Leicestershire Partnership NHS Trust

Clinical Risk Assessment and Management Policy

This policy describes the process to be followed when assessing the clinical risk of a service user. It presents principles underpinning risk assessment predominantly in Mental Health Services. It must be read in conjunction with other Trust policy and NICE guidance.

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Contents

Version Control and Summary of Changes

Version number	Date	Comments (description change and amendments)
1	June 2016	Original ratification by the CPA Standards Group
2	Sept 2016	Grammatical and spelling changes
3	November 2016	Review following consultation
4	December 2016	Review following consultation at CPA Standards Group
9	December 2017	Review of policy as expiry date approaching
10	March 2020	Reviewed in line with policy expiry date April 2020 Fully reviewed following comments received from a consultation Amended to apply to all areas of services within LPT – is predominantly relevant for AMHLD (Adult Mental Health and Learning Disability), MHSOP (Mental Health Services for Older Persons) and CAMHS (Child and Adolescent Mental Health Services) within FYPC (Families, Younger People and Children) services Amended to integrate physical health Amended to include greater emphasis on involvement of service users and carers Amended to include greater emphasis on risk formulation and using 5 'P's Amended to include sexual safety for in-patient areas

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Equality Statement
Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

Due Regard

LPT will ensure that Due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010. This process will help to ensure that:

- Strategies, policies and services are free from discrimination;
- LPT complies with current equality legislation;
- Due regard is given to equality in decision making and subsequent processes;
- Opportunities for promoting equality are identified.

Please refer to due regard assessment (Appendix 4) of this policy.

Definitions that apply to this Policy

Risk Assessment	The gathering of information through processes of communication, investigation, observation and persistence; and analysis of the potential outcomes of identified behaviours. Identifying specific risk factors of relevance to an individual, and the circumstances in which they may occur. This process requires linking the context of historical information to current circumstances, to anticipate possible future change.
Risk Management Plan	A plan that defines responses to potential (adverse) outcomes that arise. Risk management should be based on a plan to reduce the risk of harm occurring and increase the potential for a positive outcome. This creates an action plan for interventions focusing on risk i.e. what to do when a risk area is identified.
Risk Formulation	An account usually presented in a paragraph or so of text, in which the practitioner working with the client and/or colleagues in a multi-disciplinary team provides an account or explanation for the risks presented by the service user. This account will explain how and why the most relevant risk and protective factors interact with one another to create elevated risk. A process of analysis of the relevant factors relating to the risk domain in an individual, in order to create a risk management plan. The model being proposed is based upon the “5P’s.”
5 ‘P’s	Problem; Predisposing Factors; Precipitating

	Factors; Perpetuating Factors and Protective Factors
Contingency/Crisis Plan	A document designed for what the service will do to support the service user if there are indicators of relapse
Personal Safety Plan	A document designed for clinicians and service users to work together to devise coping person-centred and highly individualised strategies, problem solving and provide details of where to go and who to contact when in distress. It is held by the service user and can be paper-based or as the Staying Alive App which the Trust promotes.
Positive Risk Management	Positive risk-management means being aware that risk can never be completely eliminated. Therefore, management plans inevitably have to include decisions that carry some risk. This should be explicit in the decision-making process and should be discussed openly with the service user.

1.0. Purpose of Policy

1.1 The aim of this policy is to:

1.2 Provide guidance to all clinical staff who undertake risk assessment and develop a management plan

1.3 Promote a thorough, consistent and high standard of practice with regards to clinical risk assessment and management in order that staff and the organisation can effectively manage clinical risk thereby increasing safety to service users, their family and carers, staff and members of the public.

1.4 Clarify the roles and responsibilities of different staff groups in relation to risk assessment and management.

1.5 Reassure service users that clinical risks presented by them will be assessed and reviewed as often as is necessary to ensure that those risks are managed safely and effectively throughout their care spell, regardless of the care setting.

1.6 Ensure all staff involved in direct clinical care should have a good understanding of the principles involved in clinical risk assessment, the requirements of their role in relation to these and the availability of guidance and tools with which to enable them to fulfil their responsibility in relation to this aspect of their work.

1.7 Support a process for clinical risk management that is determined by the nature of the service. The Trust acknowledges that specialist practitioners may use

specific evidence-based tools for clinical risk assessments. A single assessment tool will not always be clinically relevant because the services the Trust provides are so diverse.

1.8 Provide guidance on conducting risk assessments and the formulation of risk management plans. This policy provides guidance to clinical staff where there is a perceived or known risk. This includes the use of risk assessment tools, processes and escalation used by practitioners that have been approved locally. A formal process of ratification will be developed in Phase 2 of this policy work.

1.9 To have reasonable expectations that staff will work to the processes and guidelines of good practice outlined in this policy; its appendices and associated documents. The Trust will support the judgements made by its practitioners through shared corporate accountability even when things will occasionally go wrong, provided reasonable good practice has been adhered to within the resources and information available to support the decisions.

