# The Assessment and Management of Clinical Risk Policy

**Version:** 4

## Summary:
This policy describes the processes Southern Health NHS Foundation Trust (SHFT) uses to ensure risks relating to the clinical presentation of service users and their care and support are assessed and managed. It should be read in conjunction with the Practice Guidance for Managing Clinical Risk Document (SH CP 28) which supports the implementation of this policy.

## Keywords (minimum of 5):
(To assist policy search engine)

- Risk assessment
- Risk
- Clinical risk
- Assessment

## Target Audience:
All clinical staff within the Mental Health and Learning Disabilities Division.

## Next Review Date:
August 2020

## Approved & Ratified by:
| Paula Hull – Director of AHP & Nursing | Date of meeting: 06/10/2018 |
| Karl Marlowe – Medical Director |

## Date issued:
November 2018

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## Accountable Executive Lead:
Dr Karl Marlowe, Medical Director
## Version Control

### Change Record

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<th>Version</th>
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<td>Tim Coupland</td>
<td>Version 2</td>
<td></td>
<td>Full revision of policy</td>
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<tr>
<td>Sept 2014</td>
<td>Tim Coupland</td>
<td>Version 2</td>
<td></td>
<td>Further refinements to policy to reflect developments and training ambitions</td>
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<tr>
<td>Sept 2014</td>
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<td>Version 2</td>
<td></td>
<td>Change to title of policy to reflect comments from Consumer Advisor</td>
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<tr>
<td>July 2015</td>
<td>Louise Hartland</td>
<td></td>
<td>15</td>
<td>Updated TNA (appendix 2) and contents page</td>
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<tr>
<td>Aug 2015</td>
<td></td>
<td></td>
<td></td>
<td>Review date extended from Aug to Nov 2015</td>
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<td>Version 3</td>
<td></td>
<td>Further refinements to policy to reflect changes in national guidance and practice</td>
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<tr>
<td>Sept 2018</td>
<td>Carole Adcock</td>
<td>Version 4</td>
<td></td>
<td>Following an SI in Southampton, an action stated to review this policy along with three others to ensure there are no contradictions.</td>
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### Reviewers/contributors

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<th>Name</th>
<th>Position</th>
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<td>Version 2 Feb</td>
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<td>Risk Assessment Task &amp; Finish Group</td>
<td>Comments returned from Dr Lesley Stevens</td>
<td>Version 2 Sept</td>
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<td>Lesley Herbert</td>
<td>Consumer Advisor</td>
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<tr>
<td>Liz Durrant</td>
<td>Area Manager - AMH</td>
<td>Version 3 Dec</td>
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<td>Policy review task &amp; finish group</td>
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This policy has used direct contributions from Policies from Northumberland Tyne and Were NHS Trust, East London NHS Foundation Trust and West London Mental Health Trust.
### Contents

1. Introduction........................................................................................................................................... 4
2. Scope.................................................................................................................................................... 4
3. Duties / Responsibilities .................................................................................................................. 4
4. Positive risk taking ............................................................................................................................ 5
5. Key principles underpinning risk assessment and management.................................................. 6
6. Types of Risk ......................................................................................................................................... 6
7. How to undertake a collaborative risk assessment ............................................................................ 6
8. When you should look at and consider the current Risk Assessment ............................................ 7
9. How to formulate and develop a Risk Management Plan .................................................................. 8
10. Restrictive practices and managing risk .......................................................................................... 10
11. Recording Risk Incidents ................................................................................................................ 10
12. Training Requirements ................................................................................................................... 10
13. Monitoring Compliance with the Contents of this Policy ................................................................ 10

**Appendices**

A1 Training Needs Analysis .................................................................................................................. 12
A2 Equality Impact Analysis Screening Tool .......................................................................................... 14
The Assessment and Management of Clinical Risk Policy

1. Introduction

1.1 There are three core components in relation to risk, these are: risk assessment, risk formulation and risk management and apply to any Mental Health and Learning Disability assessment in any setting. Department of Health, Best Practice in Managing Risk (2009) states that risk management is a core component of mental health care and the Care Programme Approach.

