Essex Partnership University
NHS Foundation Trust

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Related Trust documents (to be read in conjunction with)
(Refer to the main body of the text)

- Adverse Incident Policy CP3
- Being Open Policy CP36
- Freedom of Information Act 2000 Policy CP25
- Ligature Risk Assessment and Management CP75
- Access to Health and Social Care Records Policy and Procedures
- Mental Capacity Act Deprivation of Liberty Safeguards Policy & Procedure
- Care Programme Approach (CPA) CLP 30 & Non CPA (Standard Care) Policy CLPG30
- Confidentiality and Information Sharing Protocol
- Policy for Consent to Examination or Treatment
- Discharge Policy
- Getting it Write guidance
- Guidelines for the Use of an Integrated Mental Health Information System
- (Paris)
- Incident Reporting Policy and Procedure
- In-Patient Leave Procedure and Policy
- In-Patient Observation and Engagement Policy
- Mandatory Training Matrix
- Manual Handling Policy and Procedure
- MAPPA Agreement
- National Mental Health Policy *A Vision for Change,* (DH&C, 2006).
- Operational Policy for the Mental Health Care Record and Information System (Paris)
- Patient Safety Environmental Standards
- Physical Health Care Policy
- Prevention and Management of Violence and Aggression at Work, Policy, Procedure and Guidelines
- Safeguarding Children Policy
- Safeguarding Adults Policy
- Searching of Patients and their Property Policy
- Therapeutic and Safe Interventions (TASI) in the Management of Aggression and Violence (Including de-escalation and 'time out' and post incident reviews and debriefing) Policy
- The Unified Written Health and Social Care Record Policy
- The Use of Medicines Policy and Procedures Handbook
- Transfer of Care Policy
- Ligature Risk Assessment and Management Policy and Procedure

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1 Introduction

1.1 Risk is viewed by the Trust as being dynamic and multi-dimensional, where the process of managing risk is not just focused on eliminating risk, but on realising potential benefits while reducing the likelihood of harms occurring as a result of taking risks, which fits well with a recovery approach to mental health.

1.2 This clinical policy promotes the safety of patients, carers and the public in relation to a range of clinical risks to self and others (including, self-harm, suicide, neglect, vulnerability and violence) whilst maximising the patients independence, social inclusion, and recovery.

1.3 The policy and associated guidelines identifies key principles for assessing and managing clinical risk with patients: promoting open and honest communication between all patients and staff; treating each patient as an individual, promoting choice, collaborative risk assessment and safety management and positive risk taking.

1.4 For patients subject to CPA the Trust's Care Programme Approach (CPA) CLP30 - CPA Policy.pdf and Non CPA Policy provides documentation and further information on the principles to be followed by staff with regard to the CPA process, which includes risk assessment and risk management.

1.5 Specific objectives are to:

- ensure that clinical risk is robustly managed including in the event of a patient safety incident, which may include a patient safety incident framework investigation or internal investigation as required.
- improve practice and/or systems and policies;
- minimise the risk of incidents and accidents occurring;
- adhere to practice and governance requirements.

1.6 A person's care must be based upon an individual assessment of needs and risks that is developed in a collaborative and therapeutic manner, in accordance with the Trust's CPA (CLP30) CLP30 - CPA Policy.pdf . The development of the therapeutic relationship is considered the most valuable tool in reaching decisions regarding care and treatment.

1.7 This clinical policy considers ongoing recommendations made by the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) https://www.hqip.org.uk/wp-content/uploads/2025/02/REF-553-Mental-Health-Clinical-Outcome-Review-NCISH-FINAL.pdf and the Health Quality Improvement Partnership (HQIP) Making Mental Health Care Safer (Annual Report and 20-year Review, October 2016) https://www.hqip.org.uk/wp-content/uploads/2018/02/making-mental-health-care-safer-annual-report-and-20-year-review.pdf

Forming an open and transparent therapeutic relationship with a service user and carer is critical to the process of developing a meaningful, collaborative risk assessment and risk safety plan. Professional skills and clinical judgement are key to

the success of this collaboration and require professionals to critically consider each patients individual circumstances and to develop interventions that are directly tailored to the individual.

1.8 Provides consistency with The assessment of clinical risk in mental health services (NCISH,2018) https://pure.manchester.ac.uk/ws/portalfiles/portal/77517990/REPORT_The_assessment_of_clinical_risk_in_mental_health_services.pdf

2 Scope

2.1 This policy is for all Trust and social care seconded staff, whether permanent or temporary, who are working with patients in EPUT Mental Health and Learning Disability Services, including Nursing Homes.

2.2 This policy should be used in conjunction with the associated Trust policies, procedures and protocols, covering aspects of care pathways and risk/safety management including CPA CLP30 - CPA Policy.pdf and ligature risk assessment and management CP75 - Ligature Environmental Risk Assessment and Management Policy

2.3 This policy and associated procedure endorses that working in partnership with patients, carers, families and colleagues to provide care and interventions that not only make a positive difference, but also do so in ways that respect and value diversity including age, race, culture, disability, gender, spirituality and sexuality.

2.4 To provide an agreed Trust-wide structure for assessing clinical risks presented by mental health primary and secondary care patients.

2.5 To embed Clinical Risk/Safety Management principles in day-to-day practice, in particular as part of the Care Programme Approach (CPA).

2.6 To enable staff to feel that risks can be identified and reduced by intervention and that tragedies are not always inevitable.

2.7 To enable staff to feel that the clinical management of risk can be strengthened.

3 Duties

3.1 ***Accountability for managing risk*:** Responsibility for managing clinical risk is one that is shared between the organisation, individual practitioners, patients and carers

3.2 **The Trust Board** is responsible for:

- Ensuring that the principles of this policy and procedure and other associated policies are implemented across the organisation;
- Ensuring necessary financial resources.

