CAMHS Eating Disorders Team Operational Policy

Child and Adolescent Mental Health Services (CAMHS)

Version:	**V2.1**
Executive Lead:	**Exec Director Quality and Safety**
Lead Author:	**CAMHS Community Manager**
Approved Date:	**5th March 2015**
Approved By:	**East and North SBU Quality and Risk Committee**
Ratified Date:	**24th March 2015**
Ratified By:	**Policy Panel**
Issue Date:	**20th April 2015**
Review Date:	**20th April 2018**

Target Audience:
This Policy must be understood by:

- Advanced Eating Disorder Practitioners
- CAMHS practitioners and clinicians
- CAMHS Crisis Assessment & Treatment Team (C-CATT)
- Single Point of Access Service staff
- All CAMHS staff working with service users with eating disorders
- Staff team and users of CAMHS services

Preface - concerning the Trust Policy Management System (PMS)

P1 - Version Control History:
Below notes the current and previous Version details-

Version	Date of Issue	Author	Status	Comment
V1	February 2011	CAMHS Manager	Superseded	**New Policy**
V2	20th April 2015	CAMHS Community Manager	Superseded	**Full Review**
V2.1	September 2015	CAMHS Community Manager	Current	**Updated for Care Act 2014**

P2 - Relevant Standards:

a) NICE Guidelines – evidence based practice for Eating Disorders 2013

b) Equality and RESPECT: The Trust operates a policy of fairness and RESPECT in relation to the treatment and care of service users and carers; and support for staff.

.

P3 - The 2012 Policy Management System and the Policy Format:
The PMS requires all Policy documents to follow the relevant Template in

- **Policy Template** is the essential format for most Policies. It contains all that staff need to know to carry out their duties in the area covered by the Policy.
- **Operational Policies Template** provides the format to describe our services ,how they work and who can access them
- **Care Pathways Template** is at the moment in draft and only for the use of the Pathways Team as they are adapting the design on a working basis.
- **Guidance Template** is a sub-section of the Policy to guide Staff and provide specific details of a particular area. An over-arching Policy can contain several Guidance's which will need to go back to the Approval Group annually

Symbols used in Policies:

RULE **=internally agreed, that this is a rule & must be done the way described**

STANDARD **= a national standard which we must comply with, so must be followed**

Managers must bring all relevant policies to the attention of their staff, where possible, viewing and discussing the contents so that the team is aware of what they need to do.

Individual staff/students/learners are responsible for implementing the requirements appropriate to their role, through reading the Policy and demonstrating to their manager that they understand the key points.

All Trust Policies will change to these formats as Policies are reviewed every 3 years, or when national Policy or legislation or other change prompts a review.
All expired & superseded documents are retained & archived and are accessible through the Compliance and Risk Facilitator Policies@hpft.nhs.uk
All current Policies can be found on the Trust Policy Website via the Green Button or http://trustspace/InformationCentre/TrustPolicies/default.aspx

Contents Page

PART 1 – Preliminary Issues:

1. Introduction

1.1 Child and Adolescent Mental Health Services (CAMHS) describe the broad range of services, which support the emotional wellbeing, and mental health of children and young people.

In the last 10 years a raft of policy heralding the way for the development of a comprehensive Child and Adolescent Mental Health Service (CAMHS) has emerged.

Key strategic direction has been found in:-

- Change for Children – Every Child Matters, Department for Children, Schools and Families (DCSF), 2004;
- The National Service Framework for Children, Young Peoples and Maternity Services, Department of Health, 2004;
- The Children's Plan-Building Brighter Futures, DCSF, 2007;
- Children and Young People in Mind: the final report of the National CAMHS Review, DCSF, 2008
- Care Act 2014
- Children and Families Act 2014
- Model specification for Children and Adolescent Mental Health Services (CAMHS) http://www.england.nhs.uk/resources/resources-for-cggs/

The Care Act requires that the wellbeing of each young person or carer must be taken into account so that assessment and planning is based around individual needs, wishes and outcomes. Early conversations provide an opportunity for young people and their families to reflect on their strengths, needs and desired outcomes and to plan ahead for how they will achieve their goals.

The purpose of carrying out a transition assessment is to provide young people and their families with information so they know what to expect in the future and they can prepare for adulthood. Transition assessments can be of benefit in providing solutions that do not necessarily involve the provision of services and which may aid planning that helps to prevent and reduce or delay the development of needs for care and support.

Professionals from different agencies, families, friends and wider community should work together in a coordinated manner around each young person to help them achieve their desired outcomes.

The duty to conduct a transition assessment applies when a young person is likely to have needs for care and support under the Care Act. A transition assessment must be conducted for all those who have likely needs. However, the timing of this assessment would depend on when it is of significant benefit to the young person. The provisions in the Care Act relating to transition to adult care and support are not only for those who are already receiving CAMHS services and/or Children's Social Care, but for anyone who is 'likely to have needs' for adult care and support after turning 18. 'Likely to have needs' means they have any likely appearance of need for

care and support as an adult, not just those needs that will be deemed eligible under the Care Act

In addition the Hertfordshire Emotional Wellbeing and Mental Health Strategy (2009/12 sets out the vision to ensure that a broad range of services are available to support children and young people. The strategy has 4 main strategic objectives:

PROMOTION AND PREVENTION: Promote emotional wellbeing and positive mental health through effective engagement of the wider community; to raise awareness; tackle stigma; advocate early help seeking; and involve children, young people and their families and carers in the development and review of services.

EARLY IDENTIFICATION AND INTERVENTION: Work in partnership to deliver a range of integrated, preventative, and early intervening services that are flexible and accessible in supporting and meeting the needs of all children and young people.

TARGETED PROVISION: Take a coordinated approach to the delivery of targeted provision for children and young people from vulnerable groups.

SPECIALIST SERVICES: Work better together to ensure that children and young people with complex mental health needs have timely access to the level of support and expertise they need.

"The CAMHS vision and values are based on the following clinical principles (in line with the principles underpinning CYP-IAPT and CAPA":

- **Evidence based** – interventions are informed by the best research evidence
- **Goal focused** – interventions focus on the goals and wishes of the service user/family
- **Feedback informed** – session-by-session feedback on clinical progress and therapeutic alliance, facilitates better working relationships and outcomes
- **Outcomes focused** – use of routine outcomes monitoring informs service development and clinical practice
- **Service user led** – authentic participation guides service development to meet local populations needs

1.2 The **Eating Disorder Service** is designed to address the needs of young people and their families who present to CAMHS with restricted eating/ eating disorders. The term

"Eating Disorder" refers to a number of different conditions having in common a disturbance either in attitude towards or relationship with food, weight and/or shape. There are a number of different classifications for eating disorders; these classifications are:-

- Anorexia nervosa
- Bulimia nervosa
- Binge eating disorder
- Other Specified Feeding and Eating Disorders – covering a group of conditions which do not fulfil the diagnostic criteria for those above.

These present with a diverse range of symptoms varying in severity as well as impact on the individual's physical, psychological, social and educational functioning.

1.3 DSM GUIDANCE

The chapter on Feeding and Eating Disorders in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) includes several changes to better represent the symptoms and behaviours of patients dealing with these conditions across the lifespan. Among the most substantial changes are recognition of binge eating disorder, revisions to the diagnostic criteria for anorexia nervosa and bulimia nervosa, and inclusion of pica, rumination and avoidant/restrictive food intake disorder. DSM-IV listed the latter three among Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence, a chapter that will not exist in DSM-5.