1.10 Clinical staff need to consider other Trust policies that have elements of risk assessment as part of the approach to service user safety. The following list of policies must be considered, where relevant, in conjunction with this policy:

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- Self-Harm Policy
- Violence and Aggression Policy
- Ligature Risk Assessment Policy
- Management of Service Users who have Dual Diagnosis (coexisting problems related to substance/ alcohol use) Policy
- Safeguarding Adults at Risk Policy
- Safeguarding Children Policy
- Care Programme Approach Policy
- Delivering Single Sex Accommodation Policy
- Physical assessment and examination of service users admitted to Mental Health Unit and Community Hospitals
- Incident Reporting Policy
- Lone Working Policy
- Resuscitation and Management of Deteriorating Service user Policy
- Physical Health – Adult Services Policy
- Pressure Ulcer Prevention and Management Policy
- Prevention and Management of Slips, Trips & Falls Policy
- Adult Nutrition and Hydration Policy for Community Use and In-Service user
- Safe Administration of Insulin to Adult Service users in a Hospital and Community Setting Policy
- Prevention of Venous Thromboembolism (VTE) Policy for In Service user Adult Service users
- Integrated Policy: Safe Use of Bed Rails for Adults

- Trust policy in line with Psychiatric disorders: assessing fitness to drive (Gov.UK 2016)

2.0 Summary and Key Points

2.1 Dealing with clinical risk is an essential and unavoidable aspect of the work of health practitioners and risk management is a core component of healthcare. It is important that all clinical staff are familiar with the principles of good practice which underpin effective risk management for their specific area of practice.

2.2 Clinical risk in mental health covers a broad spectrum of risk which includes risk of suicide, self-neglect, harm to self and/or others and requires practitioners to help service users manage their behaviour in relation to these.

2.3 This policy aims to be concise and practicable. It does not attempt to cover all eventualities and has to be read in conjunction with other Trust and national policies, especially Department of Health and NICE (-National Institute for Health and Care Excellence) guidance as referenced.

2.4 This policy must be read in conjunction with the Trust's Care Programme Approach (CPA) policy which provides a framework and detailed procedural guidance for mental health practitioners within AMHLD services and will not be duplicated in this policy.

2.5 This policy must be read in conjunction with all specialty policy and guidelines relating to assessment and care planning.

2.6 All clinical risk assessment and care planning needs to take into account local Standard Operating Procedures that have been ratified.

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2.7 The Trust is in the process of providing a single electronic service user record (EPR) on SystmOne. Where this involves a move from RiO documentation, all staff must continue to use all risk assessment forms that are currently provided. This policy makes reference to the documentation to be completed and will be reviewed further following the implementation of SystmOne.

2.8 CAMHS has a risk assessment form specifically with risk factors for young people and are using it on SystmOne ahead of the wider Trust move onto a single electronic service user record.

3.0. Introduction

3.1 This policy is for use by staff across all settings within LPT and is relevant to all areas of clinical risk assessment and management. This includes community hospitals and associated services and makes reference to areas of physical health care that are key areas of risk. It is also recognised that people with physical health needs long-term conditions need to be monitored for depression

as per NICE guidelines. This will also include risk assessment of any substance misuse as this is a factor in self-harm and suicide. Clinical risk assessment and management is a core function of mental health and learning disability and is relevant to every service provided within AMHLD (Adult Mental Health and Learning Disability), MHSOP (Mental Health Services for Older Persons) and CAMHS (Child and Adolescent Mental Health Services) within FYPC (Families, Younger People and Children) services.

3.2 Good risk management is underpinned by widely acknowledged principles for the assessment and management of risk that are evidence-based This policy needs to be read in conjunction with local and national guidance primarily Department of Health (2007) *Best Practice in Managing Risk - Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services*

3.3 Throughout this policy, the term 'service user' is a generic term meaning patient, service user, client or resident receiving LPT physical, rehabilitation, mental health or learning disability services.

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4.0 Principles of Risk Assessment

4.1 This policy is based on the following principles:

4.2 Service users should expect that the clinical risks presented by them will be assessed and reviewed as often as deemed necessary in order that the risks identified can be managed effectively, safely and progressively over time;

4.3 Service users should expect staff in Leicestershire Partnership Trust to demonstrate a good level of competence in the assessment and management of clinical risk and that competence in this area will be promoted by:

- Trust sponsored training courses that are freely available and appropriate for the needs of clinical staff in the different divisions;
- An easily accessible network of qualified support and advice with which care plans incorporating risk management guidance can be checked and improved.

4.4 Positive risk management of service users will be promoted but only when:

- There is a shared and good understanding of the risks posed and experienced by the service user;
- When risk can be effectively and repeatedly assessed and there are the resources to manage the risk and protective factors identified as relevant;
- Where the outcome of assessment and management interventions will be an improvement in the service user's quality of life and mental health over time.

4.5 Decisions involving clinical risk always involve balancing the health and safety of service users and others with service users' quality of life, their personal growth and their right to exercise choice and autonomy in the care they receive. It is acknowledged that achieving this balance is often a complex task where absolute safety can never be guaranteed.

4.6 Risk assessment and management is an integral part of routine clinical care and therefore relies upon a good therapeutic relationship with the service user.

4.7 Collaboration with the service user and those involved in the service user's care should be intrinsic to the risk management process.

4.8 Risk assessment should always inform risk management and contribute to clinical care and the wider assessment and planning of care needs.

4.9 All forms of risk should be considered and assessed together, bearing in mind that service users who present a risk to others are likely to be vulnerable to other forms of risk such as self harm, self-neglect or exploitation by others.

4.10 Risks are not static and therefore require regular review and assessment in response to the service user's changing presentation and circumstances.