3.3 The Executive Director of Nursing will ensure:

- That this policy and procedure is embedded into clinical practice;
- The regular review and updating of this policy and procedure and in accordance with national guidance;
- The identification and implementation of training to meet educational needs arising from any relevant audits, reviews, reports and lessons learnt.

3.4 Directors and Service Managers will:

- Monitor the implementation and safety issues of this policy and procedure via monthly Quality meetings and in supervision, in accordance with the Trust's Policy on the Supervision of Staff.
- Co-ordinate the management of clinical risk within the Trust and identify risks in a clinical context. This includes designing and implementing steps to investigate those risks.
- Reports to the appropriate **Committee/Quality group** for decision making.
- Have a structured, robust approach to incident investigation which looks beyond immediate actions and assumed causes and identifies the contributory factors, latent conditions and root causes which lead to an incident occurring.

3.5 Address with relevant line managers clinical risk issues such as ligature risks in line with the Trust CP75 – Ligature Risk Assessment and Management Policy) CP75 - Ligature Environmental Risk Assessment and Management Policy

3.6 Managers /Team Leaders/ Matrons/ Sisters and other Persons in Charge will:

- Ensure the procedures and principles detailed within this policy are followed, to meet with all relevant guidance.

3.7 Individual:

- Must ensure that the principles contained within this policy and associated procedures are followed.
- Must adhere to Trust policy and procedures.

3.8 In order to achieve the aim of minimising and managing risk, the following mental health practice standards will be implemented. These include standards set by the Royal College of Psychiatrists, the Nursing and Midwifery Council and the Health Professional Council for Allied staff.

3.9 Practice Standards – all staff will:

- Receive a local induction and be briefed on appropriate procedures. Individuals will be required to sign to confirm that the following areas have been covered within their induction: clinical policies; record keeping policies; agreed clinical protocol for ECT; security training for secure services.
- Have clear lines of responsibility for the administrative maintenance of clinical records, including the filing of reports and records of treatment CP9 Record Management Policy CP9 Records Management Policy
- Have access to Trust's electronic systems. That will be fully documented: within Essex, systems will be in place to ensure ease of access and 24-hour availability of information for all clinical staff (CPA and Non CPA Policy); CLP30

- CPA Policy.pdf within Bedfordshire, systems will be in place to ensure that out of hours contact is documented as soon as is practicable.
- Have a clear understanding of the interface between health and social care. It is essential that care plans, support plans and risk management safety plans record the responsible agency and individual.

4 Definitions

4.1 Risk

Is defined as a risk is the effect of uncertainty which, should it occur, will impact either positively or negatively on those who use the service, staff, the organisation and/or the system. (NHS England 2024)

4.2 Clinical Risk

Is the likelihood or probability of an adverse and / or harmful outcome to an episode of mental illness or distress, or to a particular behaviour associated with that illness or distress.

4.3 Risk Assessment

Is the process of gathering information about a patient's mental state, behaviour, intentions, personal psychiatric history, including any history of physical, sexual or emotional abuse, and social situation, and forming a judgement about the likelihood or probability of an adverse and / or harmful outcome based upon that information.

4.4 Risk Management

Risk management is a process for the systematic identification, assessment, treatment, and management of risks. It takes into account many forms of guidance: risk assessment tools, internal policies and procedures, national guidance (NICE), outcomes from investigations, legislation and best practice.

4.5 Key legal and governance frameworks underpinning approaches to risk:

- *Duty of care* – organisations must maintain an appropriate standard of care in their work and not be negligent. Individuals who have mental capacity to make a decision, and choose voluntarily to live within a level of risk, are entitled to do so. In this case the law considers the person to have consented to the risk and there is thus no breach of duty of care and the organisation or individual cannot be considered negligent.
- *Human rights* – all public authorities and bodies have a duty not to act incompatibly with the European Convention of Human Rights. A balance needs to be struck between risk and the preservation of rights, especially when the person has capacity.
- *Health and safety* – There is a legal duty on all employers to ensure, as far as reasonably practicable, the health, safety and welfare of their employees as well as the health and safety of those who use services. Health and Safety legislation should not block reasonable activity.
- *Mental capacity* – this is concerned with a person's ability to make decisions for themselves and the principle enshrined in the Mental Capacity Act, 2005

https://assets.publishing.service.gov.uk/media/5f6cc6138fa8f541f6763295/Mental-capacity-act-code-of-practice.pdf is that they must be assumed to have capacity unless it is established that they do not. People with capacity may make unwise decisions. For those who lack capacity, decisions made on their behalf must be made in their best interests and with the least restriction.

- *Fluctuating mental states and dementia* – The choices and wishes of people with fluctuating mental states and dementia must be respected and their risk agreements monitored and reviewed regularly. In these circumstances it is important to engage with families and carers.
- *Safeguarding* –All patients are potentially at risk of safeguarding issues, but some groups of patients are particularly vulnerable to harm and exploitation.

Vulnerable groups include but are not limited to:

- vulnerable adults and children(where being vulnerable is defined as in need of special care, support, or protection because of age, disability, risk of abuse or neglect)
- those with learning disabilities and cognitive impairment, including those with dementia
- those with disabilities that rely on others to access their record
- those living away from home
- asylum seekers
- children in contact with the youth justice system
- victims of domestic abuse
- those who may be singled out due to their religion, ethnicity, gender identity or sexual orientation
- those who may be exposed to violent extremism
- those with serious mental health conditions

(NHS England 2024) https://www.england.nhs.uk/long-read/safeguarding/

4.6 Formulation

The application of clinical knowledge in predicting risks, identifying cues and interviewing, to bring together a formulation of risk.

4.7 Measurement

The use of an appropriate tool that helps predict the likelihood of a risk occurring, for example the 5 P's Psychological Formulation https://www.bmindfulpsychology.co.uk/post/understanding-psychological-formulation (2023)

4.8 Safety Plan

A safety plan is a prioritised written list of coping strategies and sources of support that patients can use during or preceding crises. The intent of safety planning is to provide a pre-determined list of potential coping strategies as well as a list of individuals or agencies that patients can contact in order to help them lower their imminent risk.

Key risk/safety management/safety planning activities are treatment (e.g. psychological care, medication), supervision (e.g. help with planning daily activities, setting restrictions on alcohol use or contact with unhelpful others, and so on), monitoring (i.e. identifying and looking out for early warning signs of an increase in risk, which would trigger treatment or supervision actions), and, if relevant, victim safety planning (e.g. helping a victim of domestic violence to make herself safe in the future and know better what to do in the event of perceived threat).

This approach is consistent with the Recovery Model, which views patients as collaborators in their treatment and fosters empowerment, hope, and individual potential.

4.9 Contingency Planning

Is the process of considering what might go wrong and pre-planning strategies to minimise adverse and /or harmful outcomes.

4.10 Crisis Management

A crisis plan setting out the action to be taken if the patient becomes ill, or their mental health is deteriorating rapidly.

Any early warning signs, relapse indicators, triggers, key events, other risk indicators are to be taken into account in a crisis and the nature of response to a crisis.

4.11 Protective Factor

Any circumstance, event, factor with the capacity to prevent or reduce the severity or likelihood of harm to self, or others.

5 Key Legal and Governance Frameworks Underpinning Approaches to Risk

5.1 Duty of care

Organisations must maintain an appropriate standard of care in their work and not be negligent. Individuals who have mental capacity to make a decision, and choose voluntarily to live within a level of risk, are entitled to do so. In this case the law considers the person to have consented to the risk and there is thus no breach of duty of care and the organisation or individual cannot be considered negligent.

5.2 Human rights

All public authorities and bodies have a duty not to act incompatibly with the European Convention of Human Rights. A balance needs to be struck between risk and the preservation of rights, especially when the person has capacity.

5.3 Health and safety

There is a legal duty on all employers to ensure, as far as reasonably practicable, the health, safety and welfare of their employees as well as the health and safety of those who use services. Health and Safety legislation should not block reasonable activity.

5.4 Mental capacity

This is concerned with a person's ability to make decisions for themselves and the principle enshrined in the Mental Capacity Act, 2005 is that they must be assumed to have capacity unless it is established that they do not. People with capacity may make unwise decisions. For those who lack capacity, decisions made on their behalf must be made in their best interests and with the least restriction.

5.5 Fluctuating mental states and dementia

The choices and wishes of people with fluctuating mental states and dementia must be respected and their risk agreements monitored and reviewed regularly. In these circumstances it is important to engage with families and carers.

5.6 Safeguarding

For people who are considered to be vulnerable there is a need to consider the factors of empowerment and safety, choice and risk. Practitioners need to consider when the need for protection overrides decisions to promote choice and empowerment (DH 2007b).

6 Clinical Risk Assessment and Safety Management Philosophy: Positive Risk / Safety Management as part of best practice

6.1 The Trust is committed to a philosophy of care that values each individual patient and seeks to maximise their well-being and potential for self-fulfilment. This can only be realised if patients are enabled and encouraged to take an active role in the ordering of their own lives.

6.2 Trust practitioners must encourage independence, self-reliance and competence in all patients whilst avoiding a punitive approach. Risks should be balanced against potential benefits using professional judgement and experience within the framework for practice set by the Trust and by their professional bodies and national guidance. .

6.3 Applies to all patients and their relatives and carers.

6.4 Caring for and treating someone living with mental health problems effectively and safely is not an exact science. Consequently, there is likely to remain some risk.

This means that some therapeutic risk-taking may be necessary and unavoidable if individual patients are to progress. Methodical assessment and active management of risks are key steps towards minimising harm and maximising benefit.

6.5 Properly-managed risk-taking based on sound risk assessment can enhance autonomy, empowerment, choice, participation and social inclusion for patients and their relatives and carers, whilst combating stigma. Thus, it is vital that all those caring for and treating people living with mental health problems:

- Identify and understand the risks for and from each individual;
- Evaluate and manage those risks within an agreed framework to the highest professional standards.

- Plan for contingencies and share that plan with patient, carers and all relevant colleagues;
- Clear and concise documentation relating to risks and share appropriately.

7 Accountability for Clinical Risk Assessment and Safety Management

7.1 Responsibility for managing clinical risk is one that is shared between the organisation, individual practitioners, patients and carers.

7.2 The Board will ensure that the following is provided:

- The Clinical Risk Assessment and Safety Management procedural are updated appropriately.
- Training in the assessment and management of risk;
- Training in the use of systems and techniques that support risk assessment and management;
- Safe environments from which services will be delivered; Ligature Risk Assessment and Management policy is updated appropriately.
- Necessary agreed flexible strategies and protocols to govern practice;
- Support staff in the assessment, management and minimisation of risk through supervision and support mechanisms;
- Ensure that adherence to relevant legislation and national guidance (including NICE) is audited and procedures are updated appropriately.

7.3 Professional registered practitioners are responsible for ensuring that they are adequately trained and skilled to carry out patient risk assessments and safety management plans and that they have fulfilled their training requirements.

Practitioners also have a duty to ensure they carry out patient risk assessments and management/safety planning as part of their professional practice, in line with the principles contained within this policy and the best available evidence.

7.4 Non-registered practitioners are responsible for supporting the implementation of the risk assessment and management/safety process, under the supervision of a registered practitioner.