In recent years, clinicians and researchers have realised that a significant number of individuals with eating disorders did not fit into the DSM-IV categories of anorexia nervosa and bulimia nervosa. By default, many received a diagnosis of "eating disorder not otherwise specified". Studies have suggested that a significant portion of individuals in that "not otherwise specified" category may actually have binge eating disorder.

1.3.1 Binge Eating Disorder

Binge eating disorder was approved for inclusion in DSM-5 as its own category of eating disorder. In DSM-IV, binge-eating disorder was not recognized but rather described in Appendix B: Criteria Sets and Axes Provided for Further Study and was diagnosable using only the catch-all category of "eating disorder not otherwise specified".

Binge eating disorder is defined as recurring episodes of eating significantly more food in a short period of time than most people would eat under similar circumstances, with episodes marked by feelings of lack of control. Someone with binge eating disorder may eat too quickly, even when he or she is not hungry. The person may have feelings of guilt, embarrassment, or disgust and may being eat alone to hide the behaviour. This disorder is associated with marked distress and occurs, on average, at least once a week over three months.

This change is intended to increase awareness of the substantial differences between binge eating disorder and the common phenomenon of overeating. While overeating is a challenge for many Americans, recurrent binge eating is much less common, far more severe, and is associated with significant physical and psychological problems.

1.3.2. Anorexia Nervosa

Anorexia nervosa, which primarily affects adolescent girls and young women, is characterised by distorted body image and excessive dieting that leads to severe weight loss with a pathological fear of becoming fat. The criteria have several minor but important changes:

- Criterion A focuses on behaviours, like restricting calorie intake, and no longer includes the word "refusal" in terms of weight maintenance since that implies intention on the part of the patient and can be difficult to assess. The DSM-IV Criterion D requiring amenorrhea, or the absence of at least three menstrual cycles, will be deleted. This criterion cannot be applied to males, pre-menarchal females, females taking oral contraceptives and post-menopausal females. In some cases, individuals exhibit all other symptoms and signs of anorexia nervosa but still report some menstrual activity.

1.3.3. Bulimia Nervosa

Bulimia nervosa is characterised by frequent episodes of binge eating followed by inappropriate behaviours such as self-induced vomiting to avoid weight gain. DSM-5 criteria reduce the frequency of binge eating and compensatory behaviours that people with bulimia nervosa must exhibit, to once a week from twice weekly as specified in DSM-IV.

1.3.4 Overall Changes

The Eating Disorders Work Group intended for DSM-5 changes to minimise use of the catch-all diagnoses of Other Specified Feeding and Eating Disorder and Unspecified Feeding and Eating Disorder. A primary goal is for more people experiencing eating disorders to have a diagnosis that accurately describes their symptoms and behaviours. Determining an accurate diagnosis is a first step for clinicians and patients in defining a treatment plan.

1.4 Principles

The Eating Disorder Service is underpinned by the following values:-

- A “right first time” service with early intervention at the point of presentation/need
- Evidence-based interventions which are specific, measurable, appropriate, realistic and time-monitored
- An assessment of physical and mental health needs alongside each other by practitioner/s with the relevant skill sets who liaise closely to share progress
- Collaborative working – to ensure effective early engagement with Children & Young People services and the family to support better outcomes.

The policy has adopted the Junior Marsipan document (CR187) to provide a structure to assess children and young people with eating disorders. This allocates a RAG rating of risk in relation to the child/young person’s physical health.

The policy does not include the transition process to be followed from CAMHS Eating Disorder to Adult Eating Disorder services. These are covered in the CAMHS/Adult Services Transition Policy.

2. Purpose of the Eating Disorder Service

The Eating Disorder Service is designed to meet the needs of children and young people up to their 18th birthday where the child/young person has presented to service with -

- weight issues which are the primary reason for referral is Anorexia Nervosa;
- where the child/young person has been assessed by a relevant CAMHS professional and/or an advanced eating disorder practitioner;
- where the assessment, using the Junior Marsipan rating, has placed the child/young person at Red or Amber Risk on the eating disorder pathway; or Green and Blue Risk if the young person is deteriorating during treatment with the CAMHS team

The service is designed to meet both the physical and mental health needs of the child/young person.

The service includes both community and in-patient responses and resources which may be required depending upon the individual's physical/mental health needs.

Specialist CAMHS is designed to meet the needs of children and young people up to their 18th birthday where the child/young person has presented to the service with –

- Bulimia
- Binge Eating Disorder
- OSFED
- Weight issues where the primary reason for referral are mental health problems which are not classified as eating disorders.

3. Aims of the Service

The service endeavours:-

- To be accessible to all members of the population, including black & minority ethnic communities;
- To offer early intervention and prevention strategies whenever possible;
- To deliver evidence-based working practices and interventions in the effective assessment, formulation, treatment and management of children and young people suffering from an eating disorder;
- To facilitate partnership working between the Eating Disorder services, the young person and their families/carers which enables the child/young person to make choices which improve their health and quality of life;
- To increase stability and prevent deterioration in the child/young person's physical & mental health;
- To reduce and manage risks
- To assist in developing coping strategies
- To support families and carers
- To instil hope and optimism
- To reduce stigma

4. Inclusion Criteria

The Eating Disorder service has been developed to accept referrals for children and young people up to their 18th birthday:-

- where the child/young person is experiencing significant disturbance either in attitude towards or relationship with food, weight and/or shape;
- where anorexia is the primary reason for referral;
- where, except in exceptional circumstances, the child/young person has been assessed by a relevant CAMHS professional and/or an advanced eating disorder practitioner;
- where the assessment, using the Junior Marsipan rating, has placed the child/young person at Red and Amber Risk on the eating disorder

pathway; or Green and Blue Risk if the young person is deteriorating during treatment with the CAMHS team
- where an appropriate community (universal or targeted) intervention has not resolved the current difficulties
- where the child/young person or his/her family consent to the referral

5. Exclusion Criteria

The service is not designed to meet the needs of those with:-

- Bulimia and eating disorders not diagnosed as Anorexia Nervosa
- Children and Young People who have lost weight as a consequence of mental health issues which are not diagnosed as an eating disorder, i.e. anxiety or depression.