4.11 Risk assessment and planning should be carried out within the multi-disciplinary team to increase the sharing of information and promote a multi-perspective approach.

4.12 In AMHLD, MHSOP and CAMHS/FYPC completion of Core Mental Health Assessment should form an integral part of the assessment and review of a service user. The AMH & LD Risk Assessment Form should be completed for all new service users, including those on the Care Programme Approach. The minimum expectation is that clinicians complete the relevant Trust risk assessment documentation as outlined within 5.4 of this policy, unless the clinician is undertaking risk assessment using more sophisticated tools specific to the risk (such as HCR20) identified. Please note even when a tool like HCR20 is used for risk related to aggression, there may be other areas of risk which needs to assessed (e.g. self-injury).

4.13 The NICE Guidelines on the long-term management of self-harm (2011) states that risk assessment tools and scales should not be used to predict future suicide or repetition of self-harm, or to determine who should or should not be offered treatment. Rather, they might be used as prompts or measures of change.

4.14 The NCISH (2018) states that research has shown that despite common risk factors, risk is often individual and suggests risk management should be personalised;

4.15 The management of risk should always be personal and individualised, but it is one part of a whole system approach that should aim to strengthen the standards of care for everyone, ensuring that supervision, delegation and referral pathways are all managed safely.

5.0 **The Risk Assessment Process**

5.1 Clinical risk assessment, formulation and management are integral to health care. The format described below is intended to support and enhance current practice when assessing and managing clinical risks within LPT.

5.2 In mental health, structured professional (or clinical) judgement is the approach recommended as the core technique for assessing and managing the risks posed by service users to themselves or to others. Structured professional judgement is a method designed to promote best practice in risk assessment by the linking of judgement to an evidence-base, both of the risks to be managed (e.g. risk of violence) and good clinical practice. The structured professional judgement approach lends itself to multidisciplinary team work, leading to the formulation of risk potential, and transparent risk management planning linked to the risk factors and protective factors identified in a single individual.

5.3 A clinical risk assessment should make reference to the following elements: A clear statement about the nature of the harmful outcome to be prevented (e.g. harm to others, harm to self, and suicide). Risk assessment tools may be considered to help structure risk assessments as long as they include the risk areas identified.

5.4 Risk assessment and management plans should be developed and reviewed and whenever new relevant information becomes available or there is a change in the service user's clinical presentation or circumstances including:

- Admission, discharge or leave from a service (including in-patient units)
- At the point of referral and transfer between services
- Change or unavailability of nominated practitioner or care co-ordinator
- Significant life event (e.g. suicide attempt, non-compliance with treatment, loss of contact with service, disengagement)
- Deteriorating health – physical and/or mental
- Significant changes in treatment plan (e.g. medication change)
- Increased hostility towards others and/or property
- Reviewing progress (e.g. review of CPA care plan)

5.5 Risk assessment tools and scales are not to be used alone for the following:

- To predict future suicide or repetition of self-harm.
- To determine who should and should not be offered treatment or who should be discharged.

5.6 The staff member/s receiving and responding to a referral for a service user should ensure that the agreed minimum of risk information is obtained prior to commencing assessment or providing care to the service user. In some circumstances, more detailed information may be sought prior to the service user being seen for assessment and treatment but this may be influenced by the urgency and immediacy with which care is required.

5.7 Where possible and considered necessary, risk information should be sought from a wide variety of sources some of which are listed below for consideration:

- Family/Carer/Partner/Significant Other/Friend

- General Practitioner
- Accommodation Provider
- Other NHS Trusts/Hospitals and Teams
- Probation Services
- Local Authority
- Local Police - Local Intelligence Units often have additional information which they will disclose when there a public protection issues at stake and information can be sought by contacting the intelligence officer at the local police station
- Prisons – following remand in custody, prison establishments may have a significant amount of risk information about an individual which can be accessed via contact with hospital/medical wings, psychology and probation departments or difficulties in obtaining information can be the Duty Governor.
- Substance misuse services /sexual abuse services
- Voluntary and third section agencies providing support and care to the service user
- Multi Agency Public Protection Panels (MAPPAs) – convened by local probation services to help manage the risks associated with a small number of individuals with the potential to cause serious harm and requiring management on an inter-agency basis. Any agency can refer a case to the MAPPA and the main purpose of the panel is to share information, jointly assess risk, and devise strategic plans to manage the dangerousness of individuals by agreeing and documenting the role of each agency and individual in the risk management of the case.

5.8 A brief summary of the risk and related protective factors that are relevant to the harmful outcome to be prevented. Tools such as the MUST, Waterlow, Falls Assessment or tools like the HCR-20, can be used to help practitioners identify what the most important risk and protective factors are in each case.

5.9 Clinical risk assessment in practice requires the gathering of information from as many sources as possible in a spirit of collaboration and co-production with the service user and their carers, based on knowledge of the research evidence, the service users experience and social context, and clinical judgement.

5.10 Risk assessment for suicide should take account of the following:

- **Risk factors**
  These can be static (unchangeable e.g. history of self harm) or dynamic (change over time e.g. misuse of alcohol)
- **History**
  Considering the recency; severity; frequency and pattern of risk incidents or behaviour.
- **Mental State**
  Consider the appearance, speech content, mood, affect, thought, perception, cognition, insight and judgement. Note evidence of symptoms indicating external control such as delusions or command hallucinations; emotions expressed related to violence or suicide; is there evidence of specific harm to others or themselves. This needs to include and increase or change in substance or alcohol use.
- **Intent**

A statement of intention from the service user is a clear indication of risk and should not be ignored.