1.2 Effective care includes an awareness of a person's overall needs as well as an awareness of the degree of risk they may present to themselves or others. Many practitioners make decisions every day about how to help a service user to manage their potential for violence, self-harm, suicide or self-neglect.

1.3 This policy also recognises that clinical risk management is a key component of Learning Disabilities clinical practice and this policy relates to the whole of the Mental Health and Learning Disabilities Division.

1.4 The existing procedure Practice Guidance for Managing Clinical Risk Document (SHCP 28) advocates the use of the 'structured clinical judgement approach' as recommended for all types of risk practice. The purpose of this is to decide on the 'most appropriate level of risk management and the right kind of intervention for the service user'. This is now being incorporated into this policy and forms appendix 4.

1.5 Risk assessment, formulation and management, including positive risk taking, is an essential part of person-centred practice, promoting collaborative recovery focused care. Clinicians are involved in making judgements of risk every working day, helping service users to understand and evaluate risk and develop ways of minimising risk is key in enabling recovery.

1.6 This policy recognises that for many community service users they are seen by a sole Care Coordinator. In these circumstances a risk assessment and management still occurs but may not happen within a multidisciplinary setting. This reinforces why collaborative working with the service user and carer is so important.

2. Scope

2.1 This policy applies all clinical staff within the Mental Health and Learning Disabilities Division and all service users cared for within these areas.

3. Duties / Responsibilities

3.1 Clinical Practitioners

All practitioners are responsible for ensuring that they are adequately trained and skilled to carry out clinical risk assessments and management planning and have fulfilled their training requirements as specified in the Training Needs Analysis. Practitioners also have a duty to ensure they carry out clinical risk assessments and management planning as part of their clinical work, in line with the principles contained within this policy and using the Trust's most up-to-date tools and templates available on the intranet.
3.2 **Clinical Director/ADON/Service leads**
Have a responsibility for ensuring that all their clinical practitioners are adequately trained and skilled in clinical risk assessment and management planning and have fulfilled their minimum training requirements as specified in the Training Needs Analysis. In addition to this, service directors are responsible for ensuring that clinical staff are receiving regular supervision and oversight of their clinical work and that this includes monitoring of compliance with the principles and requirements of this policy and any associated documentation.

3.3 **The Chief Executive**
Has overall responsibility for the effective implementation of this policy.

3.4 **The Trust Board**
Has responsibility for ensuring that there is an effective framework in place to assist staff in the effective management of clinical risk.

3.5 **Corporate Teams**
Teams including the audit department, training and governance will ensure and support the implementation, training requirements and monitoring of the policy.

3.6 **The Audit Department** are responsible for:
Leading on the compliance and monitoring of the policy with support from respective Divisional compliance leads.

3.7 **Training Department**
To work with the lead Directors, to identify, procure and/or provide the education, development and training required by staff to support the implementation of this policy in accordance with financial and staffing resources.

4. **Positive risk taking**

4.1 Where all of the options for management and clinical intervention involve some risk, then "positive risk taking" is necessary. The trust wishes to support clinicians and endorse positive risk taking. Over-defensive practice is associated with avoidable harms to people who use services and practitioners. Positive risk taking is an essential part of supporting recovery-focused collaborative care and treatment, enabling service users to achieve their goals and aspirations.

4.2 Within the process of risk management and safety planning positive risk management means finding a balance between either the negligent or the over protective ends of the risk management continuum.

4.3 Positive risk management is based on the fundamental principles of individual rights and responsibilities for decision making (where the person has capacity). Risk is an accepted part of everyday life for all of us; however service users may be discouraged from taking risks because of perceived limitations or fear that they or others may be harmed. Positive risk management assumes individual responsibility whenever it is possible to do so. This requires:

- an understanding of and focus on a service user’s strengths, abilities, personal qualities, wants wishes and aspirations regardless of the history and the problems a service user experiences, even when they are in crisis
- having an understanding of peoples different perceptions of risk
• making informed decisions with regard to the possible consequences of the available choices
• acknowledging that in certain circumstances the need to accept short term risks for long term benefits

4.4 The recording of the decision making process, the people involved and recognition of risks and benefits with associated with risk management and contingency plans should be documented. Including actions.

5. **Key principles underpinning risk assessment and management**

5.1 The key components to working with risk are to regularly assess the risks, to put into place plans with the person which help to minimise and manage the risk and thus improve safety and to keep such plans under regular review.

6. **Types of Risk**

6.1 **Risk of harm to the person** accessing services – including deliberate self-harm, self-neglect, physical health/infection, social isolation or the potential for abuse by others, including, physical abuse, the potential for actively or passively leaving the unit/department/scheme/care home without the knowledge and agreement of staff or exploitation of any kind, including financial, drug, politically (or otherwise) motivated abuse such as terrorist exploitation

6.2 **Risk of harm to others** – including physical violence or harm, abuse including physical, emotional, sexual, domestic abuse, verbal or psychological abuse, harassment, potential harm to others through passive or active unsafe actions including fire setting or other dangerous acts

6.3 **Risk of damage to property** – including damage to fabric or structure of buildings or objects, including as a result of passive or active fire setting.

6.4 **Iatrogenic risk** - the potential to create harm by staff/services involvement in the risk itself

7. **How to undertake a collaborative risk assessment**

7.1 A collaborative risk assessment should be undertaken with the service user and carer whenever possible. If this is unable to occur, the reasons should be documented and collaboration should be sought from other members of MDT or external agencies who are involved in their care. The risk assessment should be drawn up for the whole person being taken into account biological, psychological and social needs, or other needs including e.g. spiritual, economic, and legal, into account. This should be created in as collaborative a way as possible with service users alongside their families/friends. Service user engagement increases the likelihood of the plan being realistic and utilised.

7.2 The risk assessment tool to be used is the RiO Risk Assessment page. The risk assessment tools that are used within each specialism are:

- Adult Mental Health  RiO Risk Assessment form Part B
- OPMH, RiO Risk Assessment form Part A
- LD, RiO Risk Assessment form Part A
- Specialised Services, RiO Risk Assessment form Part A
7.3 Other specialist/ empirically tested Risk Assessment tools can be used as directed by the MDT

7.4 A comprehensive risk assessment should include:

- Historical risks
- Current situation
- Risk of harm to self
- Risk of harm from others
- Risk of harm to others
- Physical health related risks
- Risk of accidents
- Consideration of any other risk behaviours and issues
- Psychological and psychosocial factors
- Demographic factors
- Protective factors

7.5 **A Risk Assessment is required to be completed in the following situations:**

- As part of the initial assessment by any Clinical Team in all Service Divisions.
- At the beginning of each new episode of care.
- Within four weeks of transition, e.g. between Community Teams. (MH/LD specific)
- During the first assessment of the service user’s condition
- Following admission to hospital. (Within 4 hours)
- Annually (as a minimum), as part of CPA/Care Plan Reviews, if a new Risk Assessment has not been completed in the previous 6 months.
- When there are changes to support infrastructures e.g. carer circumstances, change of clinicians
- When alerted by carers/relatives to their concerns. e.g. about changes to presentation/personal circumstances/an incident
- At transition between one team to another

7.6 **Other Sources of Information for Risk Assessments** - the process of collecting information should be collaborative, if appropriate multidisciplinary decision making will occur and lead to a clear formulation of risks. When staff are assessing a person for the first time, they are responsible for ensuring that they access relevant sources of information to complete the risk assessment such as family, referral letter and previous assessments. The assessment should be done in collaboration with the person being assessed, and their family and other relevant agencies which may include, but not limited to: Adult or Children Services, Criminal Justice System or Health Visitors.

8. **When you should look at and consider the current Risk Assessment**

8.1 This will ensure that the process remains dynamic and is therapeutic in responding to the service user’s changing presentation and ability to self-care.

8.2 **Community Service Users** this includes but is not limited to:

- At each CPA/Care Plan Review
- If there is evidence of a change in the presentation, as shown in the following areas;
  - Behaviour, especially known risk behaviours
  - Mental state
  - Physical condition
- If there is information from a third party, including, carers, family members or other informants which suggests that the service users risk has changed.
- Significant change in life events.
- If an SI indicates that the incident could have been prevented or the harm lessened and it is appropriate to do so, then the risk assessment must be reviewed and updated to reflect the clinical information identified as missing. This specific review should be undertaken and the risk assessment updated by the current MDT caring for the service user.
- If there is evidence either from the service user’s history or from a third party (e.g. family member or other) that a vulnerable other person such as a spouse (in domestic abuse) or child or other (vulnerable) person are at potential risk from the service user, thus raising safeguarding concerns
- If there is evidence that the service user may be at risk of exploitation from others
- As part of the clinical assessment of suitability for transfer to another team.
- Within 7 days of discharge from an inpatient service or on the same day if the service user had been assessed as a high risk of suicide at any point during the admission (Mental Health specific)
- If a new risk incident occurs

8.3 **Inpatients** this includes but is not limited to:

- At each Multi-Disciplinary Ward Review/CPA/Care Plan Review.
- Prior to decisions about change in the leave status of the service user (whether informal or detained under the MHA).
- Before each episode of leave
- By the Responsible Clinician (for detained service users) or the inpatient Multi-Disciplinary team, prior to discharge planning. This must include due consideration to the risk to any actual or potential victims in the community. It should also take into account the heightened risk of suicide in the first three months after discharge
- Prior to transfer between inpatient wards or inpatient units
- Evidence of change in the presentation of the service user as shown by their;
  - Behaviour, especially known risk behaviours.
  - Mental state
- Significant change in life events
- If an SI indicates that the incident could have been prevented or the harm lessened and it is appropriate to do so, then the risk assessment must be reviewed and updated to reflect the clinical information identified as missing. This specific review should be undertaken and the risk assessment updated by the current MDT caring for the service user.
- Evidence from information from a third party, including, carers, family members or other informants, which suggests that risk has changed.
- Where any safeguarding concerns are raised on the ward (institutional, from other service users)
- On the day of discharge from an inpatient ward
- If a new risk incident occurs
- Within 24 hours of being accepted onto the Acute Mental Health Team caseload

9. **How to formulate and develop a Risk Management Plan**

9.1 The risk formulation needs to have certain stages, regardless of the clinical approach.

9.2 **First**, get broad sources of information, including the service user’s account, views of relatives/carers/advocates, and any documentary sources including historical records held by the Trust / previous service providers, GP etc. This search should be proportionate.
9.3 **Second**, for each type of risk (self-harm, violence, etc.), form an idea of the general level of care to be delivered for the service user. This should be done with reference to long term risk factors, for example previous risk events, demographic status, family history, and the presence or absence of certain clinical factors like mental illness, substance misuse or personality structure/disorder. Consider widely different domains of risk such as falls, vulnerability etc. depending on the service user.

9.4 **At this stage**, the clinician might form an opinion that there is not a significant probability of some types of risk event, and so no need for a detailed assessment of that risk. Such decisions are sensible and necessary. Someone with no history of fire-setting does not need a detailed assessment for fire-setting. Anyone who has had ever done significant violence needs a violence risk formulation. For anyone who has ever had ideas or actions around self-harm, they need a formulation, however brief, of self-harm risk. The same is true for other domains of risk.

9.5 **Third**, the imminence of risk now, how soon a risk event might happen, should be considered. This should consider how the service user is now in their current clinical presentation. When formulating self-harm we should take into account factors including, for example, their intent of suicide, depressive symptoms and hopelessness or their absence, or any strengths, such as employment, future plans or engagement. For formulation of violence, we should take into account, for example, impulsivity, grievances, emotional regulation and violent attitudes.

9.6 **Fourth**, a plan should be drawn up. This should be done as far as possible with service user’s and families’/friends’ inclusion. It should cover the comprehensive management of the service user as it is hoped to go forward, i.e. a routine or expected plan, taking all of the biological, psychological and social needs, or other needs including spiritual, economic, legal, etc. The plan should be all inclusive and see risk as part of the whole person. The plan should use terms that the service user and others can understand.

9.7 **Fifth**, the risk management plan should include things such as life events, stressors, destabilisers, personal support and agreement of the service user. Consideration should be given as to what might make the plan go wrong and what the contingency plans for this would be.

9.8 **Sixth**, in developing the risk management plan risky scenarios should be explicitly considered in a fairly free and imaginative way. This is the element of the risk management which has the most practical use, if the rest of the approach is sound. The essence of this is narrative exploration of the most likely or serious risk scenarios, and it must be done in order to allow us to see problems coming - what would the warning signs be? E.g., how will the service user look in a situation which may lead to attempted suicide – hopeless; drinking more; socially isolated; doing less; missing appointments. This appearance is a “risk signature” and if it arises in future, we may need to take action to keep the service user safe. Scenarios must not be discussed in a check-list fashion, or the process will not be helpful and may give false reassurance.

9.9 Contingency plans should be based on these risk signatures, and on realistic assumptions about the care that will be available.

9.10 The following points should be considered and the mitigation incorporated into the risk management plan:

- Is there a risk of harm?
- What sort of harm and of what likely degree?
- What is the immediacy or imminence?
- How long may the risk last?
- What contributory factors relate to the level of risk?
- How can the contributory factors be modified or managed?
- Are there any protective or mitigating factors?

9.11 The recording of the contingency plan should be completed using the following tool:

- AMH – MyCrisis&Safety Plan for service users graded moderate or above on the risk assessment tool. For other service users, this will be combined into their care planning documentation.
- LD – Embedded into Care Planning and CPA documentation
- OPMH – Embedded into Care Planning and CPA documentation
- Specialised – Embedded into Care Planning and CPA documentation.

10. **Restrictive practices and managing risk**

10.1 Clinical risk must always be managed in line with individual circumstances. Blanket restrictions to manage presenting risks must not be routinely utilised. Should circumstances occur where such blanket restrictions are deemed essential to the health, safety or welfare of others advice must be sought from the senior management team and clear justification noted. Any such restrictions must be reviewed and removed at the earliest opportunity.

11. **Recording Risk Incidents**

11.1 When a member of staff becomes aware that a person has come to harm the details should be written in the electronic record and the risk incident box ticked, which facilitates this being pulled through to the risk history. It is recognised that there are patients within services who frequently harm themselves and it is for a professional judgement of a registered practitioner to determine whether this should be reported via Ulysses. This threshold may differ depending on the clinical setting or recent clinical presentations. It is important that all episodes are recorded on RiO in order to maintain a comprehensive clinical record.

11.2 The person who recognises the risk is the person responsible for ensuring that the risk is either handed over to an appropriate member of staff (in the case of unregistered staff) or recording the risk on the risk assessment form and ensuring immediate actions are taken to ensure service user, public and staff safety and is shared with the appropriate members of the clinical team.

12. **Training Requirements**

12.1 All staff are required to complete training as identified on the Training Needs Analysis.

12.2 Training within Divisions will be agreed on a bespoke basis e.g. the implementation of the Team-Based Risk Assessment and Management Practice Development Initiative in Mental Health Teams.

13. **Monitoring Compliance with the Contents of this Policy**

13.1 A set of generic practice standards are in place to support audit and review

13.2 The following table sets out how the Trust will monitor compliance with key elements of this policy –
Practice Standards

- Consideration of risk is during an assessment.
- