ADULT MENTAL HEALTH SERVICES

CLINICAL RISK ASSESSMENT & MANAGEMENT POLICY AND PROCEDURE AMH

Solent NHS Trust policies can only be considered to be valid and up-to-date if viewed on the intranet. Please visit the intranet for the latest version.

Purpose of Agreement	This policy provides a system for ensuring that a thorough and consistently high standard is applied to the assessment of clinical risk in Solent NHS Trust in order that the risks identified can be managed effectively, fairly and safely, in line with the overarching Trust Risk Management Framework
Document Type	X Policy SOP Guideline
Reference Number	Solent NHST/Policy/ AMH004
Version	V11
Name of Approving Committees/Groups	Mental Health Service Line Board Policy Steering Group Clinical Executive Group
Operational Date	March 2021
Document Review Date	March 2024
Document Sponsor (Name & Job Title)	Chief Nurse
Document Manager (Name & Job Title)	Quality and Standards Lead AMH
Document developed in consultation with	AMH managers through Governance group
Intranet Location	Business Zone / Policies, SOPs and Clinical Guidelines
Website Location	Publication Scheme / Policies and Procedures
Keywords (for website/intranet uploading)	Risk, Risk Assessment, Clinical Risk, Mental Health, Policy, AMH004

Amendments Summary:

Amend No	Issued	Page	Subject	Action Date
1		6	Statement addition re triangulation of information	
2		9	Audit statement added	
3		14	Statement re medication risk	
4		18	Link to safeguarding policy	
5		20	Addition of statement re documentation and communication	
6			Appendix 1,3, 5 and 6 new additions	
7	Version 11	13	Statement re risk history review on discharge planning added	
8		26	Poorly controlled symptomology added to dynamic risk factors	

Review Log:

Version Number	Review Date	Lead Name	Ratification Process	Notes
8	02/12/15	Richard Webb	To go through policy group and then Assurance Committee	This was a review of existing policy.
9	April 2020	Kim Thorne	Approved as part of the Covid-19 review of policies	Amends made to policy content to bring up to date, insertion of overarching Emergency Statement and expiry extended to March 2021.
10	October 2020	Kim Thorne	MH Clinical Governance, MH Board, Policy Steering Group, Clinical Executive Group	
11	March 2022	Ben Martin-Lihou	Changes approved via Policy Steering Group chair's action – approval via MH Clinical Governance	Change made: statements added following Serious Incident Investigation (details outlined in table above)

EXECUTIVE SUMMARY

This policy is concerned with the assessment and management of clinical risk in all Adult Mental Health settings within Solent NHS Trust. This policy sets the standards expected for all staff to follow in respect of the assessment of all known risks and how management plans must be formulated and recorded within patient records. This policy recognises that risk assessment is a dynamic and continuous process undertaken by the highly skilled practitioners that are employed within the Mental Health Service, through the use of observation, triangulation of evidence, relevant risk tools, shared decision making and clinical judgement.

This policy acknowledges that risk is part of everyday life and it is never possible to remove all aspects of risk from staff and patient's experience. Staff have the responsibility to reduce risk as far as is reasonably practical, considering the components of positive risk taking, and ensure that risk management is an integral part of every patient's plan of care. To achieve this it is essential that patients, family and carers, other care providers and organisations are involved as routine in the assessment and management of risk and receive good quality communication from the service on how risk is being managed.

Whilst risk assessment is a continuous process, risk assessments and management plans are to be developed and/or reviewed whenever new information becomes available, and at the following opportunities:

a) **N**ew assessment of a new or previously known service user
b) **E**scalation of risk, or social factors impacting on risk (i.e. housing issues)
c) **R**eview at CPA or review of or change in circumstances
d) **D**ischarge from the ward, CRHT or a community team

There are also different opportunities outlined within the policy for specific teams. The assessment of all service user needs must take account of protected characteristics, this is equally important in risk assessment and management as at any other opportunity.

This document applies to all directly and indirectly employed clinical staff within Solent NHS Trust and other persons working within the organisation in line with the Solent NHS Trust Equality statement. This document is also to be followed by all agency, locum staff and those working for another organisation on behalf of Solent NHS Trust.

Table of Contents

Clinical Risk Assessment & Management Policy and Procedure AMH

Staff are expected to adhere to the processes and procedures detailed within this policy. During times of national or 'Gold command' emergency Solent NHS Trust may seek to suspend elements of this policy in order to appropriately respond to a critical situation and enable staff to continue to work in a way that protects patient and staff safety. In such cases Quality Impact assessments will be completed for process changes being put in place across the organisation. The QIA will require sign off by the Solent NHS Ethics Panel, which is convened at such times, and is chaired by either the Chief Nurse or Chief Medical Officer. Once approved at Ethics panel, these changes will be logged, and the names/numbers of policies affected will be noted in the Trust wide risk associated with emergency situations. This sign off should include a start date for amendments and a review date or step-down date when normal policy and procedures will resume

1. INTRODUCTION & PURPOSE

1.1 Purpose

1.1.1 Solent NHS Trust (referred to in this document as Solent) is committed to the safety and wellbeing of service users, staff and all people visiting or working within the Trust.

1.1.2 Clinical risk assessment and management is part of the Trust's overall risk management framework and is fundamental to maintaining safety.

1.1.3 This policy defines the overarching standards to be employed within all local services relating to the risk assessment and management of individual service users. It should be used by all staff involved in the assessment and management of clinical risk.

1.1.4 This policy should be considered in the context of other Trust policies, particularly those on supportive observation and the prevention and management of aggression and health and safety.

1.1.5 This policy aims to promote the safety of service users, 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 service user's independence, social inclusion, and recovery.

1.1.6 This policy provides staff with guidance and a set of principles and risk tools to support the provision of up-to-date, high quality clinical risk assessment.

1.1.7 This policy aims to promote the safety of service users, carers and the public in relation to a range of clinical settings where risks to service users and others (including, accidents (e.g. falls), self-harm, suicide, neglect, vulnerability and violence) whilst maximising the service user's independence, rehabilitation, social inclusion, and recovery.

1.1.8 The Trust endorses positive risk management and will support any risk-related decision if it is:

- Considered – carefully, collaboratively, based upon the best information available and conforming with relevant guidelines/best evidence
- Recorded – In accordance with the tool/structured prompt and record system in place and that identified risks are reflected in overall treatment/care/risk management plans
- Communicated – the relevant people are involved/informed in a timely way

1.1.9 This policy details expected standards of practice derived from:

- The Community Mental Health Framework for Adults and older Adults, DH, 2019
- The assessment of clinical risk in mental health services. National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). Manchester: University of Manchester, 2018.
- 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, DH, June 2007, updated March 2009.
- Violence and aggression: short-term management in mental health, health and community settings, National Institute for Health and Care Excellence, 2015
- Independence, choice and risk: a guide to best practice in supported decision making, DH, May 2007.
- It also takes in to account a range of other relevant guidance (See Reference, Bibliography and Cross-references).
- Rabone & Anor v Pennine Care NHS Trust [2012]

1.1.10 This policy aims to ensure risk assessments and management plans are based on a holistic view of the person as an individual and not on stereotypes, and accounts for the diverse nature of our service users and the different contexts in which risk is assessed.

1.2 Definitions

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

1.2.2 Risk relates to an event happening with potentially harmful or beneficial outcomes for self/and or others and covers a number of aspects (DH, March 2009).

- How likely it is the event will occur.
- How soon it is expected to occur.
- How severe/beneficial the outcome will be if it does occur.

Note: A beneficial outcome may for example be increased independence.

1.2.3 Risk assessment is an estimate of each of these aspects based on the gathering of historical and current information through the processes of reviewing case notes, engagement, communication, investigation, and observation: and identification of specific risk factors of relevance to the individual and the circumstances in which they may occur. NB: It is important that all sources of risk information eg Mental Health Act statutory documentation, is Triangulated - **Triangulation** facilitates validation of data through cross verification from more than two sources.

1.2.4 A risk factor is any circumstance, condition, or characteristic thought to have a relationship to the potential to harm oneself or others.

1.2.5 A protective factor is any circumstance, event, factor or other consideration thought to prevent or reduce the severity or likelihood of harm to self or others.

1.2.6 Risk formulation is a narrative account of how identified risk and protective factors combine to increase and decrease risk.

1.2.7 Risk management involves developing strategies aimed at preventing identified potential adverse events from occurring, and/or minimising the harm caused.

1.2.8 Positive risk management means recognising that the risk of negative outcomes can never be eliminated and that management plans inevitably must include decisions that carry some risk. Positive risk management requires balancing both the service user's quality of life and plans for recovery, and the safety needs of the service user, their carers, their family and the public.

1.2.9 Positive risk-taking is the weighing up of potential benefits and harms of exercising one choice of action over another, identifying the potential risks involved, and developing plans that reflect positive potentials and choices of the individual.

1.2.10 Reasonable Risk: Independence Choice and Risk (DoH 2007) provides the following helpful definition: "Balance and proportionality are vital considerations in encouraging responsible decision making. Reasonable risk is about striking a balance in empowering people who use services to make choices, ensuring that the person has all the information tailored to their specific needs, in the appropriate form, to make their decision.

1.2.11 Risk 'tools' refer to both published, standardised, empirically based, assessments and to 'bespoke' assessments, based on clinical and empirically based knowledge.

1.2.12 The structured clinical (or professional) judgement involves making a judgement about risk based on combining:

Assessment of presence of risk and protective factors derived from research.

- Clinical experience and knowledge
- Knowledge of the service user
- The service user and carer's own view and experience

1.3 Principles

1.3.1 Risk is an everyday component of the life of any individual and it is not possible to remove all risk from the experience of service users or staff, but healthcare staff have a duty to protect patients as far as is 'reasonably practical' (NPSA, 2007) and must avoid any unnecessary risk.

1.3.2 Risk management is not just the responsibility of individuals and this policy is part of the Trust's wider risk management framework to support individuals and teams in their assessment and management of clinical risk. It is an on-going/dynamic process.

1.3.3 Risk assessment and management should be based on physical, procedural and relational security (DH, March 2010).

Note: Relational security is the knowledge and understanding staff have of a service user and of the physical and social environment and the translation of that information into appropriate responses and care.

1.3.4 Risk assessment and management are an integral part of a service user's care and should be undertaken in the wider context of a holistic and recovery approach to care planning.

1.3.5 Risk assessments and risk management plans should involve:

- Engagement and the building of a trusting relationship with the service user and care
- Collaboration with the service user and carer
- Discussion and consultation with all members of the multidisciplinary team, private services, and other agencies involved in the service user's care
- Structured clinical (or professional) judgement supported by the best evidence and information available in order that the best decision is made at the time
- A stepped approach and use of agreed risk tools for each care group and service area reflecting the level of detail or speciality required.

1.3.6 Risk tools provide a means to systematically identify potential risk and protective factors. These should be used more as an aid to formulation and risk management planning than a means of prediction.

1.3.7 All risk assessments, formulations management plans, and discussions should be clearly documented and communicated to all involved and relevant parties, including the service user, carer, and other agencies if appropriate.

1.3.8 All qualified and appropriately trained staff should be proactive in information sharing with other agencies if where to do so enhances the safety of the service user and/or the safety of the public, even if the service user withholds consent.

1.3.9 Risk is best managed through a positive risk management and risk-taking approach (Department of Health, 2009).

1.3.10 Risk assessment and management plans should be developed and reviewed in line with local Care Programme Approach policy, and whenever new relevant information becomes available or there is a change in the service user's clinical presentation or circumstances including:

e) **N**ew assessment of a new or previously known service user
f) **E**scalation of risk, or social factors impacting on risk (i.e. housing issues)
g) **R**eview at CPA or review of or change in circumstances
h) **D**ischarge from the ward, CRHT or a community team

1.3.11 Staff must demonstrate an awareness and sensitivity in relation to the nine protected characteristics (Equality Act 2010) (ethnicity, religion and belief, age, sex, gender reassignment, marriage and civil partnership, pregnancy and maternity, disability and sexual orientation),

1.3.12 All clinical staff must demonstrate an effective level of competence in the assessment and management of risk, monitored by attendance at training and clinical supervision.

1.3.13 Auditing risk assessment and management practice and standards are an essential part of maintaining an effective, efficient and fair service. Audits will be undertaken, using agreed audit tools (see Appendix 7) and at intervals as determined by the service.

2. SCOPE & DEFINITIONS

2.1 This policy applies to all service users and carers regardless of context.

2.2 An awareness of this policy and the importance and principles of good clinical risk assessment and management is relevant for all health and social care staff working in Solent NHS Trust, this policy however is aimed at Adult Mental Health services.

2.3 The standards of practice and training set out in this policy, however, specifically applies to all clinical practitioners working in the Trust who are required to assess and manage clinical risks whilst carrying out their duties, including temporary or bank staff.

3. POLICY STATEMENT

3.1 This policy cannot cover all eventualities and practitioners are expected to exercise their clinical judgement, experience and discretion in applying this policy and managing risk. When the optimum course of action cannot be taken, the optimum plan should be documented, along with reasons for not taking it, and details of the alternative plan.

3.2 In view of the historical stereotypical risk bias associated with BAME people and some religious groups, for example heightened risk of violence in BAME groups, and potential stereotypical views regarding older people being of lower risk of violence in view of age or associated frailty, risk assessments and management plans will be based on a holistic view of the person and not on stereotypes.

3.3 All service users will at the point of first contact or assessment have a risk assessment and formulation documented in the relevant part of the electronic records system. This should include consideration of any known historical risk factors and an initial management plan if indicated. Other risk assessments may be indicated through this assessment i.e. CAMS, HCR-20 and this is to be raised at the MDT for allocation with an available trained assessor/practitioner. Service users who pose high risk/s and/or require complex management will have a multidisciplinary/multi- agency formulation and risk management plan.

3.4 Comprehensive risk assessment and management plans can be completed by a single practitioner but where there is multidisciplinary (MDT) or multiagency input into the assessment or plan, this must be documented. Where an MDT risk assessment and management plan is indicated, this must reflect input from all involved and relevant parties. All risk assessments will be completed within the timescales agreed for the service area and reviewed in line with key CPA milestones.

3.5 The risk assessment must be undertaken in collaboration with the service user, carer or family where appropriate, and when this has not been possible, the rationale for not doing so must be clearly documented.

3.6 When risks are identified risk management plans must include, but not limited to, accessing support during crisis and out of hour's periods.

3.7 The risk assessment and management plan must be signed (or the author/s clearly documented if electronically held), dated, and involvement of the service user and carer/s/other agencies recorded.

3.8 The risk assessment and management plan must be communicated to all relevant parties in accordance with the Data Protection, Security and Confidentiality Policy, Trust Guidance on Managing Confidentiality, and the Health and Social Care (Safety and Quality) Act 2015 Particular consideration must be given to any identified risk/s to a named person and carers.

3.9 The risk assessment and management plan must be documented in the agreed section of the electronic Clinical Record System.

3.10 All new staff will be made aware of this policy during their local induction and all clinical staff will be trained in the principles, standards, and use of risk tools relevant to their care group and/or service area. Staff are expected to attend Trust Risk training provided by the Trust as appropriate.

3.11 The standards for clinical risk assessment and management practice will be audited at least yearly.

3.12 Auditing risk assessment and management practice and standards are an essential part of maintaining an effective, efficient and fair service. Audit tool appendix 7.

4. ROLES AND RESPONSIBILITIES

4.1 All staff

An awareness of the importance of clinical risk assessment and management is the responsibility of all staff and everyone should make it their business to be at all times aware that service users will potentially present a range of risk behaviours, using common sense and acting accordingly if necessary, and ensuring they report any issues or incidents of relevance to their line manager.

4.2 Chief Executive

4.2.1 The Chief Executive has overall responsibility for all aspects of Risk Management and internal control within the Trust and overall responsibility to ensure systems and resources are in place to ensure effective clinical risk assessment and management processes, as outlined in this policy, and a culture of organisational support, openness, fairness, and learning.

4.3 Chief Nurse

4.3.1 The Chief Nurse has responsibility for the strategic development of risk management and implementation of organisational risk management, of which clinical risk is a major part

4.4 Chief Operating Officer (Portsmouth)

4.4.1 Overall management of clinical risk assessment and management is the responsibility of the COO, including the implementation of the policy, training, and monitoring.

4.4.2 The COO also has responsibility for organisational learning and continuous improvement in clinical risk management, through ensuring the learning arising from the Trust-wide Integrated Action Plans

4.5 Quality and Standards Lead

4.5.1 The Quality and Professional Standards Lead will be responsible for reviewing the policy and procedure in liaison with professional groups and Head of Patient Safety, in line with the trust polices on policy approval document

4.6 Clinical Director and Operations Director

4.6.1 Responsible for ensuring implementation of this policy, high quality service provision, provision of training and ensuring learning is applied following adverse incidents.

4.7 Service Managers and Modern Matrons

4.7.1 Responsible for ensuring the appropriate risk tools and documentation are accessible and used. Responsible for ensuring systems are in place to resolve disagreements or conflicts regarding risk assessment and risk management plans within or between teams.

4.8 Service Line Clinical Governance Groups

4.8.1 Responsible for ensuring up-to-date knowledge of relevant national and local policy developments and best practice regarding clinical risk management in their field. Key areas are:

4.8.2 Contribute to the development of standards and training, in line with developments in national and local policy, guidance and research.

4.8.3 Ensure all clinical staff access appropriate supervision and training, and continuously improve their practice.

4.8.4 Having clear and robust governance and management structures to assist and ensure effective risk management at divisional level

4.8.5 Having local groups in place and managing their risks associated with their services and activities, which report to the Service Line Governance Group

4.8.6 Responsible for ensuring up-to-date knowledge of relevant national and local policy developments and best practice regarding clinical risk management are in place within their services.

4.8.7 Ensure that contribution to the development of standards and training, in line with developments in national and local policy, guidance and research.

4.8.8 Identification and management of risks, through local risk registers

4.8.9 Monitor the risks, incidents, claims and complaints within their division, ensuring that action plans are developed and progressed.

4.8.10 Having and utilising processes for escalation of risks to the Trust Operational Risk Register and Executive Directors, as per the Trust Risk Management Framework.

4.9 Team Leaders

4.9.1 Responsible for ensuring all staff are aware of the principles and procedures detailed in this policy and monitor whether staff have received the appropriate training.

4.9.2 Responsibility for ensuring all staff have regular supervision as per Trust Policy, are properly supported, and receive annual appraisals and a Personal Development Plan.

4.9.3 Responsibility for ensuring Team members are confident and competent in undertaking clinical risk management and address any developmental needs.

4.9.4 Responsible for monitoring/auditing whether the appropriate 'tools' and documentation are used and identify action plan where required.

4.9.5 Team leaders have responsibility for ensuring multi-disciplinary discussion and input into risk assessment and management where this is appropriate.

4.10 Clinical Staff

4.10.1 All clinical staff have a legal and a professional 'duty of care' which requires that they exercise a reasonable standard of care while doing something (or possibly omitting to do something) that could foreseeably harm others.

4.10.2 All qualified clinical staff with a responsibility for carrying out formal risk assessment and management plans are accountable for their actions or omissions within the sphere of their professional practice.

4.10.3 Clinical staff has a responsibility to attend training and supervision arranged and must seek advice if unsure about their own or other people's decision/s regarding risk assessment and management.

4.10.4 Clinical staff has a responsibility to inform their manager if they have not had training or supervision.

4.11 Care Co-ordinators

4.11.1 In addition to the clinical staff duties above, responsible for monitoring agreed risk management plan, and joint working across service areas/agencies when relevant.

4.12 Consultant Psychiatrists

4.12.1 As a requirement of the NPSA 2009 Rapid Response Report, Consultant Psychiatrists must be directly involved in all clinical decision making in relation to service users who are identified as posing a risk to a child.

5. PROCEDURE

5.1 The process of undertaking an assessment of risk and management plan should reflect the principles outlined in Section 1.3 of this policy.

5.2 The risk assessment and management plan should take account of the legislation arising

from the Mental Capacity Act (2005), the Mental Health Act (2007) and their principles, and the Deprivation of Liberty principles

5.3 First or renewed contact with services

5.3.1 Every service user will have a risk assessment and documented formulation using Trust agreed tools and Trust documentation, specific to the care group or service area. This will be undertaken by a suitably qualified or trained practitioner and be used to identify potential risk and protective factors and enable an initial formulation and management plan.

5.3.2 Where an escalation in risk has been noted at review which leads to a significant change in management plan for the individual, communication with Primary Care provider is required to take place to outline changes in plan and reasons concerning this. This should be via verbal communication to Primary Care and this to be recorded in the clinical records.

5.4 Mental Health Act Assessments

5.4.1 The assessment of risk to self and others is a key component of the Mental Health Act (MHA) assessment.

5.5 Those who require further assessment

5.5.1 Service users with identified high risk behaviours requiring further assessment to ensure effective management, will have a Multi-disciplinary (MDT)/Multi-agency (or equivalent inpatient MDT review) review of their risks (building on the comprehensive screening assessment) and MDT/Multiagency input regarding the risk management plan. This will include all service users admitted into acute or secure and forensic inpatient care, and Recovery Teams.

5.6 Routine or on-going Management of Severe Mental Disorder

5.6.1 Service users under CPA or the equivalent must have a review of their risk/s and management plan at each key CPA milestone. A comprehensive risk assessment appropriate to community care is contained within the assessment process and provides for a Community Plan of Care (CPoC).

5.6.2 Risk assessments must be reviewed whenever there is a change in the service user's clinical presentation/circumstances, admission to and discharge from inpatient unit, or transfer to another team/Trust. NB; Where the risk assessment indicates possible suicide risk, consideration must be given to prescriptions and access to toxic medications.

5.6.3 The review of the service user's risk at discharge planning or transfer between teams must consider the patient's risk history, reflecting whether transition has been a trigger point for escalation in the past.

5.7 Crisis & Resolution Home Treatment Team (CRHTT)

5.7.1 The CRHT will complete or update a risk assessment for all service users, whether referred from the community or inpatient services.

5.7.2 A comprehensive risk assessment appropriate to community care is contained within the assessment process and provides for a Community Plan of Care (CPoC). It must be completed on admission collaboratively by a registered practitioner and where possible the service user.

5.8 Acute Inpatient care for Adults and Older people

5.8.1 An initial assessment will have been completed by CRHTT (or Community MH Teams for Older Persons Mental Health (OPMH) as part of the gatekeeping procedure prior to admission. This may not be completed if admission is through 136 suite or where CRHTT have not had direct contact with person admitted. In these cases the assessment will need to be completed by the inpatient services.

5.8.2 A comprehensive risk assessment appropriate to acute inpatient care is contained within the acute care admission process and provides for an Inpatient Plan of Care (IPoC). It must be completed on admission collaboratively by a registered practitioner and where possible the service user.

5.8.3 The risk and mental health care plan will be reviewed daily and at the daily MDT meeting, (weekly for OPMH) and whenever there is a change in clinical presentation or circumstances known to impact of the person's risk.

5.8.4 The risk assessment and management plan will be reviewed and updated by inpatient staff prior to discharge from inpatient services, making reference to risk history as per 5.6.3 above.

5.9 Forensic Risk Case Only

5.9.1 In addition to the risk assessment (including detailed analysis of offending behaviour), those identified with a forensic risk receive a comprehensive forensic risk assessment (HCR-20) at the earliest opportunity from identification. The findings of such an assessment will be a significant contribution towards the design of the service user's care pathway.

5.9.2 Where a forensic risk has been identified (please see Appendix 3 for flow chart) there will be a referral to an appropriately trained HCR-20 assessor via an MDT review and discussion. The assessor would normally be the risk champion for the specified team/area. The HCR-20 should include all relevant care professionals involved in the individuals care. **It should be noted that adequate time should be built into the HCR-20 job plan or workload plan in order to facilitate the completion of such assessments.**

5.10 Dual Diagnosis

5.10.1 An exploration of the possible association between substance/alcohol misuse and increased risk of aggressive/anti-social behaviour, overdose, and or suicide/self-harm, must be integral to any clinical risk assessment (DH, 2006). Consideration should be given to the severity of the substance/alcohol misuse and the combination used (DH, 2006).

5.11 Forensic issues in Risk Management

5.11.1 Some users represent a particular high level of risk of harm to others and if judged appropriate should be referred to the Secure & Forensic Service for an opinion.

5.12 Positive Risk Taking:

5.12.1 **What is Positive Risk Taking?**

- Positive risk-taking is weighing up the potential benefits and harms of exercising one choice of action over another. This means identifying the potential risks involved and developing plans and actions that reflect the positive potentials and stated priorities of the service user. It involves using available resources and support to achieve desired outcomes and to minimise potential harmful outcomes.

- Positive risk-taking is not negligent ignorance of the potential risks. Nobody, especially users or providers of a specific service or activity will benefit from allowing risks to play out their course though to serious undesired outcomes. So, in practice it is usually a carefully thought-out strategy for managing a specific situation or set of circumstances.

- From the experiences of mental health services, positive risk-taking may be characterised by:

    - Real empowering of people through collaborative working and a clear understanding of responsibilities that service users and services can reasonably hold in specific situations**.**
    - Supporting people to access opportunities for personal change and growth.
    - Establishing trusting working relationships, whereby service users can learn from their experiences based on taking chances just like anyone else.
    - Understanding the consequences of different courses of action and making decisions based on a range of choices available and supported by adequate and accurate information.

- Working positively and constructively with risk depends on a full appreciation of the service user's strengths. It is very much based in the here and now but will be clearly influenced by knowledge of what has worked or not worked in the past and why. The influence of historical information lies in the deeper context of what happened, rather than the simple stigma of the events themselves. It is the knowledge that support is available if things begin to go wrong as they occasionally do for us all. It can occasionally be distinguished between its short and long- term differences, whereby short-term heightened risk may need to be tolerated and managed for longer term positive gains. It can be about explicit setting of boundaries to contain situations that are developing into potentially dangerous circumstances for all involved. It can be about taking the risk of withdrawing services that are inappropriate to needs, or have created a dependency on contact that serves no therapeutic value.

- As a concept, it needs to be appreciated and understood from the different perspectives of the service user, informal supports, and services – how they define or interpret a risk and its potential benefits will not always be congruent or compatible.

5.12.2 **Why Take Risks?**

• Risk is something we frequently initiate personally in all aspects of our lives, in order that we may develop and make changes for ourselves. We take risks with the intention of achieving positive gains, because we see a stronger potential for opportunity than for failure. Sometimes risk-taking is driven by forces or events beyond our personal control or conscious thoughts, by circumstances that we have no choice but to react to in whatever way we can**.**

• In our daily lives we take risks in order to achieve or experience specific desires, such as to be informed, exercise choices, make decisions, hold some control over direction or our own destiny, or to experience degrees of power. We also take risks to collaborate with others positively, make constructive use of opportunities, experience autonomy, and learn from experience and to grow and change.

PRINCIPLES FOR WORKING WITH RISK

- Risk is a normal everyday experience.
- Risk is dynamic; constantly change in response to changing circumstances.
- Assessment of risk is enhanced by accessing multiple sources of information, but frequently you will be working with incomplete and possibly inaccurate information
- Identification of risk carries a duty to do something about it – that is, risk management.
- Risk-taking is an integral component of good risk management
- Decision-making can be enhanced through positive collaborations.
- Risk can be minimised, but not eliminated.
- Organisations carry a responsibility to meet reasonable expectations for encouraging an accountability culture, while not condoning poor practice.

5.12.3 **Taking Positive Risks:**

• First, through a focus on strengths, giving a more positive base on which to build potential plans to support beneficial risk-taking. This considers the strengths and abilities of the service user, of their wider network and social systems, and of the wide-ranging services potentially available (statutory and voluntary sectors, and most importantly non-mental health resources).

• By a willingness on behalf of all people involved in a specific activity to think and work in this way. It can present significant challenges to the more traditional ways of working, and requires people who relish such challenges, the pursuit of new ideas, and who respond to permission for the expression of imagination. People who pay lip-service to innovation never push the limits of what is routine and comfortably known. If parts of the wider network are not signed up, confidence in being able to sustain positive risk-taking becomes undermined, as the fears associated with a blame culture are more likely to permeate people's thinking and threaten the implementation of creative ideas.

• Through high-quality supervision and support, which are essential for discussing and refining ideas, as well as providing a reality check to prevent idealism overwhelming realism?

- Through the development of appropriate crisis and contingency plans for the fears and possibilities of failure. These will aid prevention of some harmful outcomes and the minimisation of others. Risk-taking should be pursued in a context of promoting safety, not negligence.

- By risk-taking becoming part of the culture of ideas and training. Risk-taking should not be seen as a one-off experiment, but rather as a natural line of thinking. Whole-team training will be essential if the approach is to be fully understood and practised by all team members as a routine part of its culture.

- With adequate resources to enable creative work to take precedence over what usually "just happens". Resources are never open-ended, but true innovation needs organisational support to sustain its development and positive impact.

- By limiting the duration of the decision – that is, working to shorter timescales and with smaller goals broken down. This has a strong analogy with weather forecasting, whereby the predictions are more accurate for the next few hours than they would be for the next few days.

- By having team and service mechanisms in place to check on progress, providing an ability to quickly change previous decision when needed, including intervening in a more restrictive way when needed.

- Through clear definitions of individual and collective accountability and responsibility. Individual practitioners can reasonably be expected to be accountable to the standards of conduct set out by their professional body, and for the roles they play in the local implementation of guidance and legislation. However, there are also collective responsibilities for information sharing, decision-making and care planning, belonging more with the team than the individual in isolation.

- Through the organisation exercising its responsibilities to ensure adequate support and setting the tone for a culture to develop that will enable all the above points to happen.

GUIDELINES FOR POSITIVE RISK-TAKING See appendix 4

5.13 Information sharing and the police national computer (PNC)

5.13.1 Where there is a benefit to a service user in sharing information with other agencies, such as the police, third sector agencies and probation, all reasonable efforts must be made to obtain the consent of the service user to do so. In circumstances where the service user withholds consent, or obtaining consent is not possible, the healthcare team must then consider the risk to the service user and the wider public of not sharing the information. Issues considered and outcomes of this consideration must be documented, and professionals should seek advice from the Trust's Caldicott Guardian, the vulnerable person's officer (the appointed investigating officer), and the Trust police liaison officer, where appropriate.

5.13.2 The PNC has the facility to record core information about service users about whom the mental health services have significant concerns if they go absent without leave (AWOL), and can accommodate instructions on what actions to take should the service user be stopped in such 'identified circumstances' and a check made against their identity.

The service user does not have to have any previous criminal record for this facility to be utilised

Patient Information Management System (PIMS) Alert

5.13.3 If a service user presents particularly high or specific risks to self or others that need to be flagged up to colleagues and clinicians, details should be relayed to appropriate colleagues and agencies and documented in the Progress Notes under heading of Risk.

5.14 What to do in the event of a dispute or conflict of opinion regarding the risk assessment and management

When a marked difference in professional/clinical opinion exists it is vital that such differences are identified, explored, understood and resolved. A meeting arranged by the Team Leader, Service Manager, or Head of Service (depending on where the difference exists) should be arranged to this end. If resolution does not seem possible it should be escalated to the appropriate clinical lead. When a marked difference between service user/carer and the team exists every effort must be made to meet with the service user/carer to discuss, explore, understand, and resolve the differences

5.15 Safeguarding Children & Risk Assessment

Safeguarding children, young people and adults at risk policy must be followed at all times

5.15.1 In May 2009, the National Patient Safety Agency (NPSA) issued a Rapid Response asking all Mental Health Organisations to ensure that the potential risks to children are properly assessed, and all clinical risk assessments must evidence consideration of whether the service user has or may have contact with children, their own or others, and again whenever the service user's circumstances change. A referral to children's social care services must be made under local safeguarding procedures as soon as a potential risk becomes apparent. A referral must be made if a service user expresses delusional beliefs involving their child and or the service user might harm their child as part of a suicide plan. Subsequent to assessing that a service user may pose a risk to children, a consultant psychiatrist must be directly involved in all clinical decision making.

5.15.2 Additionally, the Trusts' Named Nurse for Children must be notified of any services users with an identified risk to a child, whether or not that child is already known to social services.

5.16 Safeguarding Adults at Risk of Harm & Abuse

5.16.1 In the event of an adult service user being identified at risk or the victim of abuse (physical, financial, sexual), local procedures for safeguarding vulnerable adults must be followed.

5.16.2 The **'Safeguarding Adults: The role of Health service practitioners (DH14 Mar 2011)'** seeks to support empowerment that involves risk management.

5.16.3 Empowerment involves a proactive approach to seeking consent, maximising the person's involvement in decisions about their care, safety and protection. It is not possible, nor arguably desirable, to eliminate risk. Empowerment in safeguarding involves risk

management that is based on understanding the person, understanding the autonomy of the person and how they view the risks they face. There may be risks the person welcomes because it enhances their quality of life; risks the person is prepared to tolerate and risks they want to eliminate

5.16.4 **Empowering approaches to safeguarding adults: An** adult's legal right to consent marks the fundamental difference between approaches in safeguarding adults and safeguarding children.

'Case law – powers and limitations of the Local Authority in safeguarding adults

'…whatever the extent of a local authority's positive obligations under Article 5, its duties, and more important its powers, are limited. In essence, its duties are threefold: a duty in appropriate circumstances to investigate; a duty in appropriate circumstances to provide supporting services; and a duty in appropriate circumstances to refer the matter to the court. But and this is a key message, whatever the positive obligations of a local authority under Article 5 may be, they do not clothe it with any power to regulate, control, compel, restrain, confine or coerce. A local authority which seeks to do so must either point to specific statutory authority for what it is doing…or obtain the appropriate sanction of the court….'

Para 96, Re A (Adult) and Re C (Child); A Local Authority v A (2010) EWHC 978 (Fam), Lord Justice Munby

NB Though this statement referred to Local Authorities, the implications are relevant for the roles of public bodies and their role to assist and support rather than to control.

5.17 Staff Support and Safety

5.17.1 It is essential that staff member's own personal safety needs and need for support are met.
Consideration should be given to how risks to staff safety are to be managed (e.g. gender/ethnicity of staff, where they are seeing service users, call assist arrangements etc).

5.17.2 Staff should be reminded of their rights and responsibilities to be treated with dignity and respect across all of the protected characteristics.

5.17.3 Managers are reminded of their obligations under health and safety legislation and the lone working policy.

5.17.4 Support for management of risk decisions will be obtained through discussion through the individuals MDT and through individual one to one supervision. Other forums such as Risk Panels may also be available as an opportunity for practitioners to bring cases to a senior practitioner panel as a way to reflect on plans and assessment and offer additional suggestions where appropriate.

5.18 Mental Capacity and Risk

5.18.1 Provision must be made for service users who are deemed not to have capacity or have limited cognitive ability (e.g. ensure an appropriate professional and/or advocate works with clinical team to gather information and develop formulation with, or on behalf

of, the service user). Where an appropriate professional is not within the team, the team leader must seek the assistance from another service/team.

5.19 Communicating and documenting the findings of a risk assessment

5.19.1 All professionals working in mental health services are bound by law and professional codes of conduct to a duty of confidentiality to their service users. They also have a duty of confidentiality to carers. However, there will be a few situations where permission is not required to share confidential information: where it is required by law e.g. a court order or where disclosure is in the public interest e.g. to protect a member of the public from harm and in particular in the context of a named potential victim.

5.19.2 The completed risk assessment and management plan must be shared with and communicated to the service user and carer whenever possible and where required provided in an alternative format such as Braille, large print or easy read.

5.19.3 Reports describing the findings of clinical risk assessments must be stored in the patient electronic record under the appropriate section (in Clinical Records System). For reports received in paper format of clinical risk assessments as well as reports in which a clinical risk assessment is just a part (e.g., a Care Programme Approach [CPA] report or a Mental Health Review Tribunal [MHRT] report), should be stored in the relevant parts of the Patient electronic record, clearly identified through the document referencing when stored.

5.19.4 In addition to documentation within the patient electronic record, communication of current and previous risks must be included in clinical handovers and MDT meetings

5.19.5 The person undertaking or leading on a risk assessment is responsible for ensuring that the findings and recommended actions are clearly documented, signed and dated, and communicated to all relevant parties.

- Any communication about significant risk, including reviews, should inform the care plan and contain the following elements:
- A statement about the risk or risks to be managed (e.g., violence/self-harm/suicide)
- A statement about the risk and protective factors most relevant to this possible outcome
- A risk formulation (please see appendix 2)
- A risk management plan, which will include a statement about treatment options relevant to managing relevant risk factors, supervision options and monitoring
- Crisis and contingency/Safety planning

5.20 Training, supervision and qualifications for undertaking risk assessments

5.20.1 All new staff will be made aware of this policy during their induction and all clinical staff will be trained in the principles, standards and use of risk tools relevant to their care group and/or service area. Formal training will be attended by staff member every 3 years. On-going training will take place through supervised and reflective practice.

5.20.2 Risk assessment and risk management must be addressed during routine supervision process, team reflective practice, and appraisal, drawing on the lessons from incidents and serious untoward incidents.

6. DEVELOPMENT, CONSULTATION AND RATIFICATION

6.1 This policy was reviewed by the Solent Policy Group. A wide range of professionals and managers were consulted via the Clinical and Service Directors and members of the Integrated Teams.

6.2 Service User and Carer Groups were consulted in the course of originally developing this policy. The policy was formal approved and ratified as specified on the front cover

6.3 As indicated in section 1.1.2, this policy is substantially underpinned by the Department of Health *Best Practice in Managing Risk* national guidance on clinical risk assessment and management. This document was subject to a national and international review process, including close scrutiny by a panel of service user and carer representatives.

7. EQUALITY IMPACT ASSESSMENT

7.1 An Equality Assessment was conducted, and no negative impact was highlighted for any of the nine protected characteristics.

8. MONITORING COMPLIANCE

8.1 Monitoring of the effectiveness of this Policy and how it is operating, including the quality of clinical risk assessment and management practice and training, will be audited against the standards outlined in this policy and will be routinely audited as part of the Trust-wide audit cycle. Audit reports will be disseminated for information and action.

8.2 Clinical risk assessments and management practice will also be audited across the six equality strands.

8.3 As part of the Policy review the policy sponsor and author will ensure, through consultation, the correct roles and responsibilities for staff and forums / committees are identified within the document.

8.4 Line managers and supervisors will monitor staff training needs and attendance, initially via the induction process and thereafter annual as part of the personal development review (PDR) process. Where training needs or non-attendance are identified line managers will ensure staff members are booked to attend as necessary. Monitoring of essential training non-attendance will be undertaken as detailed in the essential training policy.

9. DISSEMINATION AND IMPLEMENTATION OF POLICY

9.1 There will be a planned dissemination and implementation. This policy will be circulated to all staff by means of the bulletin, disseminated through team meetings, and will be placed on the intranet. New staff will be made aware of all the Trusts policies as part of their Induction. Copies of the policy will be available in a range of formats upon request by line managers for those with limited access to a personal computer or visual or sensory impairments.

10. REFERNCE DOCUMENTS

Department of Health, National Risk Management Programme (2009). *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*.
Policy and Procedure for Clinical Risk Assessment in High Secure Services, Mersey Care NHS Trust, Caroline Logan, 10 December 2007.

Department of Health, *Your guide to relational security: See, Think, Act* (January 2010).
Department of Health, *Independence, choice and risk: a guide to best practice in supported decision making – Executive Summary* (May 2010)

NHS England and NHS Improvement and the National Collaborating Central for Mental Health, *The Community Mental Health Framework for Adults and Older Adults* (2019)

NHS National Patient Safety Agency, *Healthcare Risk Assessment Made Easy* (2007)

NHS Yorkshire and the Humber Strategic Health Authority, *Independent Investigation in SUI 2006/8119 – Final Report Executive Summary* (November 2009)

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

National Institute for Health and Care Excellence, *Violence and aggression: short-term management in mental health, health and community settings*, 2015

National Patient Safety Agency Rapid Response Report NSPA/2009/RRR003, *Preventing harm to children from parents with mental health needs* (May 2009)

National Patient Safety Agency Rapid Response Report NSPA/2009/RRR003, *Preventing harm to children from parents with mental health needs: Supporting Information* (May 2009)

11. BIBLIOGRAPHY

Department of Health, *Code of Practice: Mental Health Act 1983* (March 1999)

Department of Health, *Code of Practice: Mental Health Act 1983* (May 2008)

Department of Health, *Reference Guide to Mental Health Act 1983* (2008)

Department of Health, *Information Sharing and Mental Heath – Guidance to Support Information Sharing by Mental Health Trusts* (September 2009)

Department of Health, *Seven Steps to Patient Safety: An overview guide for NHS staff* (April 2004)
Department of Health, *Reference guide to consent for examination or treatment* July 2009)
National Patient Safety Agency, National Reporting and Learning Services, *Seven Steps to Patient Safety in Mental Health* (November 2008)

NICE National Collaborating Centre for Mental Health (2004) Self-Harm – The short term physical and psychological management and secondary prevention of self-harm in primary and secondary care, London: The British Psychological Society and the Royal College of Psychiatrists.

NPSA (2006), *'Avoidable Deaths' Five-year report of the national confidential inquiry into suicide and homicide by people with mental illness*. The University of Manchester *(*December 2009)

NPSA (2009), *National confidential inquiry into suicide and homicide by people with mental illness. Annual report,* The University of Manchester (July 2009)

Morgan, S., 'Positive risk-taking: an idea whose time has come', *Health Care Risk Report,* (October 2004) 18-19

Royal College of Psychiatrists (2016) *Assessment and management of risk to others: Good practice guide*

12. GLOSSARY

CRHTT	Crisis Resolution Home Treatment Team
HCR-20	Historical-Clinical-Risk Management-20; a tool that is for use by practitioners who have had relevant training in its use.
CAMS	Collaborative Assessment and Management of Suicide
Immediacy	The service user presents an immediate risk of committing an act which is very likely to cause serious harm. There are very few, if any, protective factors to mitigate or reduce the risk
High risk	This service user presents a risk of committing an act that is either planned or spontaneous, which is very likely to cause serious harm. There are few, if any, protective factors to mitigate or reduce that risk.
Medium risk	This service user is capable of causing serious harm, but in the most probable future scenarios, there are sufficient protective factors to moderate that risk. The service user evidences the capacity to engage and occasionally, to contribute helpfully, to planned risk management strategies and may respond to treatment. This patient may become a high risk in the absence of the protective factors identified in this assessment.
Low risk	This service user may have caused, attempted or threatened serious harm in the past but a repeat of such behaviour is not thought likely between now and the next scheduled risk assessment. He is likely to cooperate well and contribute helpfully to risk management planning and he may respond to treatment. In all probable future scenarios in which

	risk might become an issue, a sufficient number of protective factors (e.g., rule adherence, good response to treatment, trusting relationships with staff) to support ongoing desistance from harmful behaviour can be identified.
Risk Formulation	A summary of the risks in the context of historical and current factors including triggers and signs of escalation of risk and dynamic factors which may impact on the risk posed and management plan.
IPoC	Inpatient Plan of Care: An individualised plan of care whilst an inpatient which is developed following assessment and incorporates risk assessment, safety plan, interventions to support recovery, patient and carer views
CPoC	Community Plan of Care: An individualised plan of care whilst receiving community mental healthcare, which is developed following assessment and incorporates risk assessment, safety plan, interventions to support recovery, patient and carer views

13. Cross Reference

This policy should be read in conjunction with:

- Care Programme Approach (CPA) Policy
- Data Protection, Security and Confidentiality Policy
- Trust Guidance on Managing Confidentiality
- Essential Training Policy
- Observation Policy
- Safeguarding children, young people and adults at risk policy
- Management, Reporting, Recording and Investigation of Incidents Policy
- Prevention and Management of Violence and Aggression Policy
- SIRI Policy
- Lone Working Policy

14. Review

14.1 This document may be reviewed at any time at the request of either at staff side or management but will automatically be reviewed 3 years from initial approval and thereafter on a triennial basis unless organisational changes, legislation, guidance or non-compliance prompt an earlier review.

Appendix 1 **Suicide Assessment and Treatment Pathway**

This pathway should be used in conjunction with the Supporting Guidance within this policy and the Assessment and management of Suicide Training

New referral

- Referral information suggests suicidal thoughts or behaviour
- Identify a CAMS trained practitioner to undertake the assessment and discuss with MDT if CAMS intervention is indicated and if so allocate, ideally to the assessor
- Where a CAMS trained practitioner is not available to undertake the assessment, a registered practitioner will undertake a full psychosocial assessment using the agreed assessment standards
- Following assessment, if suicide risk is identified, a CAMS trained practitioner will be allocated to provide CAMS intervention

Existing referral

- Ongoing risk assessment identifies risk of suicide
- Identify a CAMS trained practitioner to provide intervention

If service user declines either to participate in CAMS or to take positive steps to maintain their safety, then consider CRHT referral or Mental Health Act (MHA) assessment as indicated, using professional judgement, following MDT discussion, review of risk assessment and documentation. Ensure decision and rationale for decision is thoroughly documented.

If the individuals mental state is so poor or suicidal intent so high that participation is prevented (before or during CAMS), then consider any action needed to keep the person safe and review commencement when they are able to participate.

REMEMBER -: ACTED

Assess: Ask the patient and review records of their suicidal and self-rescue behaviour (history – previous self-harm/ suicidal behaviour strongest predictor of future self-harm/ suicidal behavioural. Remember patients may under report risk or overreport risk

Collaboratively agree a safety plan. Troubleshoot obstacles to the patient using it.

Treat the risk directly (CAMS)

Escalate or review assessment if indicated

Document. If you didn't document, it didn't happen

Appendix 2 **Risk Formulation Format**

Risk Formulation:
In order to support a clearer approach to recording, it is proposed the risk summary (final free text box on the risk summary form) should be formatted as below.

Risk Overview:
To include a brief description of current risks (including physical health risks).

Historical Overview:
To briefly describe any historical risks that are not covered in risk overview. Historical elements will be in the boxes above also to help keep it brief.

Dynamic Factors:
To include the signs and triggers that would indicate a possible escalation in risk. These should be both clinical factors and situational factors (housing, relationships etc.). Substance misuse should also be included here. Poorly controlled symptoms of mental illness must be considered in relation to risk assessment and treatment decisions.

Protective factors:
To include any factors that help reduce/mitigate an escalation in risk.

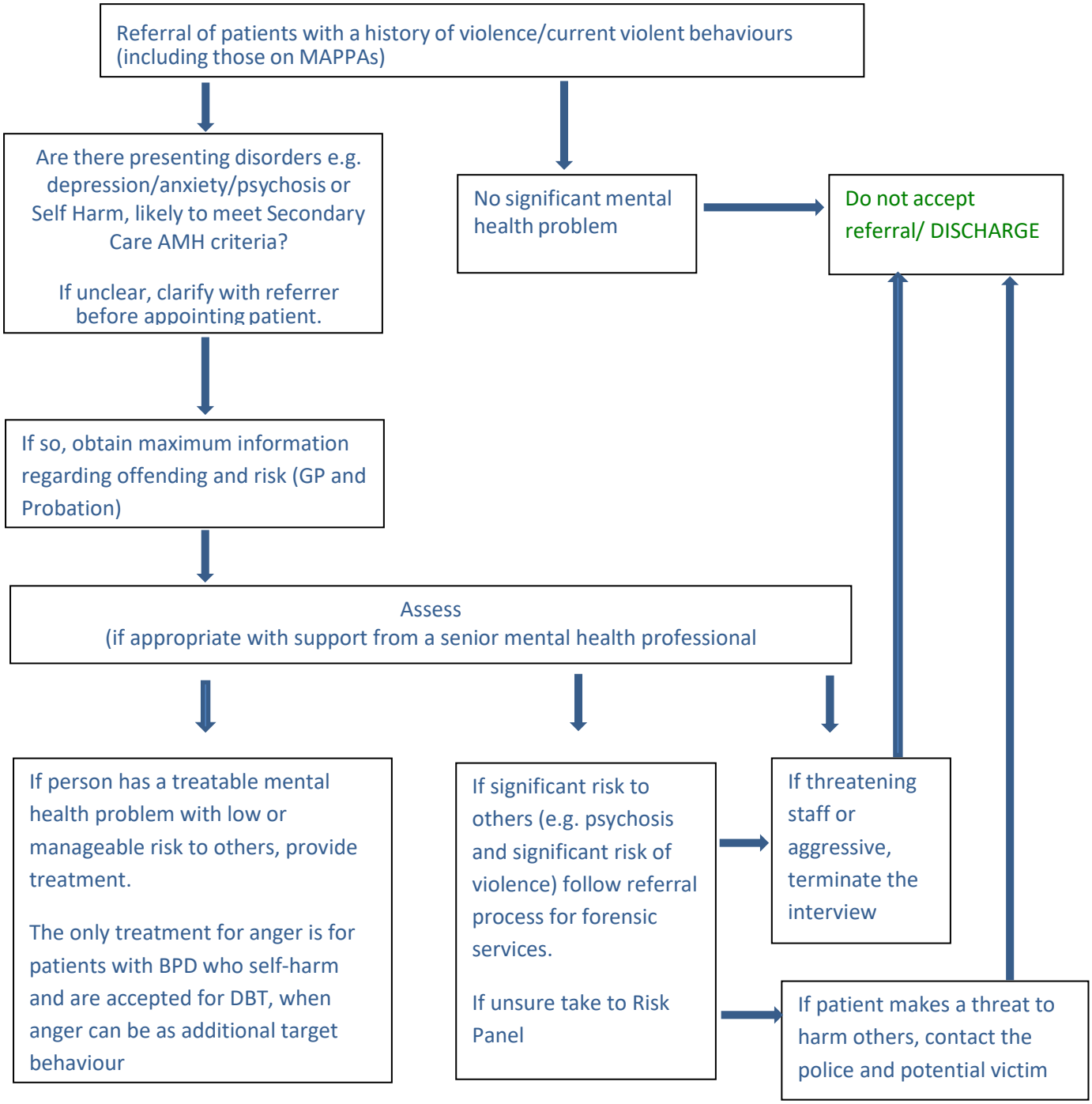
Physical Health:
Take into account the physical health care risks - Long standing existing conditions. High dose Antipsychotic treatment. Clozapine / Lithium / or other monitoring. Hospital Acquired and blood borne infections

Plan:
Bullet points for individuals plan, related to factors outlined above. EG if there is a physical health risk but there is a care plan in place the bullet point can say, Physical Risk as per care plan.

The above only needs to be brief as you should have the more detailed info in the sections above the summary box. (To be reviewed in the event of Electronic patient Records system changing).

Appendix 3

FLOWCHART - REFERRAL OF PATIENTS WITH A HISTORY OF VIOLENCE in A2i or CRHT



Appendix 4 **GUIDELINES FOR POSITIVE RISK-TAKING**

- Consider the clinical risk management policy and procedures
- Service User experience and understanding of risk.
- Carer experience and understanding of risk
- Clear definition of risk-taking in context.
- Clear articulation of the desired outcomes.
- Identification of Strengths.
- Planned stages for risk-taking.
- Awareness of potential pitfalls (and estimated likelihood)
- Potential safety nets (including early warning signs, crisis and contingency plans) IN collaboration with the service user and carers to manage the identified risks and include a Contingency/Crisis Plan
- Outcome of previous attempt(s) at this course of action
- Identify situations and circumstances known to present increased risk
- How was it managed, and what will now be done differently?
- What needs to, and can, change?
- How will progress be monitored?
- Who agrees to the approach?
- When will it be reviewed?
- Make an assessment of the risk and record the assessment formulation and plan in the patient records.

Appendix 5

GUIDANCE FOR SERVICE USERS WHO DO NOT ATTEND (DNA) OR DISENGAGE WITH MENTAL HEALTH SERVICES (INCLUDING NON-COMPLIANCE WITH TREATMENT)

This clinical guideline sets out the process to follow for the management of service users who have been referred to or accepted into mental health community services, who DNA, start to disengage with services or who are non-concordant with their treatment plans.

The report of the National Confidential Enquiry into Suicide and Homicide by people with a Mental Illness, found that non-attendance, loss of contact with services and non-compliance with medication are significant causal factors that contribute to findings of inquiries into suicide and homicide.

The purpose of this clinical guidance is to ensure that we achieve the right balance between providing a professional service and protecting the health and safety of service users who are, or appear to be, disengaging from services. This clinical guidance seeks to ensure staff always consider the clinical and risk issues in the event of disengagement and take positive action where necessary to satisfy themselves that the Service User is safe.

This Guidance sets out to assist clinicians in providing safe and appropriate care for difficult to engage services users. This guidance should apply to all those referred to, including those not yet assessed and those in receipt of services from the Trust.

Users of mental health services may choose to discontinue contact with a proportion, or all the services provided. In most cases this is not problematic and is a routine part of clinical practice, however there will be occasions when this situation presents a high risk. Staff are encouraged to discuss with service users as part of the care process, what action they will want the service to take should they disengage from services due to relapse of illness. The details of such discussions should be documented in the patient records and regularly updated. Disengagement for example might be a sign of relapse and an agreed action plan needs to be considered in deciding the best course of action.

Carers concerns – If a carer has expressed concern about risk to the service user and/or others, then a review should be held to address these concerns and a plan agreed.

SERVICE USERS REFERRED TO, BUT NOT YET ASSESSED BY, SPECIALIST MENTAL HEALTH SERVICES

Where a person is referred to services is screened and accepted for an assessment, and consequently misses an appointment without explanation, the following must be considered by the assessment service referred to:

- Are there clinical or risk issues of concern that require immediate follow up before another appointment can be made or discharge from service?
- The plan and rationale for the decision, is clearly documented

SERVICE USERS WHO HAVE BEEN ASSESSED AND ACCEPTED BY MENTAL HEALTH SERVICES

If a person misses an appointment without explanation following assessment the allocated practitioner will need to decide if there are significant clinical or risk issues that require immediate intervention.

Where a missed appointment occurs following assessment and there are known or suspected clinical and risk issues, action will need to be taken to follow up the reason for the missed appointment which include; MDT Discussion , risk assessment of the situation and document outcome and plan within 7 days. This must be sooner if considered high risk.

Care Coordination

For service users accepted for care co-ordination, active and instant follow up is essential. The Care Co-ordinator or team colleagues will need to decide on the nature and degree of follow up depending on the circumstances of the individual. It is not permitted to allow service users referred for care co-ordination to be left without follow up as this group of Service Users are likely to have more complex clinical needs and an associated risk profile and more likely to be susceptible to sudden change. Discuss within MDT.

Non-Care Co-ordination

For all other cases who have missed an appointment following assessment and due to be seen in Outpatients, Psychology, nurse led clinic etc. the treating clinician will need to follow up the case to determine the reason for the missed appointment and if there are significant clinical or risk issues. This needs to be considered in context as these services would not be expected to be managing cases with significant clinical and risk issues in the way that might be expected with care co-ordinated Service Users. This may then be taken back to the MDT for further discussion within 7 days and a plan of action agreed and documented in case notes by the clinician involved in care.

Service Users that are reluctant to engage or who have disengaged from services

Where a patient has disengaged, a risk assessment should be undertaken, and the outcome documented in the clinical record.

It may be appropriate to call a professionals meeting to formulate a future of care.

Consider whether clinically appropriate to do daily visits until contact re-established and if not, a rationale for frequency of contact with clearly detailed plan to be documented.

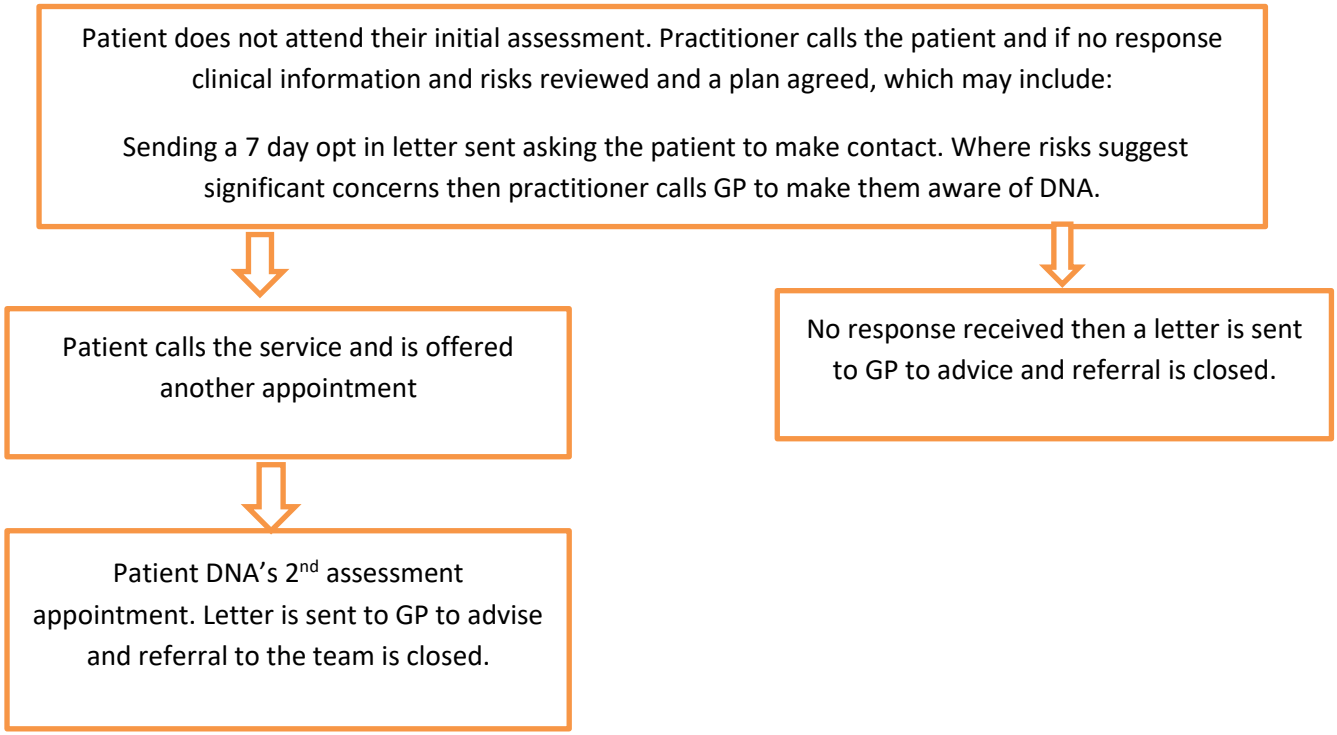
Where the situation warrants prompt intervention, an assessment under the Mental Health Act should be considered.

For cases only being seen in the Outpatient Clinic, a review of risk should be undertaken, and the outcome documented on the patient clinical record system.

Where appropriate, a consideration should be given to discussing the case within the MDT and where necessary arrange a community follow up by a clinician. This should be documented on the clinical record system

NB: Always document the plan of action taken and the reasons for decisions made

DNA FLOW CHART for individuals who have been referred and accepted for assessment



NB: Process for patients who call and cancel their appointment will be offered 3 opportunities to be seen.

Risks continue to be considered and if there are concerns GP is notified of cancellations.

DNA and DISENGAGEMENT FLOW CHART for individuals who have been assessed and who are open to Mental Health Services

Assessed and referred to Mental Health Services for Intervention/ follow up (OPA, Psychology, A2i etc)

DNA – Consider risks, review risk assessment

No known, or low risk

MDT discussion to agree plan and possible discharge

Significant risks

Where a missed appointment occurs following assessment and there are known or suspected clinical and risk issues, action will need to be taken to follow up the reason for the missed appointment which include; MDT Discussion , risk assessment of the situation and document outcome and plan within 7 days. This must be sooner if considered high risk

Under the care of Community services and/or care co-ordinated

Where a patient has not attended appointments / disengaged, a risk assessment must be undertaken. Consider whether clinically appropriate to do daily visits until contact re-established and if not, a rationale for frequency of contact with clearly detailed plan documented

MDT discussion to agree plan, which may include reporting a missing person or assessment under the MHA

If it is considered that contact with the police is appropriate, the attached document must be referred to:

http://intranet.solent.nhs.uk/ServiceLines/MentalHealthandSubstance/QualityandClinicalGovernance/_layouts/15/WopiFrame.aspx?sourcedoc=/ServiceLines/MentalHealthandSubstance/QualityandClinicalGovernance/TeamDocument/Sending%20the%20most%20appropriate%20agency.pdf&action=default

Clinical documentation regarding risks, review of risk assessment, how decision are reached and rational for decision must be clearly recorded in the patients records

Appendix 6 **Leave from MH inpatient wards**

Patients detained under the Mental Health Act 1983 (the Act) can only leave the hospital when granted leave of absence under s17 as per the 'Section 17 Leave of Absence under the Mental Health Act 1983 Policy'
http://intranet.solent.nhs.uk/DocumentCentre/PublishedPolicies/AMH002%20Section%2017%20Leave%20of%20Absence%20under%20the%20Mental%20Health%20Act%201983%20Policy%20v5.pdf#search=sec%2017%20leave

Section 17 leave decisions should be made on sound clinical and risk assessments. Each patient who is granted s17 leave must have a risk assessment recorded on SystmOne.

- Before leave commences all risks are clearly considered and are recorded.
- Registered nursing staff will assess the patient's mental state and any risks associated with the leave.
- Risk assessments should be clearly recorded at the time they are undertaken and should consider any risk assessments recorded on SystmOne.
- For short term periods of leave an up to date description of the patient should be recorded, including the clothes they are wearing, in case they do not return.
- The patient and or any escorts should have clear details of how to contact the ward in the event of a crisis.
- The time of the patient went on leave and the time they returned must be clearly recorded.
- A photograph of the person should be available in their electronic records, providing they consent or are unable to consent but it is in their best interests.

In the event of a patient absconding or not returning from leave at the specified time the Trust Missing Person policy must be followed.

Informal Patients

- The same process as above should be followed
- Where there are concerns regarding risk to self or others section 5(2) or section 5(4) of the mental health act will be considered and implemented if all the requirements of the mental health act policy are met.

http://intranet.solent.nhs.uk/DocumentCentre/PublishedPolicies/MH01%20Mental%20Health%20Act%20Policy%20v5.pdf#search=mental%20health%20act%20policy

Decision making regarding escorts on planned and Emergency leave must be based on the current risk assessment. Consideration must be given to the:

- Number of escorts
- Skills required and responsibility of the escort/s. This may vary depending on destination, for example more support will be required at an Emergency Department where access to risk items and opportunity to abscond when escorting someone who is acutely unwell may be higher than escorting someone in a planned way to their home environment on the lead up to discharge.

Appendix 7 **Audit Tool**

Audit Items	Enter: 0 = No 1 = Yes					Overall %
	To add more patients, right click a box, e.g. Pt5, then "insert" > "entire column"					
	Pt1	Pt2	Pt3	Pt4	Pt5	
A review of the Risk Plan has taken place in line with NERD.						0
Additions to Risk Plan are clearly identified at last review.						0
Formulation of Risk Plan complies with risk assessment recording standards.						0
Risk plan clearly identifies how risks are to be managed.						0
Crisis & Contingency Plan has been reviewed according to service standards.						0
All clinical notes follow format as per service standard.						0
All risk nodes with low, medium or high have a rationale.						0
Is there an Advance Directive in place?						0
Risk plans have involved service users (and carers where appropriate). Evidence should be available.						0

Appendix 8 **Equality Analysis and Equality Impact Assessment**

Equality Analysis is a way of considering the potential impact on different groups protected from discrimination by the Equality Act 2010. It is a legal requirement that places a duty on public sector organisations (The Public Sector Equality Duty) to integrate consideration of Equality, Diversity and Inclusion into their day-to-day business. The Equality Duty has 3 aims, it requires public bodies to have due regard to the need to:

- **eliminate unlawful discrimination**, harassment, victimisation and other conduct prohibited by the Equality Act of 2010;
- **advance equality of opportunity** between people who share a protected characteristic and people who do not;
- **foster good relations** between people who share a protected characteristic and people who do not.

Equality Impact Assessment (EIA) is a tool for examining the main functions and policies of an organisation to see whether they have the potential to affect people differently. Their purpose is to identify and address existing or potential inequalities, resulting from policy and practice development. Ideally, EIAs should cover all the strands of diversity and Inclusion. It will help us better understand its functions and the way decisions are made by:

- **considering the current situation**
- **deciding the aims and intended outcomes of a function or policy**
- **considering what evidence there is to support the decision and identifying any gaps**
- **ensuring it is an informed decision**

Equality Impact Assessment (EIA)

Step 1: Scoping and Identifying the Aims		
Service Line / Department	Mental Health Services	
Title of Change:	Clinical Risk Assessment and Management Policy & Procedure	
What are you completing this EIA for? (Please select):	Policy	*(If other please specify here)*
What are the main aims / objectives of the changes	Update current policy.	

Step 2: Assessing the Impact

Please use the drop-down feature to detail any positive or negative impacts of this document /policy on patients in the drop-down box below. If there is no impact, please select "not applicable":

Protected Characteristic	Positive Impact(s)	Negative Impact(s)	Not applicable	Action to address negative impact: *(e.g. adjustment to the policy)*
Sex			X	
Gender reassignment			X	
Disability			X	
Age			X	

Sexual Orientation			X	
Pregnancy and maternity			X	
Marriage and civil partnership			X	
Religion or belief			X	
Race			X	

If you answer yes to any of the following, you MUST complete the evidence column explaining what information you have considered which has led you to reach this decision.

Assessment Questions	Yes / No	Please document evidence / any mitigations
In consideration of your document development, did you consult with others, for example, external organisations, service users, carers or other voluntary sector groups?)	Yes	There were no external stakeholder consultations for this policy. Consultations have taken place via the MHS Clinical Governance Group. The assessment and management of clinical risk is determined by the needs of the individual, to show parity between different groups and fairness to all patients. Patients can share views on their experience and to help service improvements in the future.
Have you taken into consideration any regulations, professional standards?	Yes	This policy makes reference to relevant legislative frameworks, such as the Mental Health Act and Equality Act.

Step 3: Review, Risk and Action Plans

How would you rate the overall level of impact / risk to the organisation if no action taken?	Low	Medium	High
	■	☐	☐
What action needs to be taken to reduce or eliminate the negative impact?			
Who will be responsible for monitoring and regular review of the document / policy?	Ben Martin-Lihou		

Step 4: Authorisation and sign off

I am satisfied that all available evidence has been accurately assessed for any potential impact on patients and groups with protected characteristics in the scope of this project / change / policy / procedure / practice / activity. Mitigation, where appropriate has been identified and dealt with accordingly.

Equality Assessor:	Ben Martin-Lihou	*Date:*	10/02/2021

Additional guidance

Protected characteristic		Who to Consider	Example issues to consider	Further guidance
1.	**Disability**	A person has a disability if they have a physical or mental impairment which has a substantial and long term effect on that person's ability to carry out normal day today activities. Includes mobility, sight, speech and language, mental health, HIV, multiple sclerosis, cancer	• Accessibility • Communication formats (visual & auditory) • Reasonable adjustments. • Vulnerable to harassment and hate crime.	Further guidance can be sought from: Solent Disability Resource Group
2.	**Sex**	A man or woman	• Caring responsibilities • Domestic Violence • Equal pay • Under (over) representation	Further guidance can be sought from: Solent HR Team
3	**Race**	Refers to an individual or group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.	• Communication • Language • Cultural traditions • Customs • Harassment and hate crime • "Romany Gypsies and Irish Travellers", are protected from discrimination under the 'Race' protected characteristic	Further guidance can be sought from: BAME Resource Group
4	**Age**	Refers to a person belonging to a particular age range of ages (eg, 18-30 year olds) Equality Act legislation defines age as 18 years and above	• Assumptions based on the age range • Capabilities & experience • Access to services technology skills/knowledge	Further guidance can be sought from: Solent HR Team
5	**Gender Reassignment**	" The expression of gender characteristics that are not stereotypically associated with ones sex at birth" World Professional Association Transgender Health 2011	• Tran's people should be accommodated according to their presentation, the way they dress, the name or pronouns that they currently use.	Further guidance can be sought from: Solent LGBT+ Resource Group
6	**Sexual Orientation**	Whether a person's attraction is towards their own sex, the opposite sex or both sexes.	• Lifestyle • Family • Partners • Vulnerable to harassment and hate crime	Further guidance can be sought from: Solent LGBT+ Resource Group
7	**Religion and/or belief**	Religion has the meaning usually given to it but belief includes religious and philosophical beliefs, including lack of belief (e.g Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition. (Excludes political beliefs)	• Disrespect and lack of awareness • Religious significance dates/events • Space for worship or reflection	Further guidance can be sought from: Solent Multi-Faith Resource Group Solent Chaplain
8	**Marriage**	Marriage has the same effect in relation to same sex couples as it has in relation to opposite sex couples under English law.	• Pensions • Childcare • Flexible working • Adoption leave	Further guidance can be sought from: Solent HR Team
9	**Pregnancy and Maternity**	Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In non-work context, protection against maternity discrimination is for 26 weeks after giving birth.	• Employment rights during pregnancy and post pregnancy • Treating a woman unfavourably because she is breastfeeding • Childcare responsibilities • Flexibility	Further guidance can be sought from: Solent HR team