7.5 All Registered Practitioners:

7.6 The Trust expects its practitioners in undertaking their duties with patients, relatives, carers and with the public to:

- Extend their vision of risk to include:
- The patient
- The patient’s family, friends and carers
- The public
- Children

- Trust staff colleagues
- Workers in other agencies

7.6.1 To also:

- Understand the concepts of risk and risk/safety management in clinical practice, and the Trust's philosophy of care;
- Have a methodical and evidence-based approach to the assessment and management of risk, using agreed tools and methodologies only, following a structured clinical judgement approach;
- Understand risk as including environmental, psychological and physical aspects;
- Identify, assess, positively manage and, where possible, minimise risk and increase safety for all, whilst undertaking assessment.
- Formulate an initial risk assessment within 24 hours and review a risk assessment at least every 6 months and more frequently where risks are fluctuating. Inpatient risk assessment should be at least weekly.
- For Mental Health / Learning Disability in-patient services and nursing homes, the risk assessment must be reviewed as considered necessary by the clinical team, which may be as frequent as daily, with a formal evaluation of care being undertaken at least once each week, at the patients care review meeting / ward round. This will be coordinated by the named nurse.
- For community Mental Health / Learning Disability (MH/LD) services, risk assessment must be reviewed as considered necessary by the clinical team however the care coordinator is responsible for ensuring reviews are undertaken, as set out within the Care Programme Approach (CPA) and Non CPA Policy and associated guidelines at a minimum of 6 monthly CPA reviews. For non-CPA patients the allocated caseworker is responsible for facilitating reviews as considered necessary by the clinical team but at least once a year.
- Risk assessment is a dynamic process and should be under continuous review.
- Risk/safety management must always be based on awareness of the capacity for the patient's risk level to change over time and recognition that each patient requires a consistent and individualised approach.
- Be aware of Trust and national guidance on capacity and consent for all patients, irrespective of age. If the person's capacity is in question, then undertake an assessment in line with Assessment of Mental Capacity Policy.
- Weigh the risk of harm to the patient or to others against the potential benefits in relation to patient empowerment and act accordingly.
- Take no action that contributes to or increases risk;
- Plan for contingencies dependent upon the risk assessment.
- Record information about risk and share that information with all who may need it. A risk/safety management plan is only as good as the time and effort put in to communicating its findings to others;
- Adhere strictly to the guidance and direction given in this document.

8 Clinical Risk / Safety Management and the Care Programme Approach (CPA)

8.1 Clinical risk assessment and safety management is part of the CPA process; however the principles apply to those under 'non CPA'. All patients' risks should be assessed.

8.2 This involves identifying specific interventions based on an individual's support needs, taking into account safety and risk issues.

8.3 A CPA care plan is drawn up, preferably with the patient/carer to meet the patient's needs. This forms the recorded safety management plan and should include the following:

- A summary of all risks identified;
- Identify and document any unmet needs;
- Actions to be taken to manage risk in a safety plan by practitioners, patients and/or carers.

8.4 A generic risk assessment must be completed prior to every patient transfer to determine the appropriate mode of transport required for example, secure vehicle, ambulance, taxi and private cars. The risk assessment must include number of staff required for escort and band to effectively and safely carry out the role of escort. Detailed information on this can be found in the Trust Clinical Guide for Discharge and Transfer (CG24).

9 Trust Standards for Clinical Risk Assessment & Safety Management / Care Plans

9.1 Individual practitioners must always use their professional judgement about individual patients' needs to decide finally whether, when and how clinical risk should be assessed. However, as general guidance, the Trust's view is that clinical risk must be assessed in situations where:

a. A patient comes into the service for the first time in any treatment episode;

b. A patient's mental or physical state changes significantly;

c. A patient's social situation changes significantly including homelessness or change of accommodation, unemployment, change of support network, divorce

or breakdown of established relationships and periods of significant contact with other agencies such as police, courts and housing agencies;

d. Pre-determined indicators of relapse or risk (identified in previous risk assessments) are apparent;

e. A patient loses contact with the service in an unplanned way;

f. The care and or treatment offered to a patient changes significantly, including transfer between services /Trusts particularly heightens risks moving from inpatient to community care setting.

9.2 Risk assessment must also be reviewed when the practitioner delivering the majority of the care changes.

9.3 In addition to assessment of risk in response to the events detailed above clinical risk must be reassessed / reviewed routinely (but at intervals not greater than 6 months for community MH/LD services, two weekly for secure services patients and weekly ward-round for inpatients).

9.4 If a patient is admitted or transferred to an in-patient facility for assessment/ treatment, the frequency of review should increase proportionately with the risks presented with that treatment episode. This review should involve the Multi-Disciplinary Team (MDT) and any other specialist or professional input as appropriate.

9.5 It is also important that risk assessments acknowledge the reduction of risk when this occurs and the factors which have helped the patient in reducing their risk. This will serve as useful information in the formulation of future risk/safety management plans.

9.6 The Trust's minimum requirement for risk assessment is the completion of the screening tool and recording of patients' electronic records or (for services in West Essex, North Essex, Mid Essex) Risk Assessment Module on Paris (with the exception of substance misuse services, who use the Theseus database and Integrated Drug Treatment System (IDTS) Her Majesty Prison (HMP) / Young Offender Institution (YOI) Chelmsford and the Marginalised and Vulnerable Adult Service (MVA) who use SystmOne).

9.7 The Trust's minimum requirement for a CPA review is the completion of all CPA tools including the care plan and recording in the patient's records that a CPA review has been done.

10 Assessing Risk and Compiling a Safety Management Plan / Care Plan

10.1 Guidelines for good documentation and structured approach to decision making are in Appendix 1 and 2.

11 Managing Challenging / Enduring Risk

11.1 It is inevitable that assessment of clinical risk in people with mental illness or distress will sometimes uncover a level of risk that may be outside the capacity of the assessing practitioner and / or their colleagues to manage, e.g. an identified unmet need or gap in service provision.

