Essex Partnership University
NHS Foundation Trust

Secure Services Structured Clinical Risk Assessments Protocol

PROCEDURE NUMBER:	**SSOP63**
VERSION NUMBER:	2.1
AUTHORS:	**Specialist Services Policy and Procedures Group**
CONSULTATION GROUPS:	• Psychology Department, Secure Services • Consultant Forensic Psychiatrists • Secure Services Senior Management Group
IMPLEMENTATION DATE:	December 2017
AMENDMENT DATE(S)	
LAST REVIEW DATE:	December 2023
NEXT REVIEW DATE:	December 2026
APPROVAL BY SECURE SERVICE SENIOR MANAGEMENT TEAM:	Approved by SSMG on January 2024

The Director responsible for monitoring and reviewing this procedure is:

The Director of Specialist Services

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Secure Services Structured Clinical Risk Assessments Protocol

CONTENTS	
Title	**Section No.**

SCOPE		
Services	**Applicable**	**Comments**
Secure Services Essex	✓	
Secure Services Bedfordshire & Luton	✓	

Secure Services Structured Clinical Risk Assessments Protocol

1.0 INTRODUCTION

1.1 The Clinical Guidelines for the Assessment and Management of Clinical Risk (CG28) promotes the safety of patients, carers and the public through risk assessment. CG28 highlights the importance of ratified risk assessment tools being used to assess risk.

1.2 Within Secure Services, this includes the use of structured professional judgement risk assessments such as the HCR-20 Version 3 (HCR-20), Risk of Sexual Violence Protocol (RSVP), and other specialist (and validated) tools deemed appropriate for the specific risk being assessed. Such tools allow an evidence-based approach to assessing and reviewing service user's risks; this contributes to informing appropriate management strategies in line with least restrictive practice.

1.3 The main aim of this protocol is to establish an agreed process by which professionals can work together to complete risk assessments reports in order for targets to be achieved, and to maintain standards of good practice in relation to the content of the risk assessments. This will include outlining responsibilities of different groups of professionals.

2.0 SCOPE

2.1 This procedure relates to the completion of structured risk assessments within all four secure services within the Trust namely Brockfield House, Robin Pinto Unit, Wood Lea Clinic and Edward House. Therefore, all appropriately trained professionals involved in completing risk assessments should be aware of this policy.

3.0 DEFINITIONS

3.1 Commonly used terms throughout this document are defined as follows:

3.1.1 The HCR-20 is a Structured Risk assessment tool commonly used within forensic units to formulate the future risk of violence.

3.1.2 Structured Professional Judgement: this is an approach that attempts to bridge the gap between actuarial and unstructured clinical approaches to risk assessment (Douglas & Kropp, 2002[1]). Such instruments are deployed with a multi-disciplinary clinical approach inclusive of different professional groups and clinicians.

[1] Douglas, K. S., & Kropp, P. R. (2002). A prevention-based paradigm for violence risk assessment: Clinical and research applications. *Criminal Justice & Behaviour, 29,*617–658.

4.0 RESPONSIBLE PERSONNEL

4.1 The following professionals or groups of professionals have responsibilities as follows:

4.1.1 The Secure Services Psychology Department has responsibilities for completing the initial three month risk assessment and discharge risk assessment, monitoring of compliance for assigned ward and/or service users; providing data to ward managers for quarterly monitoring and supporting non-psychology staff, in completing risk assessments when involved.

4.1.2 The Head of Psychology for Secure Services will be responsible for monitoring compliance, as well as addressing any on-going issues with non-compliance.

4.1.3 HCR-20 assessments are stored in the patients' medical record (MOBIUS/PARIS) and are available to all staff who require access.

4.1.4 Multi-disciplinary Team (MDT) Members (Consultant Forensic Psychiatrists; Specialist Trainee/Junior Doctor; Social Workers; Occupational Therapists; Nursing Keyworker) will provide input into HCR-20 reports for patients whose care plans they are involved in. This may involve writing some sections of reports for 6 monthly updates, with the support/supervision of an appropriate member of the Psychology Department where necessary. On other occasions, this may involve verbal contributions only. The supervising, qualified, psychologist will always remain responsible for the completion of the final document.

5.0 TARGET TO BE ADDRESSED

5.1 The current Commissioning target addresses the completion of violence risk assessments as follows:

- All service users should have an initial HCR-20 risk assessment completed within the first three months of their admission to any secure service ward;
- Following this first report, HCR-20s should be updated at six-monthly intervals.

5.2 These targets are monitored on a quarterly basis across the Secure Services.

5.3 Data regarding completion is requested by Ward Managers and then submitted accordingly in order for performance to be monitored.

5.4 Due to the varied nature of risk which can be presented by service users, the most appropriate risk assessment will be used to formulate this, and inform risk management plans. In cases where there is no evidence of violence to others, a brief HCR-20 will be completed and signpost the reader to another more applicable structured professional judgement risk assessment (for example, the RSVP).

5.5 **Initial three month HCR-20 assessment**:

5.5.1 Secure Services Psychology Department will take responsibility for writing the initial risk assessment. This includes gathering relevant information from the patient's electronic record, liaising with other professionals etc. This phase is thus psychology led, informed by available information and input from other professionals as appropriate.

5.5.2 During this process, it may be decided that additional risk factors are required. This will allow a thorough understanding of the service users offending behaviour, as well as to appropriately formulate and understand risk. For example, for female service users, the Female Additional Manual (de Vogel *et al,* 2014[2]) should be included within the HCR-20. Additional risk factors will be highlighted in the 'other considerations' sections of reports where applicable.

5.6 Update risk assessment report at 6 monthly intervals:

5.6.1 In order for reports to be updated, other appropriately trained professionals from the MDT will be identified and allocated by the MDT to take responsibility for updating specific sections. This will continue to be supervised and monitored overall by the allocated Qualified Psychologist, who shall retain overall responsibility for the completion of the final revision document. The aim of this is to provide support and develop the skills of other professionals, whilst achieving organisational targets.

5.6.2 At the point of updating a report, all risk factors should be reviewed and any new or additional information which has been gathered since admission should be included. This might include a fuller review of a service user's history where it may not have been possible to complete it all previously, for various reasons, or because another past incident of violence has come to light or has occurred since the last evaluation.

5.6.3 The formulation, risk scenarios and case management sections should also be reviewed and updated in order to reflect any changes to the care / risk management plans for the next six month period.

5.6.4 From here up until discharge, the updating of reports will be ***supervised*** and ***monitored*** by an appropriate member of the Psychology Department. Responsibility for the updating of reports may lie with other appropriately trained professional/s, as stated in 5.6.1 above, but overall responsibility will remain with the Qualified Psychologist.

[2] de Vogel, V., de Vries Robbé, M., van Kalmthout, W., and Place, C. (2014) *Female Additional Manual (FAM, English edition) Additional guidelines to the HCR-20v3 for assessing risk for violence in women.* Van der Hoeven Kliniek.

5.7 Discharge and Transfer risk assessments:

5.7.1 At the point when a service user is being transferred or discharged, it is appropriate to update the relevant risk assessment. This should be undertaken by the allocated Qualified Psychologist.

5.7.2 Discharge risk assessments should focus on the plans made by the MDT with the service user, and preferably refer to the knowledge and skills developed by the service user which now mitigate their risk of recidivism. This should assist in presenting a summary of how the service user has addressed their risk during admission, and highlight the areas where support is required going forwards.

5.7.3 Where possible, this risk assessment should be completed collaboratively with the service user. The service users input should be clearly highlighted within the document, for example by using *italic font* to indicate their views.

5.7.4 At this point, responsibility for the completion of the risk assessment document will transfer back to the allocated Qualified Psychologist, but again is likely to be informed by other professionals, as well as the service user themselves. The involvement of the service user may be particularly helpful when considering risk scenarios and management.

5.7.5 The completed document should then be shared with the receiving service, and when this has been completed it should be uploaded to the service user's electronic medical record.

5.7.6 Patients who are discharged to the Specialist Community Forensic Team (SCFT) will have their HCR-20 updated every 6 months. Responsibility for updating the risk assessment will rest with the team's psychologist who will undertake the update with the assistance of the MDT.

6.0 COMPLETION PROCESS FOR RISK ASSESSMENTS

6.1 The allocated psychologist for each ward should initiate a discussion with their MDT regarding how all professionals will contribute to risk assessments. This may include, but is not limited to, separate discussions before or during CPA meetings, ward rounds, etc.

6.2 This will provide an opportunity for each team to identify a way of working in order to meet the Organisational target.

6.3 In the event that not all professionals are able to contribute to risk assessments, this process should be reviewed and an alternative identified, in order to prevent non-compliance.

7.0 USE AND AVAILABILITY OF RISK ASSESSMENTS

Use of risk assessments:

7.1 In accordance with CG28, risk assessments referred to within this procedure should be used to assist professionals to take positive risks (paragraph 3.4 of CG28). In order for risk assessments to contribute to such decision making processes, they should be reviewed regularly and referred to at the point of decision making within the MDT. This may, for example, include making decisions with regard to a service user's leave within and/or outside the hospital.

Availability of risk assessments:

7.2 After a risk assessment has been completed and signed by professionals who have inputted into the report, the document will be uploaded to the services Electronic Patient Record (EPR).

7.3 It is most important that a copy of the completed assessment should also be stored on a shared drive, which is accessible to members of the individual MDT. This will assist with information sharing, as well as gathering audit data, and can be referred to and used as a starting document for subsequent six monthly updates.

7.4 Thus when reports are due to be updated, the Microsoft Word copy in the shared drive can be copied and amended. For professionals using Mobius, risk assessments will be 'trending forms' and so can be updated in workbaskets and then, when finalised, uploaded directly onto the EPR.

Transfer/discharge risk assessments:

7.5 At the point of transfer/discharge, a copy of the updated risk assessment should be shared with the receiving service if that service does not have access to the patient's EPR.

8.0 REVIEW AND MONITORING

8.1 Monitoring will be carried out by Secure Services Psychology Department.

8.2 Each ward's compliance with the commissioning target will be monitored by the qualified psychologist in order to ensure that it will be met. Compliance of each part of the service will also be reviewed within the Secure Services Psychology Department team meetings, as well as in individual line management supervision.

Non-compliance:

8.3 Instances of non-compliance, should they occur, with failure to meet the commissioning targets should be initially addressed within line management supervision. Ideally, this will be identified early enough not to impact on the target as progress in this regard will be closely monitored as aforementioned.

8.4 Supervision should be used to formulate a plan of how the non-compliance will

be resolved and subsequently monitored going forwards.

8.5 Continued non-compliance will become a performance management issue, and further instances may lead to disciplinary procedures being initiated.

9.0 ASSOCIATED TRUST DOCUMENTS

9.1 Policy for the Supervision of Staff (CP26)

9.2 Clinical Guidelines for the Assessment and Management of Clinical Risk (CG28)

9.3 Care Programme Approach (CPA) Policy and Handbook (CLP30)

END