CAMHS Eating Disorders Referral Pathway

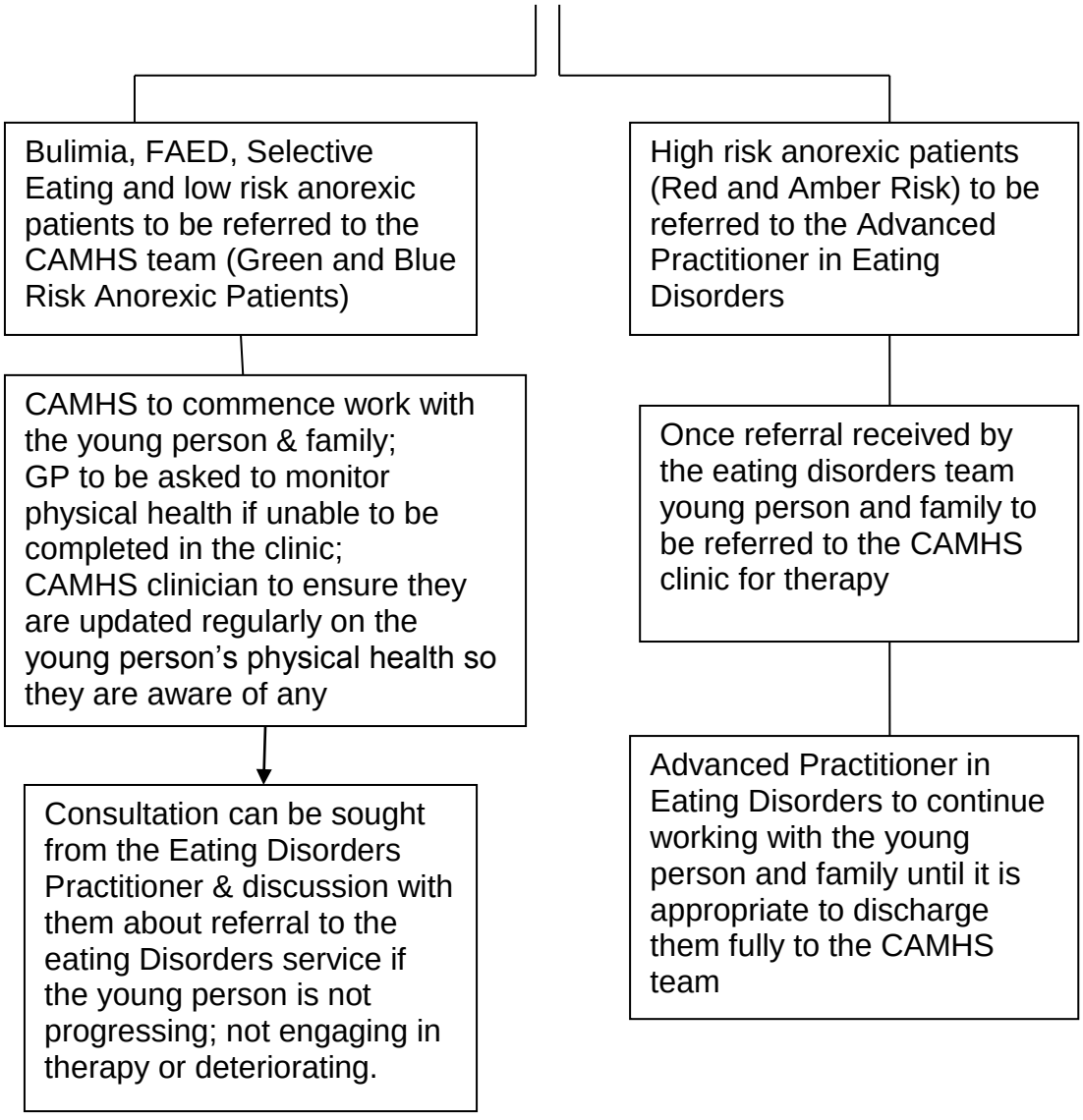
Referral received by SPA who initially screen the referral for all the necessary physical information, fax the GP to request the information if missing and phone the family asking them to make an urgent GP appointment (for weight, height, BP and Pulse to be measured).

↓

SPA to assess the patients risk level using the Junior Marsipan risk summary as a guide (please use the weight for height excel document to calculate % weight for height – last column on the form is % weight for height).

↓

SPA may contact the Advanced Practitioners in Eating Disorders for advice via email, however if a patient is clearly green or blue risk please forward straight to CAMHS (if a young person appears green or blue risk but has lost significant amounts of weight quickly please contact the Advanced Practitioner in Eating Disorders as they may be higher risk than they appear)



6. Detailed Operational Policy

6.1 Team Location & Opening Hours

The Advanced Practitioners in Eating Disorders are based at:

15 Forest Lane
Kingsley Green
Harper Lane
Radlett
WD79HQ
Tel: 01923 633402

However, treatment with the Advanced Practitioners will either be at the above location or another appropriate setting whenever possible i.e. young peoples' home address, CAMHS clinic, school etc.

Eating Disorder Services working hours are between 9.00am – 5.0pm Monday to Friday. When the office is closed team bases have an answer phone message.

6.2 Staffing

The Eating Disorder Service consists of 4 wte senior clinicians.

6.3 Referrals into Service

All referrals into the CAMHS Eating Disorder service are received via the Single Point of Access, C-CATT, CAMHS and Paediatric wards.

The Single Point of Access clinician will assess the initial referral, using the agreed CAMHS initial assessment format/protocol to determine the appropriate route into CAMHS service.

All referrals will be processed as either "routine" as per Junior Marsipan Risk Table or as "urgent". The SPA Clinician will complete the initial triage utilising the relevant CAMHS process guides, triage tools / risk Assessment. This will involve telephone contact with the referrer, the child/young person, their parent/carer & GP.

In particular, the SPA Clinician will gather, in a timely manner, the relevant information necessary to inform the next step.

These will/may include:-

>Record of current/previous weight
>Record of current/previous height
>Weight for Height Percentage
>Blood pressure, pulse & temperature
>Results of blood tests (FBC, ESR, LFT, U & E, CR, CK, RG)
>ECG
>Record of menstrual cycle (f)

➢ 6.4 Referral Screening

Where the referral indicates an eating disorder in the presentation, the Junior Marsipan rating will be used for the initial screening within the CAMHS service to determine the route into/through the eating disorder pathway.

The Junior Marsipan Risk rating table is included in Appendix 1.

The RAG rating allocated by the Junior Marsipan Risk assessment determines the timescale within which an assessment should be completed as follows:

> **>Red** –Assessment by Advanced Eating Disorder Practitioner (AEDP) within 2 working days
> **>Amber** – Assessment by Advanced Eating Disorder Practitioner (AEDP) within 5 working days of referral
> **>Green/Blue** – P1 – seen by CAMHS clinician in P1 rota – 28 day choice appointment or multi-disciplinary team assessment

The RAG rating above determines the steps to be taken following referral. These are detailed in the tables in Appendices 2, 3 and 4 respectively.

➢ 6.5 Assessment & Formulation

The goals of all the assessments are to evaluate the child/young person's needs & strengths in the following areas:-

- Current physical health functioning and weight restoration needs
- Support in the family (as the main indicator for change in the CYP)
- An exploration of underlying mental health issues and the symptoms in the CYP
- Identification of healthy behaviours to be promoted

The assessment should include gathering further/information on the history of the presenting difficulties, together with questions on the following issues:-

- Information on food and fluid intake to identify whether the young person is at risk of re-feeding syndrome, guidance on re-feeding from the Junior Marsipan to be used to reduce this risk and liaison with the GP regarding bloods as appropriate.
- Potential co-morbidities
- Social, educational, family context
- Relationships with family, friends and peers
- Past or current mental health difficulties for parent/s or carer/s – e.g. mood disorders or eating disorders.
- Safeguarding issues

Generally the child/young person referred should be seen initially with his/her parent/s or carer/s. However as is always the case, it may be appropriate to offer an individual appointment at the request of the child/young person. In such cases, the assessing clinician/s should give consideration as to whether they meet the national Fraser guidelines.

In line with NICE guidelines, it is recommended that children/young people with anorexia nervosa should be offered individual appointments with a health care professional separate from those with his/her family members or carers.

The child/young person should be given an opportunity to discuss the following in private:-

- Any alcohol or drug use
- Any bullying
- Abuse of any kind
- Self-harm
- Suicidal ideas

Consideration may be given to using screening tools to support or refine assessments and formulations. These may include:-

- RCADS – Revised Children's Anxiety and Depression Scale
- Eating Disorder Examination Questionnaire – EDE- A
- Clinical Impairment Assessment – CIA
- Accommodating and Enabling Scale in Eating Disorders - AESEDS

The information from the assessment can then provide a working formulation to inform

- The individual's risk rating going forward (low, medium, high);
- whether the symptoms are better understood as being primarily related to another mental health disorder e.g. secondary to depression or physical illness;
- an offer of intervention and support for the CYP, his/her family or carers; this will bring together the evidence-base for intervention/treatment with the stated goals and wishes of the CYP and his/her family);
- an individualised plan of care, including advice on nutrition and a plan for the management of the child/young person's physical health and risk by the identified qualified practitioner; this may be the AEDP or the GP
- allocation to the appropriate CAMHS practitioner or AEDP

All assessments should consider whether an in-patient admission is required and where it is, take all necessary actions to arrange this in accordance with referral to High Risk Pathway via the CAMHS Team Consultant Psychiatrist via either Eating Disorder Team or C-Catt.