11.2 In managing difficult risk, it is the assessing practitioner's responsibility to:

a. Inform his/her line manager as soon as possible;

b. Take reasonable steps to minimise any risk to him/herself, or members of the public where this may be the case;

c. Seek assistance and or guidance from practitioner colleagues and the multi-disciplinary team;

d. Identify other agencies and individuals that may be able to manage and minimise the risk posed and inform them of the risk as a matter of urgency;

e. Identify other agencies and individuals that may themselves be at risk from the patient in question and inform them as a matter of urgency;

f. Ensure that the action taken is documented electronically and appropriately, shared with individuals and relevant agencies, in accordance with local agreements and practice guidance.

g. Discuss caseload management in relation to risk/safety regularly in mandatory supervision

11.3 It is imperative when a difficult-to-manage risk is identified that consideration be given to holding a professionals meeting.

11.4 The practitioner's line manager must:

a. Inform the Director for the area or service concerned about the risk identified and the action taken;

b. Identify and attempt to resolve any equipment, skills, or staffing deficits that exacerbate the risk;

c. Mobilise the resources of the Trust and other agencies and individuals to manage and minimise the risk if possible. This may include authorising emergency

treatment outside the Trust, authorising the temporary employment of extra staff and or involving the police or other emergency services.

11.5 Self Harm in people aged 8 and over.

a. Guidance for the longer-term psychological treatment and management of self-harm in people aged 8 and over are in NICE Guidance CG16 and CG133.

b. Staff working with people who self harm should make reference to NICE Guidance CG133 research recommendations which can be downloaded from:

c. https://www.nice.org.uk/guidance/cg133/chapter/2-research-recommendations

d. This guideline covers the longer-term psychological treatment and management of self-harm in people aged 8 and over. It aims to improve the quality of care and support for people who self harm and covers both single and recurrent episodes of self-harm

e. The recommendations in NICE CG133 include :

I. General principles of care
II. Primary care
III. Psychosocial assessment in community mental health services and other specialist mental health settings: integrated and comprehensive assessment of needs and risks
IV. Longer-term treatment and management of self-harm
V. Treating associated mental health conditions.

12 Risk Assessment Tools

12.1 A clinical risk assessment tool is a contribution to an overall view of the risks presented by a particular patient at a particular time. Completing a risk assessment tool in the company of the patient is not all that is required. The results of a tool-based assessment must always be combined with information on relevant aspects of the patient's life and current situation, including his or her sources of strength – or protective factors. The assessment is complete only when the practitioner develops a formulation based on the assessment findings and then develops a risk/safety management plan covering treatment, supervision and monitoring options. Most risk assessment tools don't help evaluate the role of protective factors or to derive formulations or risk/safety management plans.

a. **Clinical judgement** is integral to interpreting scores attained in any tool due to the range of influential variables (i.e. cultural considerations, understanding, and stigma).

b. Risk assessment tools should not be used on their own, but as part of a comprehensive assessment at points of key decision making.

c. Risk assessment tools are not diagnostic and their utility remains founded on excellent clinical practice.

12.2 Practitioners with responsibility for risk assessment may also use one of the recognised and agreed, validated risk assessment tools.

12.3 This should be clearly documented in patients' electronic CPA records or Paris / Mobius / Theseus / System1 and the completed tool scanned into the patient's record as well as a copy given to the patient and family/carer.

12.4 The following tools are recognised for use in the Trust. Some tools require specialist knowledge/training to implement/interpret correctly. It is the responsibility of the practitioner to ensure that only validated tools are used and their training in the use of specific tools is up to date:

12.5 For services in West Essex, North Essex, Mid Essex:

- Sainsbury Centre for Mental Health Tool for Clinical Risk Assessment
- Beck Scales/Inventories – Hopelessness Scale, Depression Inventory - require specialist training and competency prior to use. (*copyright laws – ensure tools are purchased by the service)*
- Suicide Ideation Scale, Suicide Intent Scale
- Edinburgh Post Natal Depression Scale
- Worthing Weighted Risk Indicator
- Assessment Tools for Risk of Violence – HCR20 and Hare's Psychopathy Checklists - require specialist training and competency prior to use. (*copyright laws – ensure tools are purchased by the service)*
- Short CANE (Camberwell Assessment of Need for the Elderly)
- Pressure Ulcers/Sores – Waterlow Pressure Sore Risk Assessment,
- Assessment of Manual Handling Needs
- Risk of Sexual Violence (RSV) (*copyright laws – ensure tools are purchased by the service)*
- Transport Risk Assessment Checklist for Staff Using Private Cars to Transport Clients
- Structured Assessment of Violence Risk in Youth (SAVRY)
- Drug Use Screening Tool (DUST)
- Mother and Baby Assessment (from Mother and Baby Facilities Operational Policy)
- Falls Risk Assessment Screening Tool (from Prevention and Management of Falls Policy)

- Domestic Abuse, stalking, harassment and honour based violence (DASH) 2009 Risk Model for (MARAC – multi agency risk assessment committee)

12.6 For services in Bedfordshire, South East Essex and South West Essex:

12.6.1 Inpatient services/Nursing Homes

- Assessment forms on Mobius, Electronic Records. *(On Mobius - Form 2.1)*
- Trust Needs and Risk Assessment Tools Form 2.1, 2.2 and risk section in Form 16.10. *(On Mobius and on InPut)*
- Malnutrition Universal Scoring Tool (MUST). *(Form 3.5 on Mobius and on InPut)*
- Waterlow Tool. *(On Mobius and InPut (3.33-06)*
- Falls Risk Assessment Tool. *(On Mobius under 2.25-06 and on InPut under Policy/Guideline CG58 Appendix2)*
- Manual Handling Risk Assessment and Care Plan. *(On Mobius, 10.16-02 on InPut under RMPG 03)*
- Infection risk on admission / transfer. *(On Mobius 1.6-00)*
- VTE risk assessment. (*On Mobius 3.16-00 / InPut Form 3.12*)
- The Trust Handover tool. (*On InPut Policy/Guideline CG20 Appendix 1*)

12.6.2 Secure Services:

- Secure Services risk assessment. (*on Mobius 2.31-00 Risk profile*)
- Risk of Sexual Violence Protocol (RSVP) – require specialist training and competency prior to use. (*copyright laws – ensure tools are purchased by the service*)
- Stalking Assessment Manual (SAM) - require specialist training and competency prior to use. (*copyright laws - ensure tools are purchased by the service*)
- Historical & Clinical Risk – 20, 3rd edition (HCR-20) - require specialist training and competency prior to use. *(copyright laws – ensure tools are purchased by the service) [on Mobius under 2.28]*

12.6.3 Learning Disability Services:

- Specific Task Risk Assessment Tool. (*Service specific - kept in team system drive)*
- Initial Risk Assessment Checklist. (*Service specific - kept in team system drive)*
- Learning Disability Therapists Referring Screening Tool. (*2.8-04 on Mobius)*
- CPA documents.

12.6.4 Community Mental Health Teams and Crisis Resolution & Home Treatment

- ECPA Assessment forms including risk component on the care plan. (on *Mobius 10.7-01)*
- Trust Needs and Risk Assessment Tools Form 1.2, 2.1, 2.2 and risk section in Form 16.10. (on *Mobius 10.7-01)*
- Health of the Nation Outcome Scales Payment by Result (HoNOS. PbR.). *(On Live cycle only)*

- Cardio Metabolic Proforma 3-2:01CP which is on Trust intranet. *(on Mobius)*
- Geriatric Depression Scale - commonly used in older people's services. *(on Mobius)*
- Montreal Cognitive Assessment - commonly used in older people's services. *(on Mobius)*
- The Domestic Abuse Stalking, Harassment & Honour Based Violence Risk Assessment (DASH). *(on InPut – with Safeguarding tools)*

12.6.5 Early Intervention services

- EI suicide risk assessment tool which is used occasionally. *(Service specific - not kept on the system)*
- Sad Personas (Sex, Age, Depression, Previous Attempt, Excess Alcohol or Substance Use, Rational thinking, Social support, Organised plan, No Spouse, Sickness). *(Service specific – not kept on the system)*
- Positive and Negative Syndrome Scale (PANSS). *(Service specific - not kept on the system)*
- Comprehensive Assessment of at risk mental state (CAARMS) – requires specialist training to use it. (*Service specific - not on the system)*
- Process of Recovery Questionnaire (QPR) required by Access and Waiting Time (AWT) standards. *(Service specific - kept in team system drive)*
- Dialogue – required by AWT standards. (*Service specific - kept in team system drive)*
- Safety plans used where there is concern. (*Service specific - kept in team system drive)*

12.6.6 Psychology Department:

- Risk Assessment and Management Psychology Services (RAMPS) – used in CMHTs. [*On Mobius (2.25-03) and InPut]*

12.6.7 (NHS TALKING THERAPIES)

- NHS TALKING THERAPIES Risk Assessment form. (*Service specific - kept in team system drive)*
- NHS TALKING THERAPIES Risk Management form. (*Service specific - kept in team system drive)*

12.7 Use of other specialist tools not included in this procedure is prohibited, unless the tool has been approved by the Trust's Clinical Governance & Quality Sub-Committee.

12.8 Any new tools should be submitted for recognition approval by the Clinical Governance & Quality Sub-Committee including the rationale for changing or adding to the above list of validated tools in use in the Trust.

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13 Safeguarding

13.1 All practitioners should be aware of their responsibilities for Safeguarding and be able to fulfil their obligations required as detailed in the Trust's Safeguarding Policies which are located on the Trust intranet.
https://input.eput.nhs.uk/DocumentCentre/Policies/Forms/AllItems.aspx?RootFolder=%2fDocumentCentre%2fPolicies%2f00%20%2d%20Local%20%26%20Operational%20Policies%2fSafeguarding&FolderCTID=0x01010083222C5BB86FC44B944ABE50AC22BCEF0021A3F7266481464BBE38557B9A032F30

14 Confidentiality and Sharing Protocols

14.1 Trust staff have a responsibility to make themselves familiar with the Trust policies and procedures which are on the Trust intranet and these will support staff in making the right decision when to disclose and when not to disclose patient information.

14.2 The following documents can be useful to staff when assessing and managing clinical risk:

- Information Sharing & Consent Policy and Procedure
- Access to Health and Social Care Records Policy and Procedures
- The Unified Written Health and Social Care Record Policy
- Confidentiality and Information Sharing Protocol
- Information Sharing Protocol/Memorandum of Understanding agreed between Police, Probation Service, Social Services and Mental Health Trusts in Essex (MAPPA)
- Whole Essex Information Sharing (WEIS) (internet only)

14.3 All staff are required to protect confidential information concerning patients/clients in line with the Trust Data Protection and Confidentiality Policy CP59, and Records Management Policy CP9.

15 Monitoring and Audit

15.1 All inpatient wards are required to undertake regular audits of the care plan and risk assessments for patients as follows:

15.1.1 For non-secure inpatient wards: To audit 10 patients each month using the Perfect Ward Record Keeping audit

15.1.2 For secure services: To audit 5 patients per quarter using the Perfect Ward Record Keeping audit

This is a brief audit covering basic essential information: Care plan present in notes

a. Evidence of carer involvement

b. Information in patient's care plan is linked to identified risk

c. Care plan signed by staff

d. Care plan signed by patient

e. Care plan recorded in patient's records on Paris/Mobius as shared

f. Care plan review date

g. Risk assessment completed and dated

h. Risk management plan in place

15.2 The Quality Care Plan and Risk Assessment Audit consisting of set of standards (covering care planning, risk assessments, physical health, crisis plans, consent & capacity, carers and service user involvement in care planning) against which the inpatient units and community teams are to audit monthly. The audits are completed by ward managers in the team with generally a sample of five records audited per month (less than where agreed).

15.3 As the care plan and risk assessment audit is self-reported, a spot check process to be implemented whereby a few team's results from different services are spot checked at random by the quality or audit team. This is to ensure that team reported results are accurate and independently verified so that additional support can be provided to teams requiring it.

15.4 Community mental health team managers are required to undertake checks of care plan and risk assessment during monthly supervision with staff.

16 Mandatory Record-Keeping and Training

16.1 The Trust's primary recording instrument is the electronic health record which is accessible at all Trust sites via the Trust's network to those authorised professional staff, that must access and use the system to record patient details and all clinical activity.

16.2 For substance misuse/HMP/YOI Chelmsford (IDTS)/MVA, the electronic recording systems are Theseus and SystmOne respectively. To ensure we minimise risk to patients, Trust staff and the public, all clinical risk assessments and risk/safety management plans for a patient must be recorded in full detail on the electronic systems, providing 24 hour electronic access to the information for other Trust professional staff who may need access to the patient's risk assessment/safety plan;

this is particularly pertinent to out of regular working hours, weekends and Access and Assessment teams:

- For any substance misuse/IDTS/MVA information on patients this can be obtained during office hours by calling the services directly.
- All substance misuse admin staff has access to 'read only' Paris in order to obtain details of patient risk assessments/safety plans.
- Outside of regular hours, all Access and Assessment Teams have 'read only' access to Theseus in order to obtain patient risk/safety plan information.
- IDTS Chelmsford offers 24 hour access via telephone for any patient risk/safety plan information.

16.3 All staff will receive training in line with the Trust Induction and Mandatory Policy. Team managers who feel they need specific training in relation to clinical risk should contact the Workforce Development Education and Training department.

16.4 All clinical staff to undertake an eLearning ligature risk assessment training.

16.5 Staff who work in Secure Services will receive yearly mandatory security training as face to face and online training (OLM) in line with their work area protocols.

16.6 Clinical staff providing clinical care should have a basic understanding of personalised care planning and the importance of involving patients in their process. Detailed training will be provided as required for clinicians delivering care i.e. registered nurses, therapists, doctors and any other clinicians who develop care plans. Ward

Managers/Sisters / Team Leaders will provide coaching and support to new team members to ensure effective, high quality personalised care plans.

16.7 The Assessment and Management of Clinical Risk training programme will include the following:

- Principle types of risks
- Indicators of risk
- The process of assessing and managing risk
- Conducting risk assessment through a collaborative approach, involving different sources of information
- Communication between professionals, patients, agencies, and with the carer(s)
- The use of approved risk assessment tools and documentation
- Positive risk taking
- Reference to a series of associated trust clinical policies and procedures.

16.8 In addition, the Trust will provide educational programmes on the following:

- Mental Health Act
- Restrictive practices.
- Staff training needs have been identified as part of a Trust-wide training needs analysis, as summarised below:

Training Needs Analysis	Staff Category	Delivery Method	Duration	Update Interval
Clinical Risk for registered mental health professionals	Nursing staff, Medical staff, Social care, Allied health – therapists Psychologists	Class	All day	Every three years
Clinical Risk for unregistered mental health nursing assistant staff	Nursing support workers, unregistered assistant staff	Class	Half day	Every three years

16.9 The Workforce Development and Training Department will report monthly on compliance levels for mandatory training.

16.10 The Workforce Development and Training Department will report monthly on compliance levels for mandatory training.

16.11 Managers are responsible for ensuring staff who are approaching update deadlines and those that are out of date take action to undertake training as soon as possible.

16.12 A service manager will be able to check which training has been undertaken by a member of staff through the Trust online Training Tracking List, which will be validated to confirm training has taken place.

17 Approval and implementation

17.1 All policies and guidelines will be approved by the Clinical Governance & Quality Committee, which is the specialist group with the authority to approve local documents. These will then be forwarded to the Policy team for submission and ratification by the Policy Oversight and Ratification Group.

17.2 It is the author's responsibility to inform Clinical Governance & Quality Committee of the approved documents when they are uploaded to the Trust's Intranet.

18 Preliminary equality analysis

18.1 The Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

(Refer to appendix 3)

19 References

Health Quality Improvement Partnership (HQIP) (2016) Making Mental Health Care Safer (Annual Report and 20-year Review. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. https://www.hqip.org.uk/wp-content/uploads/2018/02/making-mental-health-care-safer-annual-report-and-20-year-review.pdf

Mental Capacity Act, 2005
https://assets.publishing.service.gov.uk/media/5f6cc6138fa8f541f6763295/Mental-capacity-act-code-of-practice.pdf

National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH 2024)https://www.hqip.org.uk/wp-content/uploads/2025/02/REF-553-Mental-Health-Clinical-Outcome-Review-NCISH-FINAL.pdf

The assessment of clinical risk in mental health services (NCISH 2018) https://pure.manchester.ac.uk/ws/portalfiles/portal/77517990/REPORT_The_assessment_of_clinical_risk_in_mental_health_services.pdf

The Power of Understanding Psychological Formulation: A Guide for Mental Health Professionals (2024) https://www.bmindfulpsychology.co.uk/post/understanding-psychological-formulation

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Appendix 1: Aide Memoire for Assessing Risk & Compiling a Safety Management Plan

A Structured Approach to Risk Decision Making

[From: Morgan, S. (2010) Making good risk decisions in mental health and social care. *Health Care Risk Report*, 16(5), 16-17.]