- **Planning**
  If the person has thoughts to harm these should be explored to establish whether they have considered how they will do this; presence of a plan indicates a higher degree of risk – if they also have the means to carry out their plans the risk increases.
- **Protective factors**
  Consideration should also be given to any factors with the capacity to prevent or reduce the likelihood of risk. Care should also be taken to equally consider any threats to these factors. These factors can make a significant contribution to the risk management plan.
- **Risk Formulation**
  Taking into account all of the above information the aim is to identify factors likely to increase or decrease risk (as far as is possible) and should seek to determine how serious the risk is; whether it is specific or general; how immediate and volatile the risk is; what circumstances may increase the risk and therefore what specific treatment and management plan can best reduce the risk. The risk management plan should also specify who will be responsible for implementing each of the actions; this can include service users and their carers.
- **Review**
  This should be planned in advance with the involvement and in co-production with service users and their carers, and not be completed only in response to crisis. Efforts should be made to anticipate circumstances which may trigger a review such as anniversaries. Review should also be considered at other periods recognised to increase risk such as prior to leave, discharge and changes of key staff. Please also see 5.4

5.11 The period of review (other than following a change in risk presentation) is down to clinical/professional judgement, but as a maximum is 6 months for people under CPA (Care Programme Approach). For in-patients risk assessment is ongoing and should be reviewed weekly in the Multi-Disciplinary Team meetings. Service Users receiving Crisis Team support will be assessed on every contact and documentation completed as necessary, but an update always made in the progress notes.

5.11 Provision should be made for service users who have limited cognitive ability or limited language or communication skills. For example, the risk assessor may work more closely with fellow practitioners and family members or carers to gather information and develop the formulation. If the service user's first language is not English or if the service user has hearing problems, an interpreter should be used to ensure communication is possible.

5.12 Attempts must also be made to engage service users who are acutely mentally unwell. However, if risk of harm to the self or others is regarded as imminent and unacceptably high or potentially unmanageable, the risk assessment and escalation of management plan should proceed urgently. The absence and disengagement – and indeed, the presence – of involvement should be recorded in all communications made following the assessment. Efforts should be made to engage these service users in a collaborative risk assessment on the next occasion one is required and it is safe for all parties to do so.

6.0 Risk Formulation

6.1 Risk formulation is based on all factors and all other items of history physical health and mental state. It should take into account that risk is dynamic and, where possible, specify factors likely to increase the risk of dangerousness or those likely to mitigate harm, as well as signs that indicate increasing risk.

6.2 Risk formulation brings together an understanding of personality, history, physical health, mental state, environment, potential causes and protective factors, or changes/destabilising in any of these. It should aim to answer the following questions:

- How serious is the risk?
- How immediate is the risk?
- Is the risk specific or general?
- How volatile is the risk?
- What are the signs of increasing risk?
- Which specific treatment, and which management plan, can best reduce the risk?
- What are the protective factors/strengths?

6.3 The process of summarising the assessment, identifying the risks and triggers, and how these interact together. Risk formulation (i) identifies 'why' someone engages in problematic behaviour not just 'if' they will engage in it, and (ii) encourages a shift away from simply identifying risk factors to thinking about how key variables interact and connect in the expression of risk. National Confidential Inquiry into Suicide and Safety in Mental Health (2018)

6.4 A risk formulation, which is an account usually presented in a paragraph or so of text, in which the practitioner working with the client and/or colleagues in a multi-disciplinary team provides an account or explanation for the risks presented by the service user. This account will explain how and why the most relevant risk and protective factors interact with one another to create elevated risk. This is documented within the Risk Summary on the Trust AMH & LD Risk Assessment Form.

6.5 Risk factors can be categorised using the following formulation focused (5P's):

Problem	The specific risk or concern that is being assessed
Predisposing Factors	The factors that increase vulnerability to develop the risk behaviour(s): historical factors, i.e. trauma, early attachment, life adversity, past relationships, social developments, substance use.
Precipitating Factors	The factors that trigger the onset or exacerbate the risk behaviour(s): recent

	triggers, issues, i.e. acute life events, events that have meaning, sudden changes, past reminders, substance use
Perpetuating Factors	The factors that maintain the risk and prevent its resolution: beliefs and interpretations, relationships, psychosocial stressors, self-care, substance use
Protective Factors	The factors that prevent any deterioration in the risk. This can include any interventions in place: evidence of resilience, engagement, interpersonal qualities, and social support.

7.0 Risk Management Planning

7.1 A risk management plan will be linked directly to the risk and protective factors used in the risk formulation. The plan will provide suggestions of treatment strategies designed to repair or restore psychological (and/or physical) functioning. It will provide suggestions for supervision strategies, designed to contain or organise or structure the service user's day-to-day life thus reducing the potential for harmful outcomes to be triggered. The plan will also make some suggestions for how risk can be monitored during the periods between reviews, by identifying early warning signs of a relapse and suggestion what might be done to prevent them from resulting in a harmful outcome.

7.2 It is expected that the risk management plan will help change the most important risk or protective factors, reducing the potential for harmful outcomes to happen. Reviews examine the effectiveness of risk management strategies and recommend either their continuation because risk is being effectively managed or their improvement in order to manage risk more effectively or confidently. A risk management plan should recommend what those conducting future reviews need to look out for as evidence of improved or insufficient risk management.