Co-morbidity forms part of the initial assessment and the working formulation. Where co-morbidity is judged likely to influence the progress on an evidence-based intervention, this will be monitored closely and recommendations made for different and/or additional interventions, as appropriate.

➢ 6.6 Community Treatment Plan

Where a young person and his/her family is receiving care from either the AED service or the CAMHS clinic or both, s/he should have in place a Community Care/Treatment plan. The elements within such a plan will depend upon the individual's need and may include all or some of the following:-

- Weight monitoring (aim for restoration of 0.5kgs a week)
- Re-feeding & meal planning as appropriate
- Physical monitoring including request additional test/monitoring from GP where appropriate
- Support family involvement unless assessed as inappropriate; this includes supervision, support strategies, boundaries, expectations & psycho-education
- Psycho-education on medical and psychological implications of illness
- Motivational Enhancement Therapy, CBT techniques or Solution-focussed work as appropriate by assessment and treatment
- Body Image Work
- Support to develop appropriate coping strategies
- Problem Solving.

In addition, the community plan may also include other **Evidence based Interventions**

The evidence based interventions will be informed by the working formulation and the child/young person and his/her family/carer's view and identified goals.

The options for intervention may include:-

- Weight restoration as a primary goal
- Family Intervention, supporting the child/young person, parents and carers as agents of change
- One-one Psychological therapy which may also address any issues of co-morbidity

Family interventions may be offered unless there is a clear rationale for one-one only work; this will have been identified during the assessment phase. These may include:-

- Core Intervention with family therapist (6-8 sessions weekly; review) OR
- Family Therapist and AEDP joint intervention using Maudsley model OR Family Therapy (with team) goals identified relevant to this model of working in eating disorders

- Core Partnership any modality (NOT if weight restoration is primary need) – 6 sessions & then review with psycho-education and mental health symptom tracking
- CBT (some evidence for use with Anorexia; good evidence for use with Bulimia)
- Motivational enhancement therapy (good idea for CYP along with family work)
- Cognitive remediation therapy

- Cognitive Analytical Therapy
- Interpersonal Psychotherapy
- Focal Psychodynamic Therapy

The Family Therapy and Psychological one-one interventions will be offered following referral to the local CAMHS clinic by the AED Practitioners and service as appropriate and in line with the referral processes, detailed in Appendices 2-4 below. Where the Advanced Eating Disorder Practitioner/service and the CAMHS clinician/service are both involved in providing care to a young person and their

family, it is the responsibility of the AEDP and CAMHS clinician to ensure that s/he has a clear and shared understanding of their individual roles as well as to ensure a robust plan is in place to provide regular and effective liaison and information sharing.

➢ 6.7 Medical Management & Physical health monitoring by qualified professionals

The specific risk level of the pathway may determine who has the responsibility to undertake the regular physical monitoring of the young person. This may be the role for the AEDP, a CAMHS practitioner, the young person's GP or parents.

In all cases, it is essential to implement a robust plan to ensure effective monitoring, of the weight restoration; re-feeding; the interpretation of results from the GP checks and pursuit of additional necessary medical tests and their results.

These may all be required to ensure the child/young person's physical health needs are met. These must also be recorded on PARIS and shared with other relevant professionals, the child/young person and his/her parents/carers.

➢ 6.8 Care Coordination

All children & young people with an eating disorder will be on CPA, with the Care Coordination role being allocated to an appropriate professional practitioner/clinician within the Specialist CAMHS service. This applies to all children & young people, including those who are under the care of the Eating Disorder Service.

The CPA is particularly important for those children/young people who:-

- Are admitted to or discharged from in-patient unit
- Are in transition to adult mental health services
- Are at significant risk of danger to life and/or health
- Have extreme challenging behaviour to a point that is likely to require out-of-hours assistance

➢ 6.9 In-patient Admission

Admission to hospital for service users with eating disorders only occurs when the clinical picture indicates extremely high risk if the person remains at home.

Admission will be to either Forest House or a Specialist Eating Disorders unit as decided by the Advanced Practitioners in Eating Disorders in discussion with the Specialist CAMHS service.

In the event that an in-patient admission is required for a young person with an Eating Disorder, a 'NHS England CAMHS Tier 4 referral for access to treatment' form must be completed by the Care Co-Ordinator (either a Specialist CAMHS clinician or an advanced practitioner in eating disorders). This will be sent to the NSH England and if the advanced practitioner is not involved a copy should be sent to them too. If the advanced practitioner in eating disorders is not involved prior to referral (which should not be the case as a referral should have been made before admission is required)

then the Specialist CAMHS clinician should liaise with them regarding the most appropriate resource.

The Advanced Practitioners will be informed of the funding decision and will inform the Specialist CAMHS to proceed with the in-patient referral or will initiate the in-patient referral themselves.

Children and young people who are involved with the Advanced Practitioner in Eating Disorders prior to admission to Forest House and The Phoenix Centre will continue to receive support from the Advanced Practitioners along with the Specialist CAMHS staff who will be invited to CPA review meetings

Rhodes Farm provides an aftercare package for three months only for young people who have been admitted. APED will remain involved post discharge and will liaise with Rhodes Farm on roles and responsibilities during the period of the aftercare package.

Children and young people may need to be admitted and stabilised on a medical ward or A&E prior to a Specialist bed becoming available or funding being agreed.

Support during a hospital admission is particularly important for those suffering with eating disorders and the Care Co-ordinator will ensure regular contact occurs.

The Care Co-ordinator will ensure the multi-disciplinary team are advised of any issues that may affect progress towards discharge from hospital. In particular any housing, welfare benefits or family relationship will be identified, discussed with the children and young people and the care team and addressed within the care plan

Prior to the planned discharge date, a CPA Review Meeting should be convened and relevant carers invited. The CPA care-plan and risk assessment will be reviewed. Indicators of relapse will be identified and recorded on the care-plan. A contingency plan will be agreed. A date for the next CPA review meeting will be set. The Service user, relevant carers and the GP will be sent a copy of the documentation of these plans

In-patients discharged to the care of Specialist CAMHS, or when a recent account of non-fatal deliberate self-harm is recorded, will be given a date, time and place for a follow-up community appointment within 7 days of discharge. This will be in accordance with the HPFT Policy “Follow up after discharge from Mental Health In-patient Units”

When any unplanned discharge from hospital happens, a pre-discharge CPA review will not have occurred. The Care Co-ordinator (Specialist CAMHS) must arrange an early CPA review and contact within 7 days after the discharge.

- **6.10 Phase & Expected Journey Time**

All children/young people receiving such eating disorder services will be monitored closely for progress in relation to both their physical & mental health. Interventions will be subject to regular review every 3 months in line with partnership throughput strategy in order to:-

- Assess progress
- Manage changes in need
- Facilitate reformulation and required change to interventions
- Facilitate coherent intervention strategy & throughput across service

The exact journey times will be determined by the individual, diagnosis, intervention plan and progress.
However it is acknowledged that a longer plan of care and treatment may be required in some circumstances. In such cases,

- the needs of the individual child/young person will be reviewed at each CPA meeting where the care plan with identified goals and timescales will be approved by the senior CAMHS clinician/practitioner;
- there will be close liaison and discussion with the primary care team, the Specialist CAMHS and the child/young person, their parent/s/carer/s to determine who will hold primary responsibility for monitoring progress.

6.11 Pathway End Phase and Transition or Discharge

6.11.1 Transition to Adult Services

When the young person is receiving treatment for an eating disorder and is approaching 18 years, a decision will be made as to whether s/he should be transferred to adult services. If so, the Care Coordinator will make an internal referral to the Adult Community Eating Disorder Service. This should be a minimum of 6 months before the young person's 18th birthday.

The Care Coordinator together with a practitioner/clinician form the adult services, should develop a transition plan in partnership with the young person & their parent/carer, (the latter with the young person's permission/consent).

The Care Coordinator will communicate effectively with all concerned and implement the care plan jointly with the adult services practitioner/clinician. The Care Coordinator will ensure and provide continuity of care across the transition into adult services.

It should also be recognized that not all young people in the care of CAMHS will transfer to adult mental health services. All young people should have a written and agreed plan, if no further interventions or treatment are planned, so that the young person and, where appropriate, parents/carers know what to do if they become unwell.

Consideration of 'significant benefit' is related to the timing of the transition assessment. Factors in establishing the right time to assess can include the following:

- Current mental state including any planned medical treatment
- Stage of education and any upcoming exams
- Aspirations around further education and training or employment
- Needs relating to accommodation
- Whether the young person will have care leaver status
- The time it may take to carry out an assessment
- The time it might take to put in place the adult care and support plan
- Any relevant family circumstances

This process should commence at least 6 months before transition.

For children with Special Educational Needs with an Education Health and Care Plan (EHC plan), under the Children and Families Act, preparation for adulthood must begin from year 9 and should be undertaken as a combined assessment where possible and appropriate.

Local arrangements should be put in place across Adult Mental Health services and CAMHS to facilitate good communication and case discussion so that transfer arrangements are clear and work well.

In considering transfer of care, the needs of the carer should also be considered and a carer's assessment offered if appropriate.

- **6.11.2 Discharge from Services**

At the point where the child/young person has progressed such that discharge should be considered, this will be discussed and agreed within a Care Programme Approach Review.

Where the young person is to be discharged from an in-patient admission, the procedure is described in Section 6.8 above.

- **6.11.3 Aftercare Plan**

Prior to any discharge from APED or Specialist CAMHS, an aftercare plan will be agreed with the child/young person and their parent/s/carer/s. This should include a contingency plan, identifying:-

a) relapse prevention plan including:
b) risk factors,
c) triggers,
d) warning signs and
e) actions to be taken in the event of any difficulties occurring after discharge back to the primary care/GP.

- **6.12 DNA**

6.12.1 No Treatment – in cases where the children or young person declines treatment. Specialist CAMHS and/or the Advanced Practitioners in Eating Disorders will make clear the consequences of this and encourage monitoring of physical health by the Primary Care Team and adopt an open door policy in order that service users can be re-referred at any time.

6.12.2 Where the question of discharge has arisen through the child/young person's inability to engage with the services and/or interventions offered, the situation should be discussed at a multi-disciplinary team meeting. The team will there discuss the risks to self and others in order to inform an appropriate action plan, incorporating both risk and need. If the decision is made to proceed with discharge, the Care Coordinator/key therapist must inform the GP and the primary care team immediately

6.13 Outcome Measures

The following measures may be used to monitor outcomes along the pathways in this service, depending upon the specific condition, its severity and the nature of intervention.

- CIA: Clinical Impairment Assessment (start and end of treatment)
- ASEDS: Accommodation and Enabling Scale for Eating Disorders (start and end of treatment)
- RCADS: Revised Children's Anxiety and Depression Scale (start and end of treatment)
- EDE-A: Eating questionnaire – every 3 months from treatment start

In addition, additional measures arising from the practitioner's own professional background & guidance may be used where appropriate.

7. Access to healthcare for people with a learning disability

PFT have a responsibility to ensure that all people with a learning disability access appropriate services and that they receive the best treatment available in line with good practice and legal frameworks. Therefore all services will ensure that

- Reasonable adjustments are made to ensure that each person has the same opportunity for health, whether they have a learning disability or not. (Equality Act 2010)
- Assume that each person presented to the service has capacity. If assessment shows they don't, a decision must be made in their best interest. (Mental Capacity Act 2005)
- Everyone has a right to expect and receive appropriate healthcare. (Human Rights Act 1998)

Adjustments will include:

- Spending time with the individual to gain an understanding of their preferences for treatment
- To ask them where they would prefer to be treated,
- To provide additional support to assist with communication, this support will be available via easy read material/and/or audio equipment. Templates for appointment letters and easy read information leaflets are available via the Performance page on the intranet.
- If an individual continues to have difficulty understanding their treatment it is the responsibility of the staff to refer them to a specialist learning disability service for additional support
- All people with a learning disability may have a Health Action Plan or Purple Folder and all HPFT staff will ask for permission to see these and contribute to the plan when appropriate
- To value and welcome the contribution of the relative/carer/advocate

8. Clinical Risk Assessment/Management

Clinical Risk Assessment and Management is defined by the Trust as a continuous and dynamic process for judging risk and subsequently making appropriate plans considering the risks identified.

‘Modern risk assessment should be structured, evidence based and as consistent as possible across settings and across service providers’ (Best Practice in Managing Risk, Department of Health, March 2009)

Essentially clinical risk assessment and management is fundamental so that:

- Risks to the wellbeing of children, young people, their families staff and others are assessed and identified
- Indicators of possible adverse outcomes e.g. non-compliance with treatment or non-attendance at appointments are addressed
- Risks to children, young people, their families, staff and others are regularly reviewed
- Risks to children, young people, their families, staff and others are communicated appropriately
- Shortfalls in services are identified and addressed

And ultimately

- Children, young people, their families, staff and others are safeguarded.

This is particularly important for children and young people with eating disorders, where minor changes especially in relation to weight can have major impacts & consequences. As referred to above, the Trust has adopted the Junior Marsipan Risk Table to identify and monitor risk in a regular and ongoing way.

Identified risks will be shared with all HPFT staff working with the child, young person and their family. A copy of the risk assessment will be placed on the care records. It is a clinical decision who outside the organisation the risk assessment is shared with, this will be done in line with the guidance on consent to share information.

9. Consent to Share Information

Consent to Share Information should be discussed at the Choice Appointment/initial assessment and a 'consent to share information form' completed. This should also be recorded on Paris.

The requirement for the individual's consent to disclosure will not apply if the duty of care to the individual or the public interest makes disclosure essential for example:

- Notifiable infectious diseases
- Poisoning and serious accidents/incidents in the work place
- The information is required by statute or court order
- The information is required by the Coroner
- There is a serious risk of harm to the individual
- There is a serious public health risk or a serious risk of harm to others
- The information is required for the prevention, detection or prosecution of serious crime within the Crime and Disorder Act 1998
- A child protection investigation is being carried out or the child is on the child protection register, and disclosure is necessary to assess the risk to the child or to promote the effective protection of the child
- The child is looked after, and the sharing of information with carers is necessary to ensure the best possible care for the child

Where Safeguarding Children is an issue, the overriding principle is to ensure the safety of the child.

10. Safeguarding

Where there is reason to believe that a child under the age of 18 years or an unborn baby has suffered, is suffering or is likely to suffer significant harm a referral should be made to Hertfordshire Children's Services. Professionals should seek to discuss concerns with the parent / carer and where possible seek their agreement to making a referral. This should only be done where such discussion and seeking of agreement will not place a child at increased risk of significant harm.

Referrals should also be made to Children's Services where it is thought the family may benefit from family support services. In this situation agreement of the parent / carer is always required.

If staff are unsure about making a referral then consultation should take place with the Lead Nurse or Lead Doctor for safeguarding children

Referrals to Hertfordshire Children's Service should <u>always</u> be made in writing. The named nurse for safeguarding children <u>must</u> receive a copy of the referral. Professional referrals cannot be made anonymously.
All cases of suspected or actual abuse must be taken seriously and acted on from what initially appears minor to serious incidents.

Professionals must ensure they record their concerns and actions taken onto PARIS, including entering an alert on notes about any Safeguarding matters or protection plans in place. Concerns regarding subsequent action taken by other agencies must be escalated by the professional to their line manager and discussed with the lead nurse safeguarding children who will advise on appropriate action.

11. Transition Arrangements for a Young Person with a diagnosed Eating Disorder to the Adult Service

The Transition period will be managed to meet the young person's need in the Adult Community Eating Disorders Service.

Following a written referral from the CAMHS or the APED, the transition will be managed over a six-month period prior to the young person reaching the age of eighteen. Therefore, referrals from CAMHS must happen when the service user is 17 ½ years old.

There will be regular interface meetings with the service user involving the CAMHS/CAMHS outreach service, the Adult Community Eating Disorders service, the responsible Clinician from CAMHS and responsible Clinician from the Adult Eating Disorder Service. As and when necessary and/or appropriate, parents, relatives and/or carers will be invited to the meetings.

Once the child or young person is 18 years old and all the appropriate transition meetings have occurred a discharge/transition meeting will be held with all services involved to officially transfer the care of the young person to the adult eating disorder team.

These meetings will be initiated by the referring service (CAMHS/CAMHS outreach/Eating Disorder Service) and notes of the meetings will be taken and distributed to all relevant parties. The Community Care Plan will be discussed and agreed by the service user, relevant carers and CAMHS services throughout the process

12. Induction, Staff Support, Supervision, Appraisal and Training in the use of this Policy/Service

The table below sets out the minimum standards for staff working for HPFT, CAMHS Eating Disorder service.

	Permanent Staff	Temporary Staff	Students/Trainees
Induction to Service	Induction on 1st day	Induction on 1st day	Induction on 1st day
Supervision Arrangements	Monthly	Monthly	Monthly
Appraisal	Annually	Annually	Annually
Training	All Mandatory Training and any other training identified as part of personal development plans.	To provide evidence of attendance of mandatory training	Any training necessary to support placement

13. Comments, Complaints and Compliments

All comments, compliments and complaints should be dealt with in accordance with the Trust Compliments Concerns and Complaints Policy and Procedure (see Policy document).

The policy requires all verbal or written complaints to be acknowledged within two working days with copies forwarded to the appropriate line manager and the Complaints Manager at Trust Head Office, Waverley Road, St. Albans. Comments and Compliments, once responded to, should be sent for information to the Complaints Team at Trust Head Office. Leaflets outlining the procedure are available [in or on location].

14. Communications

The treatment and information service users are given should meet the individual's communication needs especially where there are specific language and sensory communication requirements. The HPFT guidance on Communicating with Service Users from Diverse Communities provides further information and the procedure for the interpreting service.

Where there are specific cultural/religious practices which affect compliance with treatment the service users should be given the opportunity to discuss and agree adjustments or alternatives to enable treatment to go ahead.

15. Records Management, Confidentiality and Access to Records

Paris is the electronic patient record used by HPFT. Staff are required to record all contacts with the service user on Paris. If difficulty arises, such as there is no access to a computer, a written note can be made in the paper light record. This must be entered onto the EPR as soon as the staff member has access to the EPR (the requirement is two working days).

All matters relating to service users' health and personal affairs and matters of commercial interest to the Trust are strictly confidential and such information must not be divulged to any unauthorised person.

Requests for access to records whether by the service user or a third party including where legal access is requested, should be referred to the Eating Disorders Service Manager.

In order to provide evidence that the best possible care and treatment is given to the service users, staff must follow the record management and confidentiality polices listed below.

- Care Records Management Policy
- Clinical Information Filing Policy
- Protection & Use of Service User Information Policy
- Formal Access to Service User Records Policy
- Freedom of Information Act Policy
- Written & Electronic Communications Policy
- Corporate Records Management Policy

16. Health and Safety

Every employee and those persons working on behalf of the Trust have a duty to take reasonable care for the health and safety of themselves and other persons who may be affected by any acts or omissions by themselves. To cooperate with the organisation so far as it is necessary to enable management to carry out its legal duties relating to health and safety matters i.e. follow instructions and training, use equipment provided for their protection, report defects/damage/ health and safety concerns.

HPFT have a duty to remedy and or report any hazards or unsafe working practices in the immediate working area to the appropriate manager or supervisor.

Pregnant Mothers working in CEDS will have a 'Pregnant Workers Risk Assessment completed at the following intervals 18, 28, and 32 weeks as standard. This Risk Assessment will be updated outside of said timescales if required. CEDS fully comply with the Trusts 'Pregnant Mothers and Nursing Mothers Policy.

17. Embedding a culture of Equality & RESPECT

The Trust promotes fairness and RESPECT in relation to the treatment, care & support of service users, carers and staff.

RESPECT means ensuring that the particular needs of 'protected groups' are upheld at all times and individually assessed on entry to the service. This includes the needs of people based on their age, disability, ethnicity, gender, gender reassignment status, relationship status, religion or belief, sexual orientation and in some instances, pregnancy and maternity.

Working in this way builds a culture where service users can flourish and be fully involved in their care and where staff and carers receive appropriate support. Where discrimination, inappropriate behaviour or some other barrier occurs, the Trust expects the full cooperation of staff in addressing and recording these issues through appropriate Trust processes.

Access to and provision of services must therefore take full account of needs relating to all protected groups listed above and care and support for service users, carers and staff should be planned that takes into account individual needs. Where staff need further information regarding these groups, they should speak to their manager or a member of the Trust Inclusion & Engagement team.

Where service users and carers experience barriers to accessing services, the Trust is required to take appropriate remedial action.

Service user, carer and/or staff access needs (including disability)	APED staff will take into account the needs of people with disabilities, considering communication needs and any other access needs during the assessment process, and throughout the duration of care. . The treatment and information given will meet the individual's communication needs including where there are specific language and sensory communication requirements, APED will arrange and utilise interpreters as required by the young person and their family. Staff will support young people, parents and carers to understand any printed information that they are provided with, and will facilitate the provision of printed information such as medication information in

	appropriate formats such as easy-read, if required. All people using the service: ▪ Are treated in a way that is considerate and respectful to the person ▪ Have their privacy, dignity and independence respected and maintained. ▪ Are supported to express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support. The families of people using APED's are: Supported to express their views and involved in consultation about the care, treatment and support of the young person. This will be facilitated in line with the wishes of the young person and in line with good practice guidelines for working with families when the young person declines to consent to share information.
Involvement	Staff use young person and parent/carer feedback provided by the Having Your Say satisfaction questionnaires to inform actions to improve services. Wider Participation is encouraged through the participation group and youth council.
Relationships & Sexual Orientation	Staff take account of the needs of young people throughout the period of care from assessment, to care planning and transfer planning on from APED's. This will include consideration of sexual orientation and any needs of barriers to required care in association with relationships and/or sexual orientation. Staff offer support to parents/carers and other significant people in the young person's life. As appropriate involving other relevant people as appropriate within the care planning process.
Culture & Ethnicity	APED's provide a service that ensures the culture and ethnicity of young people is reflected in the planning of their care. Staff understand how to ask questions in the assessment process about culture and ethnicity, and that any related identified needs are documented and catered for in the agreed care plan.
Spirituality	The Assessment process takes account of individual spiritual needs, ensuring all aspects of the HOPE model are utilised as part of the care planning process and within Forest House: **H** – Sources of Hope **O** – Needs re: organised religion **P** – Personal belief structure (including non-faith) **E** – Effects on care of practicing spiritual beliefs. (positive and negative) APED's utilises available resources in the Trust and wider community where applicable to meet assessed needs.
Age	APED's is an Child and Young Person's tier 4 CAMHS Community team for young people between the ages of 0 to 18.
Gender & Gender	Where required APED's would refer to the Adolescent Gender Development Service (GIDS) at the Tavistock and Portman NHS

Reassignment	Foundation Trust work and provide support in partnership with this specialist service.
Advancing equality of opportunity	APED's will reflect on information from young people and parent/carer feedback within the unit team meeting, to inform continuous improvement of services. This promotes continued commitment to equality of opportunity in the service.
Young People who are pregnant	APED's will address this as part of the Care Plan If required additional resources and interventions will be offered and if there are any safeguarding concerns for the unborn baby a safeguarding referral will be made to Children's Services. At 28 weeks an unborn baby can be considered a 'Child in Need' and if appropriate made subject to a 'Child Protection Plan'.

Promoting and considering individual wellbeing

Under the Care Act 2014, Section 1, the Trust has a duty to promote wellbeing when carrying out any of their care and support functions in respect of a person. Wellbeing is a broad concept and is described as relating to the following areas in particular:

- Personal dignity (including treatment of the individual with respect);
- Physical and mental health and emotional wellbeing;
- Protection from abuse and neglect;
- Control by the individual over day to day life including over the care and support provided and the way in which it is provided;
- Participation in work, training, education, or recreation;
- Social and economic wellbeing;
- Domestic, family and personal;
- Suitability of living accommodation;
- The individual's contribution to society.

There is no hierarchy and all should be considered of equal importance when considering an individual's wellbeing. How an individual's wellbeing is considered will depend on their individual circumstances including their needs, goals, wishes and personal choices and how these impact on their wellbeing.

In addition to the general principle of promoting wellbeing there are a number of other key principles and standards which the Trust must have regard to when carrying out activities or functions:

- The importance of beginning with the assumption that the individual is best placed to judge their wellbeing;
- The individual's views, wishes, feelings and beliefs;
- The importance of preventing or delaying the development of needs for care and support and the importance of reducing needs that already exist;
- The need to ensure that decisions are made having regard to all the individual's circumstances;
- The importance of the individual participating as fully as possible;
- The importance of achieving a balance between the individuals wellbeing and that of any carers or relatives who are involved with the individual;
- The need to protect people from abuse or neglect;
- The need to ensure that any restriction on the individuals rights or freedom of action that is involved in the exercise of the function is kept to the minimum necessary.

18. Capacity to consent

Where the young person does not have the capacity to consent, parts of the Mental Capacity Act (MCA) will apply. They will need to refer to the Trust/ACS joint policy on the MCA to treatment, health professionals can and should provide treatment if it is considered to be clinically necessary and in the 'best interest' of the service user. Discussion should take place within the multidisciplinary team and where appropriate with relatives and carers. It may be necessary to obtain legal advice in some circumstances. Issues on capacity are fully covered in the Mental Capacity Act 2007

19. Process for monitoring compliance with this document – The process for identifying how the organisation plans to monitor compliance with the process/system being described, is presented in the table.

Action:	Lead	Method	Frequency	Report to:
Review of activity within the service.	CAMHS Community Manager	Audit and Caseload Review	Monthly	East and North SBU Quality and Risk meeting

PART 3 – Associated Issues

20. Version Control

Version	Date of Issue	Author	Status	Comment
V1	February 2011	CAMHS Manager	Superseded	New Policy
V2	20th April 2015	CAMHS Community Manager	Current	Full Review
V2.1	September 2015	CAMHS Community Manager	Current	Updated for Care Act 2014

21. Archiving Arrangements

All policy documents when no longer in use must be retained for a period of 10 years from the date the document is superseded as set out in the Trust Business and Corporate (Non-Health) Records Retention Schedule available on the Trust Intranet

A database of archived policies is kept as an electronic archive administered by the Compliance and Risk Facilitator. This archive is held on a central server and copies of these archived documents can be obtained from the Compliance and Risk Facilitator on request.

22. Associated Documents

- Clinical risk assessment and management
- Lone Worker and Essential travellers policy
- Policy on Comments, complaints and compliments
- Policy on learning from adverse events policy
- Policy for the Management of Care Records
- Mental Health Act 1983 and the Code of Practice
- Policy on Transition from CAMHS to Adult Mental Health Services
- Hertfordshire Interagency response to allegations of Abuse
- Policy on Communicating with service users from diverse communities
- Policy on Access to Records
- Policy on prevention and Management of Violence
- Hertfordshire Safeguarding Children policy

23. Supporting References

- Every Child Matters 2004
- NSF for Children DoH 2004
- The Children's plan – Building a Brighter future
- National CAMHS review 2008 (Children and Young people in mind)
- The Children's Act 1989
- Emotional & Wellbeing Strategy 2007

24. Comments and Feedback – List people/ groups involved in developing the Policy.

Managing Director CAMHS	Practice Governance Lead – CAMHS
CAMHS Service Line Lead	Lead Nurses
Quality Standards Manager	Head of Records & Access to Information
Compliance & Risk Facilitator	Patient Safety Manager
Head of Practice Governance	Information Governance Officer
Equalities Manager	Consultant Systemic Psychotherapist
Justine McMahon	CAMHS Community Manager
Programme Manager - CAMHS	Consultant Psychiatrists – Forest House Adolescent Unit
Community Eating Disorders Team	

Junior Marsipan: Summary of Risk Table

	Red Risk Level (High)	Amber Risk Level (Alert to High Concern)	Green Risk Level (Moderate Risk)	Blue Risk Level (Low)
BMI & Weight	Percentage Median BMI <70% Recent Loss of weight of 1 kg or more/week for 2 consecutive weeks	Percentage Median BMI 70 – 80% Recent Loss of weight of 500-999g /week for 2 consecutive weeks	Percentage Median BMI 80-85% Recent Loss of weight of up to 500g/week for 2 consecutive weeks	Percentage Median BMI >85% No weight loss over the past 2 weeks.
Cardiovascular Health (depending upon age & gender)	Heart rate <40bpm History of recurrent syncope, marked orthostatic changes (fall in systolic BP of 20mmHg or more) Irregular Heart Rhythm (does not include sinus arrhythmia)	Heart rate 40-50bpm Sitting BP systolic = 84-98mmHg; diastolic 35-40mmHg Occasional syncope; Moderate orthostatic cardiovascular changes (fall in systolic BP of 15mmHg or more or fall in diastolic BP of 10mmHg or more within 3 mins standing or increase of heart rate of up to 30 bpm	Heart rate 50-60bpm Sitting BP systolic = 98-105mmHg; diastolic 40-45mmHg Pre-syncope symptoms but normal orthostatic cardiovascular changes Cool peripheries, prolonged periphery capillary refill (normal central capillary refill)	Heart rate> 60bpm Normal sitting BP Normal Orthostatic cardiovascular changes Normal heart rhythm
ECG Abnormalities	Prolonged QTc interval, Evidence of tachy/bradyarrhythmia Evidence of biochemical abnormalities	Prolonged QTc interval,	Normal except expected abnormalities relating to medication or family history	Normal
Hydration Status	Fluid Refusal Severe Dehydration	Severe Fluid restriction Moderate dehydration	Fluid restriction Mild dehydration	Not clinically dehydrated
Temperature	<35.5degreeC tympanic or 35.0degreeC axillary	<36degreeC		
Biochemical Abnormalities	Hypophosphatemia, Hypokalaemia Hypoalbuminaemia Hypoglycaemia Hypoatraemia Hypocalcaemia	Hypophosphatemia, Hypokalaemia Hypoatraemia Hypocalcaemia		
Disordered Eating Behaviours	Acute Food refusal or estimated calorie intake 400-600kcal per day	Severe restriction (less than 50% required intake) vomiting, laxatives	Moderate restriction, bingeing	
Engagement	Violent when parents try to limit behaviour or encourage food/fluid intake; Parental violence in relation to feeding	Poor insight, lacks motivation, resistant to changes required to gain weight, parents unable to implement meal plan advice	Some insight, some motivation, ambivalent towards changes required to gain weight but not actively resisting	Some insight, motivated, ambivalent towards changes required to gain weight not evident in behaviour
Activity/Exercise (in context of malnutrition)	High Levels of uncontrolled exercise (>2 hours/day)	Moderate Levels of uncontrolled exercise (>1 hour/day)	Mild Levels of uncontrolled exercise (< hour/day)	No uncontrolled exercise
Self-Harm & Suicide	Self-poisoning, suicidal ideas with moderate to high risk of completed suicide	Cutting or similar behaviours, suicidal ideas with low risk of completed suicide		

Red Risk Level

Action	By When?	By Whom?
Young Person to be medically assessed:- > decision made to admit young person to A&E **or** > to make urgent referral to the Advanced Eating Disorder Practitioner while continuing to medically monitor & assess	Immediately upon presentation to the GP/SPA and as frequently after that as required by the medical assessment	GP/SPA
Young person is admitted to A&E & is medically assessed by A&E staff:- > decision made whether to admit to paediatric/medical ward	Same Day	A&E Staff
The Advanced Eating Disorders Practitioner will be contacted & will complete an urgent assessment:- >decision made whether specialist admission required or >support in the community appropriate	Within 2 working days	Advanced Eating Disorder Practitioner
EDE-Q completed	At Assessment & at 3 months	Advanced Eating Disorder Practitioner
Data Collection Forms	At Assessment	Advanced Eating Disorder Practitioner
Satisfaction Questionnaire	On discharge	Advanced Eating Disorder Practitioner
Specialist Admission not required		
Once medically stable, young person discharged home and Advanced Eating Disorder Practitioner commence community treatment package	Initial meeting on the same day as discharge (assessment already completed on ward/A&E)	Advanced Eating Disorder Practitioner
Advanced Eating Disorder Practitioner refer to CAMHS clinic for:- >allocation of Care Coordinator >additional therapeutic input including individual & family therapy	On allocation to Advanced Eating Disorder Practitioner	Advanced Eating Disorder Practitioner
CAMHS clinic to:- >allocate Care Coordinator >offer Individual/family therapy	Ongoing	CAMHS Therapist
Review continued involvement of Advanced Eating Disorder Practitioner If involvement of AEDP no longer required, physical monitoring to be arranged via:- >AEDP >GP >Parents	4 weekly As appropriate	Advanced Eating Disorder Practitioner & CAMHS Therapist Advanced Eating Disorder Practitioner
Discharge Planning		

When appropriate, CPA review to decide on discharge to :- >GP for continued monitoring >Adult Eating Disorder Service (transition to commence 6 months prior to 18th birthday) >Complete discharge with prevention relapse plan	On completion of specialist CAMHS treatment	Advanced Eating Disorder Practitioner and/or CAMHS Therapist
Specialist Admission Required Following assessment & decision to admit, consideration about most appropriate in-patient placement :- >Forest House >Rhodes Farm **Forest House** – >Refer to Consultant Psychiatrist >Agree admission date **Rhodes Farm** – AEDP to:- >Request funding >Refer to Rhodes Farm >Discuss possible admission date Where delay in admission, AEDP assess whether young person requires admission to medical ward until specialist admission can be organised	Same Day Same Day Same Day Same Day	Advanced Eating Disorder Practitioner Advanced Eating Disorder Practitioner Advanced Eating Disorder Practitioner Advanced Eating Disorder Practitioner & GP
Discharge Planning CPA Review to consider most appropriate discharge package following period as in-patient:- >AEDP & CAMHS clinic service >CAMHS clinic service only >AEDP only	CPA review meeting	Advanced Eating Disorder Practitioner and/or CAMHS Therapist & Ward team

Amber Risk Level

Action	By When	By Whom
Request urgent bloods & ECG to be conducted by GP	Same Day	SPA
Specialist Assessment to be completed EDE-Q Data Collection Forms Satisfaction Questionnaire	Within 5 working days of referral At Assessment & at 3 months At Assessment On Discharge	Two Advanced Eating Disorder Practitioners AED Practitioner AED Practitioner AED Practitioner
Advanced Eating Disorder Practitioner to commence with community treatment package Advanced Eating Disorder Practitioner refer to CAMHS clinic for:- >allocation of Care Coordinator >additional therapeutic input including individual & family therapy CAMHS clinic to:- > allocate Care Coordinator > offer Individual/family therapy Review continued involvement of Advanced Eating Disorder Practitioner If involvement of AEDP no longer required, physical monitoring to be arranged via:- >AEDP >GP >Parents	Within 5 working days of Assessment On referral to the AEDP Ongoing 4 weekly As appropriate	Advanced Eating Disorder Practitioner Advanced Eating Disorder Practitioner CAMHS Therapist Advanced Eating Disorder Practitioner & CAMHS Therapist Advanced Eating Disorder Practitioner
If Young Person deteriorating or not progressing:- **Implement steps for "specialist admission" as detailed in Red Risk pathway above**	As appropriate during treatment	Care Coordinator
Discharge Planning When appropriate, CPA review to decide on discharge to :- >GP for continued monitoring >Adult Eating Disorder Service (transition to commence 6 months prior to 18th birthday) >Complete discharge with prevention relapse plan	On completion of specialist CAMHS treatment	Advanced Eating Disorder Practitioner and/or CAMHS Therapist

Green & Blue risk Levels

Action	By When	By Whom
CAMHS Assessment to be completed & routine bloods & ECG to be requested from GP	Within 28 days of referral	SPA Clinician CAMHS Clinician
EDE-Q	At assessment & at 3 months	CAMHS Clinician
Data Collection Forms	At Assessment	CAMHS Clinician
Satisfaction Questionnaire	On discharge	
CAMHS Clinic to:- >commence a community treatment package including individual/family therapy >allocate a Care Coordinator	Ongoing	CAMHS Clinician
CAMHS Clinic to review frequently with view to :- >discussion with AED Practitioner >referral to AED service	Ongoing	CAMHS Clinician/AED Practitioner
If young person deteriorating:- **>refer to AED Practitioner/service** **>Implement steps for "specialist admission" as detailed in Red Risk section above**	As appropriate during treatment	CAMHS Clinician/AED Practitioner
Discharge Planning When appropriate, CPA review to decide on discharge to :- >GP for continued monitoring >Adult Eating Disorder Service (transition to commence 6 months prior to 18th birthday)	On completion of specialist CAMHS treatment	Advanced Eating Disorder Practitioner and/or CAMHS Therapist

Our Values

Welcoming Kind Positive Respectful Professional