- Is the required decision *reactive* (to what the person is doing or plans to do) or *proactive* (to be initiated more by the service providers)?
- Is the Patient's understanding and experiences of risk clearly understood (it may be very different from the professional's assessment of the risks)?
- Is the carer's (as appropriate) understanding and experiences of risk clearly understood (it may at times contradict that of the Patient)?
- What behaviours are identified as being risky in relation to the specific circumstances of the decision (i.e. what is your risk assessment)?
- What is the clear definition of the risk that is being taken (the emphasis is on the detail)? Have you considered the other options that are available?
- What are the positive desired *outcomes* to be achieved through taking the specific risk (short &/or long-term)?
- What *strengths* can be identified and used in pursuit of a positive risk-taking plan (including personal qualities, abilities, achievements, resources, motivations and wishes)?
- Are there any clearly defined stages to be accounted for in a risk-taking plan?
- What are the potential pitfalls, and estimated likelihood of them occurring? Have you thought of these in relation to the other appropriate options? [Important for demonstrating that alternatives have been evaluated in the risk decision-making process]
- What are the potential safety nets (inc. early warning signs, crisis and contingency plans)?
- Has this course of action been tried before, and if so what were the outcomes?
- If tried before, how was the plan managed and what can now be done differently (what needs to, and can change)?
- What is your *formulation* from all the above information (clearly weighing up the different alternatives considered and presenting the reasoned decision that has been taken, with appropriate reasons why you have not taken the alternative decision)?
- Who agrees (and importantly disagrees) with the plan?
- How will progress of the plan be monitored?
- When will the plan be reviewed?

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Appendix 2: Guidelines for Good Documentation

Guidelines for Good Documentation

The first question is who are you recording information for (the Trust, you & colleagues, the Patients)?

- Write in language everyone can understand… jargon only serves to exclude people, so if it has to be used add an explanation
- Less use of abbreviations, or clearly reference what they mean
- History is a collaborative process… avoiding making assumptions based on history that are not substantiated in the present… be clear about the relative weight being given to historical information as it links to the present
- Quality chronology of events (an event diary) is about the accuracy of dates and the detail of information (inc. creating a timeline electronically)
- Recency and frequency of events could reflect urgency
- Include a specific focus on individual's strengths and protective factors
- Reference decisions against something!
- Focus on *safety* rather than risk (i.e. we assess the risks in order to increase a person's safety)

Remember

Risk/safety management works best when a Patient's strengths are recognised alongside the possible problems they might encounter and with which they might present. Every time *a problem* is identified, a strategy should be suggested and explored, *building on the strengths* of the Patient. The emphasis should always be on a recovery approach and on the next stage in developing the Patient's ability to cope when they are feeling vulnerable or as if difficult demands are being placed on them.

Appendix 3: Initial Equality Impact Assessment analysis

This assessment relates to: CLP28 Clinical Risk Assessment and Safety Management Policy
(Please tick all that apply)
Link to Full Equality Impact Assessment can be found in InPut Here:

Does this Policy/Service/Function effect one group less or more favourably than another on the basis of:	Yes / No	What / where is the evidence / reasoning to suggest this?
Race, Ethnic Origins, Nationality (including traveling communities)	Yes	No mention of how risk formulation, planning and assessment may require interpreters, availability of clinical information in specific languages to ensure shared understanding between clinicians, families and patients
Sex (Based on Biological Sex; Male, Female or Intersex)	No	
Age	No	
Sexual Orientation Including the LGBTQ+ Community	No	
People who are Married or are in a Civil Partnership	No	
People who are Pregnant or are on Maternity / Paternity Leave	Yes	How does the policy and guidelines get shared with our staff who may be on maternity or paternity leave so understanding is fully shared
People who are Transgender / who have had gender reassignment treatments As well as gender minority groups	No	
Religion, Belief or Culture Including an absence of belief	Yes	I would expect a strengths focus and bio psycho social risk formulation to be explicit that religion, belief and culture needs to impact on risk formulation.

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Does this Policy/Service/Function effect one group less or more favourably than another on the basis of:	Yes / No	What / where is the evidence / reasoning to suggest this?
Disability / Mental, Neurological or Physical health conditions Including Learning Disabilities	Yes	No mention of the importance of accessible information, easy read options to ensure collaborative partnerships in risk formulation assessment and management.
Other Marginalised or Minority Groups Carers, Low Income Families, people without a fixed abode or currently living in sheltered accommodation.		

Guidance on Completing this Document

This screening tool asks for evidence to ensure that these considerations are done in collaboration with groups that may be affected. Listed below are the ways that this evidence can be gathered to support this decision:

- Reviews with Staff who may be impacted by these changes
- Service User / Carer feedback or focus groups
- Guidance from national organisations (CQC / NHS Employers)
- The Equality and Inclusion Hub (on the Staff Intranet)
- Input from Staff Equality Networks or the Equality Advisor
- Reviewing this against good practice in other NHS Trust

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Initial Screening Question	Response
If you have identified no negative impacts, then please explain how you reached that decision. please provide / attach reference to any reasoning or evidence that supports this: (Nature of policy, service or function, reviews, surveys, feedback, service user or staff data)	
Is there a need for additional consultation? (Such as with external organisations, operational leads, patients, carers or voluntary sector)	As the new policy is being developed it would useful to share with networks within the Trust and VCSE partners, also to ensure alignment with PSIRF principles and EPUTs plan
Can we reduce any negative impacts by taking different actions or by making accommodations to this proposed Policy / Service / Function?	This EIA needs to be used to inform the full review of the policy in March 2024
Is there any way any positive impacts to certain communities could be built upon or improved to benefit all protected characteristic groups?	
If you have identified any negative impacts, are there reasons why these are valid, legal and/or justifiable?	

Please complete this document and send a copy to EPUT's Compliance, Assurance & Risk Assistant / Trust Policy Controller) at [I/S] **as part of the Approval Process, if this proposal / policy etc. has no positive or negative impacts on protected characteristic groups, a Full Equality Impact Assessment will not need to be completed**

To be completed by the Trust Policy Controller					
Is a Full Equality Impact Assessment Required for this Policy, Service or Function?	**Yes**		**No**	**x**	
Name:	**Glenn Westrop**				
Date:	**23rd November 2023**				