7.3 The practitioner may sometimes be working alone, but in most situations the best assessments and the most effective decisions are made by a team of experienced practitioners in consultation with the service user and carer. Decisions and assessments should also be based on collaboration between health and social care agencies in hospitals and in the community. In some cases they should be based on collaboration between general and specialist services. Substance misuse care plans should be shared with commissioned drug services.

7.4 The judgements made in a risk assessment should be made in collaboration with others in the multidisciplinary team and with the service user and carer. In instances where the risk is unknown and/or seems high, the involvement of

senior colleagues to advise and support should be sought to enable safe decision-making. All discussions relating to decisions must be documented.

7.5 Multidisciplinary teams should think about the way that they communicate and work together as a team: effective decision-making is more likely in an atmosphere of openness and transparency, where all views are welcomed and responsibility is shared. Teams should consider the best way to resolve disagreements about a decision, to ensure that the best decisions are made and that team cohesion and safety is preserved. Teams should also be alert to group processes such as the pressure to conform and the potential for groups to recommend more risky courses of action than an individual would. When working across agencies, a common understanding and language should be established for the issues that will be addressed.

7.6 All practitioners should be clear about their role and responsibility for responding to, documenting and communicating any changes to a service user's risk, regardless of their direct involvement in that service user's care. Where there are a number of people involved in risk assessment, it should be clear as to who is responsible for ensuring completion and documentation of the assessment and subsequent management plan.

8.0 Positive/Therapeutic Risk Taking

8.1 DH (2009) what is positive risk management?

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

Positive risk management includes:

- Working with the service user to identify what is likely to work – and what is not;
- Paying attention to the views of carers and others around the service user when finally deciding a plan of action;
- Weighing up the potential costs and benefits of choosing one action over another;
- Being willing to take a decision that involves an element of risk because the potential positive benefits outweigh the risk;
- Developing plans and actions that support the positive potentials and priorities stated by the service user, and minimising the risks to the service user or others;
- Being clear to all involved about the potential benefits and the potential risks;
- Ensuring that the service user, carer and others who might be affected are fully informed of the decision, the reasons for it and the associated plans;
- All positive risk taking plans should be evaluated – this is particularly important for substance misuse service users.

NB: Clinicians are able to use the Therapeutic Risk Tool currently on the electronic patient record.

8.2 Good decision-making can be seen as supported decision-making. *Independence*, *Choice and Risk* states: "The governing principle behind good approaches to choice and risk is that people have the right to live their lives to the full as long as that does not stop others from doing the same. Fear of supporting people to take reasonable risks in their daily lives can prevent them from doing the things that most people take for granted. What needs to be considered is the consequence of an action and the likelihood of any harm from it. By taking account of the benefits in terms of independence, well-being and choice, it should be possible for a person to have a support plan which enables them to manage identified risks and to live their lives in ways which best suit them."

9.0 Specific Physical Health Risk Assessment

9.1 Clinical risk assessment and management is concerned with supporting the Physical, mental health and well-being of service users and should be reflected in in the electronic care record.

9.2 It is recognised that this is often provided in partnership with primary care. In some settings the main role of Trust clinical staff is in promoting and enabling access to mainstream health promotion, health screening and physical health services in primary and secondary care.

9.3 Staff are required as part of a holistic approach to care to:

- Promote awareness of the importance of physical health monitoring.
- Identify service users that may have a pre-existing physical health problem or medical condition
- Monitor service users' physical health problems which may change while under our care
- Identify deterioration or improvement to physical health of service users through effective communication and handover
- Improve service users' awareness and knowledge of the potential side effects of their medications and lifestyle behaviours which may affect their physical and mental health.
- Lack of awareness of previous use of alcohol, nicotine and other substances could adversely affect management of both physical and mental wellbeing.
- Raise awareness of accessing health promotion/ screening/ primary and secondary physical health care.
- Acknowledge that a service user may be too disturbed or may refuse physical examination or assessment and to ensure this is followed up and documented appropriately

9.4 Physical illness can have a significant impact on a person's mental health and conversely mental illness can seriously impact on a person's physical health:

- Prescribed medications are associated with important and sometimes serious physical side effects which can result in increased risk of disease e.g. cardiovascular disease.
- Service users with poor physical health and/or mental illness may be prone to the effects of poverty and poor quality life-style
- People with Learning Disabilities have a lower life expectancy compared to the general population. They have a high prevalence of general health problems, noted within the public health strategy for England (DH, 2010) which stated that people with learning disabilities have significantly poorer life expectancy than would be expected based on their socioeconomic status alone. Health problems include Cancer, Coronary Heart Disease, Respiratory Disease, Epilepsy, Dementia, Mental Illness, Osteoporosis, Poor Oral Health, Hypertension, Thyroid disorder, Diabetes
- Areas to be considered should include exercise, smoking cessation, information about alcohol and safe drinking, physical effects of substance misuse, dietary advice and sexual health.
- Some service users can be reluctant to visit their GP and are generally less likely to report physical problems or access preventive health services. It is therefore essential that the physical health of both in-patient users and community service users should be monitored and any identified health needs sign-posted or escalated to a relevant practitioner (e.g. GP). This needs to include those service users vulnerable to blood born virus, needle stick injuries, HIV, Hep B & C.

10.0 Collaborative Risk Assessment

10.1 The key to effective risk management is a good relationship between the service user and all those involved in providing her or his care.

10.2 Three-way collaboration between the service user, her or his carer and the care team should be based on trust in an atmosphere of openness and transparency.

10.3 If, for whatever reason, the service user is not involved in some element of risk management, this should be documented

10.4 NCISH (2018) suggests families and carers should have as much involvement as possible in the assessment process, including the opportunity to express their views on potential risk. The management plan should be collaboratively developed where possible. Communication with primary care may also be may also be helpful.

11.0 Assessment Following an Incident

11.1 A more detailed risk assessment or the updating of an existing risk assessment and the management plan is required following any incident or crisis which would include: deterioration in physical health, domestic abuse, suicide attempt or a violent incident. The assessment should generally include the following:

- Detailed reconstruction based on evidence of the incident from the service user, witnesses and / or the victim
- Details of trigger factors, e.g. use of alcohol or drugs, events such as contact with relatives/children, refused requests etc.
- Details of situational factors, e.g. the person living with vulnerable others or people whom the person has threatened before? Are relatives, carers available to offer support?
- Consideration of the service user's current feelings and attitude to past incidents
- Observations by staff of the service user's responses to stressful situations
- Review of what crisis or safety plans have helped and which need amending in light of any increased risk for example, confiscation of drugs and alcohol and in line with NCISH (2018) safe prescribing and other national guidance.

12.0 Sexual Safety in In-Patient Areas

See the Trust's Delivering Sexual Safety Policy for full guidance relating to providing care in single sex accommodation. Please note that whilst this section is specific to mental health, the principle of sexual safety is relevant for all individuals receiving care within LPT services.

12.1 National guidance states there is no acceptable justification for admitting a mental health service user to a mixed sex accommodation. However it also states that it may be acceptable (justifiable) in mental health and learning disabilities, if it is in the service user's best interests if they are at immediate risk of harm to themselves or others (i.e. in a clinical emergency) to admit a service user temporarily to a single, en-suite room intended for the opposite gender. In such cases, a full risk assessment must be carried out and complete safety, privacy and dignity maintained.

12.2 Service user risk assessment must be completed and recorded within the care records. Service user's safety, privacy and dignity must be maintained in line with trust policy.

12.3 Dependent upon the circumstance risk assessments may consider:
- Sexual orientation and sexual orientation preference
- Safeguarding history or risks related to self or others
- Sexual inhibition relating to mental health issues

12.4 Supporting sexual safety is central to a trauma-informed approach to care

13.0. Duties within the Organisation

13.1 **The Trust Board** has a legal responsibility for Trust policies and for ensuring that they are carried out effectively.

13.2 **Trust Board Sub-Committees** have the responsibility for the development of policies and protocols.

13.3 **The Accountable Executive** for this policy is the Medical Director and Director of Nursing. The Head of Nursing AMHLD is responsible for developing and reviewing the policy.

13.4 **Divisional Directors and Heads of Service** are responsible for ensuring that the policy and procedures are followed. They are also responsible for:

- escalating any operational or professional barriers to following the policy
- Investigating and implementing action where there is non-compliance with the requirements of the policy

13.5 **Clinical Staff**

Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered. Consent can be given orally and/ or in writing. Someone could also give non-verbal consent as long as they understand the treatment or care about to take place. Consent must be voluntary and informed and the person consenting must have the capacity to make the decision.

In the event that the service user's capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed and recorded. Someone with an impairment of or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following:

- Understand information about the decision
- Remember that information
- Use the information to make the decision
- Communicate the decision

In addition, **Individual Staff** are responsible for:

- Being aware of this policy and demonstrate compliance with it
- Undertaking the required mandatory or role specific training related to this policy
- Reporting incidents of self-harm and all safeguarding via the Trust electronic incident reporting system
- Ensuring risk assessment and management of vulnerable adults in areas where gender mixing occurs for therapeutic purposes
- Accepting responsibility for the professional standards of conduct set out by their professional body i.e. GMC, NMC or HCPC
- Working collaboratively with other professionals within their team, across the Trust and other agencies with respect to information sharing, decision-making and care planning in line with DH (2014) *Information sharing and suicide prevention-consensus statement*
- Working collaboratively with service users and carers throughout the clinical risk assessment process, using legislative guidance such as the Mental Capacity Act (2005) to support this as necessary

- Making thorough assessments of risk and to clearly document reasoned judgements
- Recording all clinical risk assessments and management plans within the Trust's electronic specialty specific risk assessment form.

13.6 **Managers and Team Leaders** are responsible for:

- Facilitating available training and of knowledge and implementation of this policy
- Ensuring that all clinical staff have access to role essential Clinical Risk Assessment and Management training and other relevant specialty training – for example, STORM training for all registered staff working with suicidality.
- Promotion of and facilitation of multi-disciplinary processes for risk decision making, i.e. within team meetings; handovers; ward rounds, supervision and peer meetings.

13.7 **Ward / Unit Managers and Matrons** are responsible for:

- Making staff aware of this policy, its content and how to access the policy
- Reporting of any non-compliance or concerns about any poor practice by staff to the relevant Head of Service

14.0 Training needs

There is a need to continue the Clinical Risk Assessment and Management 2 yearly role essential training already provided within the Trust Learning and Development Department. Registered staff from AMHLD, MHSOP and FYPC are expected to attend. The current training package has been revised in line with this policy where possible.

The course directory e-source link below will identify who the training applies to, delivery method, the update frequency, learning outcomes and a list of available dates to access the training.

A record of the event will be recorded on U-Learn.

The governance group responsible for monitoring the training is the Learning and Organisational Development Group reporting into the Strategic Workforce Group.

15.0. Monitoring Compliance and Effectiveness

The provisions outlined within this policy apply to all services providing mental health and learning disability care. They will be subject to evaluation and monitoring by the Clinical Effectiveness Group who will have responsibility for commissioning clinical audit and any other quality monitoring arrangements as required. This will include

monitoring responsibilities and duties, training, and the appraisal and approval (process to be developed under Phase 2 or policy development) of clinical risk assessment tools within the Trust.

Quarterly reports detailing indicators on the Quality Schedule will be completed for submission to commissioners via the Clinical Quality Review Group (CQRG).

Quarterly audit against Trust Risk Assessment Policy including standards for in-patient, service user and community.

Commented [UP4]: Line spacing 1.15

Ref	Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
	A. Number of staff completing risk assessment training	Trust Clinical Role Essential Compliance	Directorate & Corporate Monthly workforce reporting	Strategic Workforce Group	Monthly
	B. % of eligible service users with risk assessment in place against audit criteria	Local and annual care records audits	Directorate Quality & Safety	Heads of Service	Annual audit Local monthly care plan audit Bi-annual audit
	C. Number of service users supported to develop a safety plan	Local peer review/supervision	Directorate Quality & Safety	Heads of Service	Bi-annual audit
	D. Number of service users' circle of support documented	Local peer review/audit	Local audit	Heads of Service	Bi-annual audit
	E. Number of service users with a crisis/contingency plan in place detailing the support from services	Local peer review/supervision	Directorate Quality & Safety	Heads of Service	Bi-annual audit
	F. Number of service users with a crisis/contingency plan that details circle of support	Local peer review/supervision	Directorate Quality & Safety	Heads of Service	Bi-annual audit

16.0. Standards/Performance Indicators

TARGET/STANDARDS	KEY PERFORMANCE INDICATOR
CCG requirements as above	A to F are Quality Schedule Indicators
Compliance with relevant and associated NICE guidance	

17.0. References and Bibliography

The policy was drafted with reference to the following:

Department of Health (2007) *Independence, Choice and Risk: a Guide to Best Practice in Supported Decision Making*

Department of Health (2007) *Best Practice in Managing Risk* - Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services

National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) (2018) *The assessment of clinical risk in mental health services*. Manchester: University of Manchester

National Institute for Health and Care Excellence (NICE) (2011) *Self-harm in over 8s: long-term management. Clinical guideline*. London: NICE, 2011.

https://pathways.nice.org.uk/pathways/learning-disabilities-and-behaviour-that-challenges/assessing-behaviour-that-challenges-shown-by-people-with-learning-disabilities

https://pathways.nice.org.uk/pathways/autism-spectrum-disorder

National Institute for Health and Clinical Excellence. (2009). Borderline Personality Disorder: recognition and management. NICE clinical guidance 78.

DH (2014) Information sharing and suicide prevention - Consensus statement

NICE guideline [NG10] (2015) Violence and aggression: short-term management in mental health, health and community settings

Boardman J, Roberts G (2014) *Risk, safety and recovery*. (Implementing Recovery through Organisational Change Briefing). London: Centre for Mental Health.

DHSC & Agenda alliance (2018) The Women's Mental Health Taskforce

Appendix 1

Training Requirements

Training Needs Analysis

Training topic:	Clinical Risk Assessment and Management
Type of training: (see study leave policy)	☐ Mandatory (must be on mandatory training register) ✓ Role specific ☐ Personal development
Division(s) to which the training is applicable:	✓Adult Mental Health & Learning Disability Services ✓Community Health Services (MHSOP) ☐ Enabling Services ✓Families Young People Children ☐ Hosted Services
Staff groups who require the training:	All registered staff working in AMH/LD, FYPC and MHSOP services
Regularity of Update requirement:	2 yearly
Who is responsible for delivery of this training?	LPT Learning & Development
Have resources been identified?	On-going
Has a training plan been agreed?	
Where will completion of this training be recorded?	✓ ULearn ☐ Other (please specify)
How is this training going to be monitored?	

Appendix 2

The NHS Constitution

The NHS will provide a universal service for all based on clinical need, not ability to pay. The NHS will provide a comprehensive range of services

Shape its services around the needs and preferences of individual service users, their families and their carers	✓
Respond to different needs of different sectors of the population	✓
Work continuously to improve quality services and to minimise errors	✓
Support and value its staff	✓
Work together with others to ensure a seamless service for service users	✓
Help keep people healthy and work to reduce health inequalities	✓
Respect the confidentiality of individual service users and provide open access to information about services, treatment and performance	✓

Appendix 3

Stakeholders and Consultation

Key individuals involved in developing the document

Name	Designation
Heather Crozier	
Mat Williams	
Rachael Shaw	
John Hague	
Jenny Worsfold	
Girish Kunigiri	
Kelly Fenton	
Michelle Churchard	

Circulated to the following individuals for comment

Name	Designation	Name	Designation
Eldessouky Rachael		Dugmore Lois	
Shaw Rachael		Beacher Nikki	
Travis-Pruden Rachel		Galbraith Jules	
Hague John		Elcock Sue	
Bessant Tracy		Smith Jude	
Armitage Claire		Williams Lyn	
Darlow Heather		Churchard Michelle	
Ali Alvina		Perfect Helen	
Tombs Debbie		Rennie Deanne	
Worsfold Jennifer		Ward Tracy	
Moore Jackie		Fenton Kelly	
Crozier Heather		Martin Jane	
Moore Jacqueline		Compton Elizabeth	
Balan Nisha		Gangadharan Satheesh	
Noushad Fabida		Newton Jacqui	
Kunigiri Girish		Belshaw Laura	
Latham Sarah		Persand Jodhun	
Hiremath Avinash		Colledge Rebecca	
Henry Tracey		Acovski Vesna	
Cooke Paul		Palmer Annie	
O'Kelly Noel		Williams Mathew	
Salter Denis		Wyburn Sue	

Appendix 4

Due Regard Screening Template

Section 1	
Name of activity/proposal	Clinical risk and management
Date Screening commenced	
Directorate / Service carrying out the assessment	All LPT services
Name and role of person undertaking this Due Regard (Equality Analysis)	Ann Jackson (policy author) Interim Suicide Prevention Lead
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: This policy describes the process to be followed when assessing the clinical risk of a service user. It presents principles underpinning risk assessment across the Trust services	
OBJECTIVES: To provide skilled and safe standards of risk assessment and management for all service users; To provide guidance for all LPT clinical staff who are working with service users	

Section 2	
Protected Characteristic	**If the proposal/s have a positive or negative impact please give brief details**
Age	No negative impact
Disability	No negative impact
Gender reassignment	No negative impact
Marriage & Civil Partnership	No negative impact
Pregnancy & Maternity	No negative impact
Race	No negative impact
Religion and Belief	No negative impact
Sex	No negative impact
Sexual Orientation	No negative impact
Other equality groups?	None identified

Section 3			
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please <u>tick</u> appropriate box below.			
Yes		No	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	✓

Section 4			
If this proposal is low risk please give evidence or justification for how you reached this decision:			
The policy has been amended to provide greater involvement of service users and carers in risk assessment and management. It is not a new clinical process or a major service change.			
Signed by reviewer/assessor	Ann Jackson	**Date**	11.02.2020
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed		**Date**	

Appendix 5

BEST PRACTICE POINTS FOR EFFECTIVE RISK MANAGEMENT

(Department of Health, 2007)

Introduction

1. Best practice involves making decisions based on knowledge of the research evidence, knowledge of the individual service user and their social context, knowledge of the service user's own experience, and clinical judgement.

Fundamentals

2. Positive risk management as part of a carefully constructed plan is a required competence for all mental health practitioners.
3. Risk management should be conducted in a spirit of collaboration and based on a relationship between the service user and their carers that is as trusting as possible.
4. Risk management must be built on recognition of the service user's strengths and should emphasise recovery.
5. Risk management requires an organisational strategy as well as efforts by the individual practitioner.

Basic ideas in risk management

6. Risk management involves developing flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused.
7. Risk management should take into account that risk can be both general and specific, and that good management can reduce and prevent harm.
8. Knowledge and understanding of mental health legislation is an important component of risk management.
9. The risk management plan should include a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions to be taken by practitioners and the service user in response to crisis.
10. Where suitable tools are available, risk management should be based on assessment using the *structured clinical judgement approach*.
11. Risk assessment is integral to deciding on the most appropriate level of risk management and the right kind of intervention for a service user.

Working with service users and carers

12. All staff involved in risk management must be capable of demonstrating sensitivity and competence in relation to diversity in race, faith, age, gender, disability and sexual orientation.
13. Risk management must always be based on awareness of the capacity for the service user's risk level to change over time, and a recognition that each service user requires a consistent and individualised approach.

Individual practice and team working

14. Risk management plans should be developed by multidisciplinary and multi agency teams operating in an open, democratic and transparent culture that embraces reflective practice.
15. All staff involved in risk management should receive relevant training, which should be updated at least every three years.
16. A risk management plan is only as good as the time and effort put into communicating its findings to others.

Appendix 6

DATA PRIVACY IMPACT ASSESSMENT SCREENING

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy. **The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.**			
Name of Document:	**Clinical Risk Assessment and Management Policy**		
Completed by:	**Ann Jackson**		
Job title	**Interim Suicide Prevention**		**Date 11.02.2020**
Screening Questions		**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.		NO	
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.		NO	
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?		YES	**It is possible that improved sharing of information will increase disclosure to primary care, other LPT services, 3rd sector organisations providing direct care**
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?		NO	
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.		NO	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?		NO	**The intention is to improve involvement of the service user and carers in all aspects of decision-making about their care**
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.		NO	**All sharing of information should be justifiable. Consent to share should be obtained where possible. The duty to share must be considered as part of the clinical reasoning.**
8. Will the process require you to contact individuals in ways which they may find intrusive?		NO	**It is always possible that contact with services will be seen negatively and/or declined.**

If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.	
Data Privacy approval name:	**Sam Kirkland, Head of Data Privacy**
Date of approval	**12/02/2020**

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust