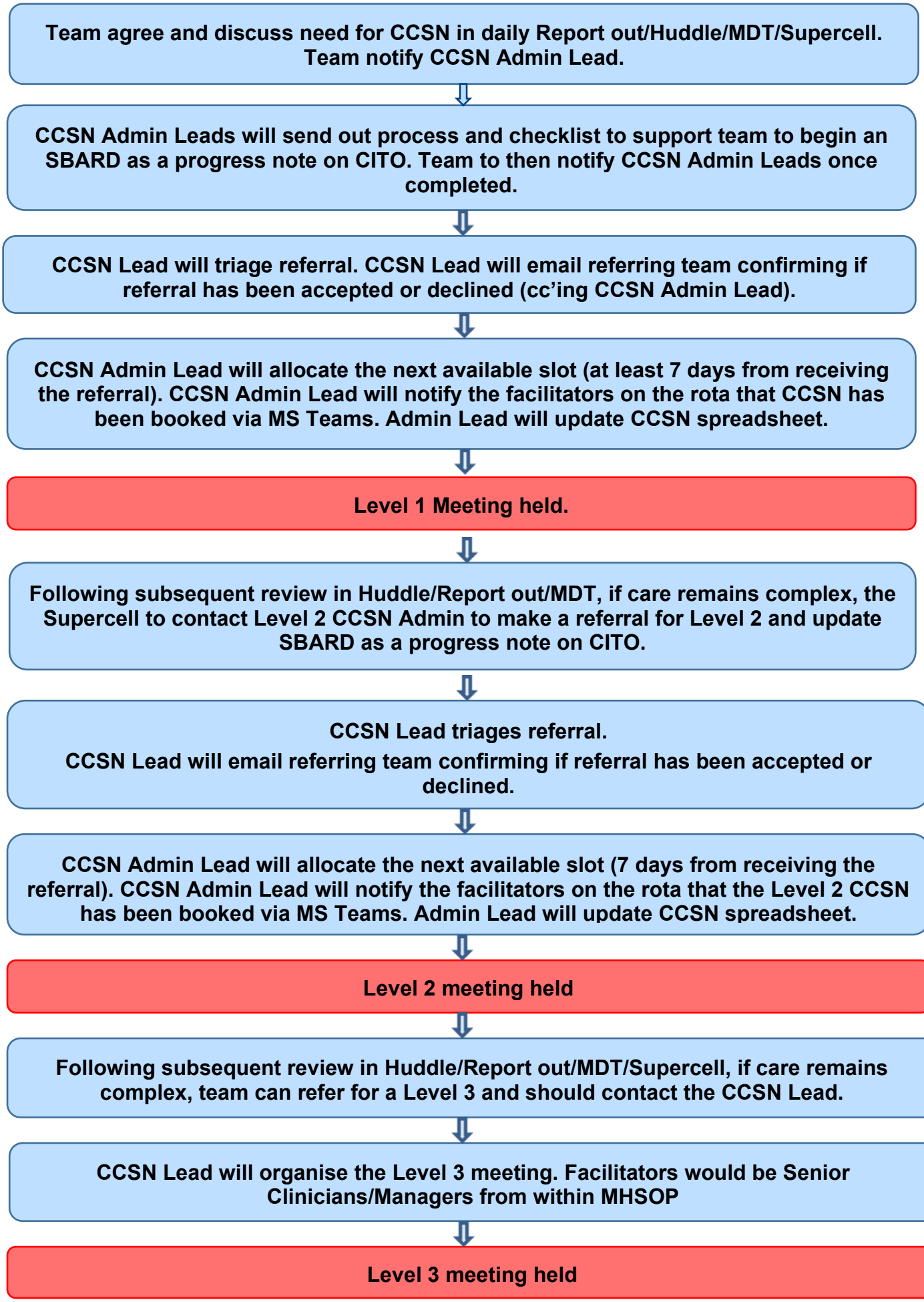
Are supporting documents referenced?	N/A	
6. Training		
Have training needs been considered?	Y	
Are training needs included in the document?	Y	
7. Implementation and monitoring		
Does the document identify how it will be implemented and monitored?	Y	
8. Equality analysis		
Has an equality analysis been completed for the document?	Y	
Have Equality and Diversity reviewed and approved the equality analysis?	Y	AH 18 August 2025
9. Approval		
Does the document identify which committee/group will approve it?	Y	
10. Publication		
Has the policy been reviewed for harm?	Y	No harm
Does the document identify whether it is private or public?	Y	Public
If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	n/a	
11. Accessibility (See intranet accessibility page for more information)		
Have you run the Microsoft Word Accessibility Checker? (Under the review tab, 'check accessibility'. You must remove all errors)	Y	
Do all pictures and tables have meaningful alternative text?	Y	
Do all hyperlinks have a meaningful description? (do not use something generic like 'click here')	Y	

Appendix 3 – MHSOP Complex Care Support Network (CCSN)

Process on a page

Please see over page.

MHSOP Complex Care Support Network (CCSN) - Process on a Page



Guidance for Referring Teams and CCSN Facilitators

Before the meeting

1. The team discuss and agree in Report out/Huddle/MDT the need for CCSN (Complex Care Support Network) input.
2. Reason for requesting a CCSN meeting: This will be clearly stated in the S & B of the SBARD (this is defined as S – why the meeting has been requested and B – brief background) that has been completed by the referring team. The team should outline, in the background section, the factors associated with complex care for the patient. Thought should be given to if the team feel stuck, split or seeking validation of existing plans.
3. Supporting materials: In addition to the SBARD (S & B), detailed information should be provided including:

    - Psychological formulation (there should have been at least 4 weeks from formulation to request of CCSN). This may include neuropsychological formulation.
    - A timeline of interventions tried and any significant events.
    - Barriers/ obstacles identified.

4. This information should be signposted in the SBARD so that it can be located within CITO. The discussions that have occurred within the team should also be captured within this document to evidence that the team have had the discussions prior to referral.
5. A member of the referring team should be nominated so the CCSN facilitators can contact for further information/ clarification if required.
6. The referring team need to ensure, wherever possible, the Consultant Psychiatrist, Psychologist and Care Co-ordinator/ Lead Professional/Nominated Nurse can attend the meeting as a minimum.
7. Invitations to the CCSN meeting should be made to all clinicians working directly with the Service User concerned. This may include Social Care colleagues if they are directly involved in the care of the Service User.
8. The CCSN facilitators should ensure they allocate time to review the SBARD and associated information on CITO.

During the meeting

1. Everyone to introduce themselves, including CCSN facilitators.
2. CCSN facilitators to outline the purpose of CCSN as a reflective exercise.
3. Team to give a brief description of the background of care and the reason for referral to CCSN.
4. It is up to the facilitators to take notes, if they wish, to aid them in developing their summary of recommendations.
5. 2 hours is the suggested length of the meeting, with 90 minutes allocated to the meeting and 20 minutes for write up and 10 minutes for feedback.
6. CCSN facilitators to consider the prompt sheet before and during the meeting.

After the meeting

1. CCSN facilitators to type up the summary of Assessment and Recommendations from the SBARD on CITO immediately following the CCSN meeting.
2. Referring team to consider the Recommendations of the CCSN facilitators and record their decision on the SBARD on CITO within 24 hours of receiving the Assessment and Recommendations of the CCSN facilitators.
3. If there are any concerns about any aspects of the process, these can be included in the evaluation form and fed back to the CCSN Lead.
4. The referring team should review the decisions and actions suggested by the CCSN facilitators. This should be reviewed after 4-6 weeks from the care discussion.

Prompt Sheet for CCSN Facilitators

Remember the aim is to facilitate a reflective space for the team and not to solve all of the problems/ difficulties.

Information to watch for and comment on/ integrate into plan

- Re-enactment of hierarchy amongst the team that is getting in the way of effective information sharing/ collaborative care planning/ making sure everyone feels safe with the team plan and their role.
- What are the emotional reactions of the team?
- How is that affecting how they're working together/ are they aware of this?
- How did they get to this point i.e. who decided to ask for help/ was this universally welcome?
- Why are they stuck with this particular patient/ what were they expecting they'd be able to achieve?
- What are they frightened of? Irritated about etc?
- Is there a narrow/ single story or explanation of (and therefore response to) the problem e.g. medical interpretation with prescription as sole solution. Or is the team tolerant of and generating competing hypotheses to challenge themselves?
- Are there different opinions in the team about what to do next – how are they handling this?
- What is not being said about the patient/ team – blind spots?
- Are processes being followed and documented?
- Have they done all the proper case management/ paperwork/ policy stuff?
- Have they thought about other services/ agencies?
- As a team have they had other bad experiences with patients that remind them of this person and is that affecting what they are / not doing?

Referring for CCSN input - Checklist for referring teams

Please ensure the following is included, or signposted to, within the Background section of your 'SBARD' progress note on CITO when referring for CCSN input:

- ☑ Psychological formulation (or 5/6Ps formulation where the team has no access to psychology)
- ☑ Neuro-psychological assessment/formulation (where appropriate)
- ☑ Any other formulations carried out with the service user (e.g. 5Ps, Newcastle Behaviours that Challenge formulation etc.)
- ☑ Timeline of key bio/psycho/social interventions (including medications) that have been attempted, their impact and also any significant events (e.g. illness, losses, family changes)
- ☑ Summary of challenges, barriers, and / or enablers, the team has encountered in engaging with the service user and delivering specific interventions
- ☑ Outline of any other factors that might be contributing to the complexity of care around the service user, as appropriate (e.g. physical health, living circumstances)
- ☑ Outline of how the team is current feeling about the overall care they are providing and its impact for the service user, e.g. what is making the team feel 'stuck'?

Appendix 4 Complex Case Panels - Ridgeway

Background:

Due to the nature of its client group, it is recognised that occasions will arise that pose complex or urgent clinical questions that cannot be addressed through the MDT alone. The service recognises that under such circumstances it may be necessary to draw upon wider expertise in order to:

- Gain new insights regarding diagnosis, formulation, treatment and/or management.
- To understand and agree a consensus position.
- To identify and manage any risks, whether to the individual, staff or the organisation.
- To identify how best to support the team e.g. emotional, practical, professional.

Arranging a complex case panel:

Initial representation should be to the relevant clinical director and/or head or service. If the need for a complex case panel is agreed, the following should be arranged:

- An agreed invite list, considering:
  - o Immediate clinical team: Responsible Clinician (RC), ward manager, named nurse, psychologist, modern matron, Independent Mental Health Advocate (IMHA) etc.
  - o Senior team; Associate Medical Director (AMD), Associate Director of Therapies (ADoT), Associate Director of Nursing and Quality (ADoNQ), Specialty Clinical Director (SCD), General Manager (GM).
  - o Relevant others, e.g. physical health practitioners, Occupational Therapists (OT), Speech and Language Therapists (S&LT), Dieticians, Positive Behaviour Support (PBS) practitioners, Dialectical Behaviour Therapy (DBT) practitioners, security leads, Positive Approaches Trainers, Mental Health Act (MHA) leads
  - o Independent others, e.g. psychiatrists, psychologists, modern matrons
- A suitable time and venue, giving as much notice as reasonably possible and ensuring adequate time is set aside to reasonably cover the issues
- An agenda which clearly articulates the clinical dilemma and question(s) being posed.
- Any relevant background information, distributed to the participants before the meeting e.g. previous reports, current care plans.

During the meeting:

- The meeting will be chaired (usually by the AMD or GM).
- Normal rules of confidentiality will apply.
- Healthy challenge and debate will be encouraged, always adhering to the Trust's Values and Behaviours.
- Contemporaneous minutes will be taken that capture the broad areas discussed and detail all decisions, all actions (including who is responsible and by when) and any unresolved issues.

Post meeting:

- Minutes of the meeting to be placed on the patient's electronic patient record (EPR), clearly identifying if any third-party information is enclosed.

- If appropriate, the outcome of the meeting is to be shared with the patient and that discussion will be documented on the EPR.
- If a duty of candour arises, this should be clearly documented and assurance given to the Associate Medical Director when it has been completed.
- Arrange to be discussed at relevant Improvement Delivery Group, particularly identifying any lessons learned or if an escalation of any issue is required.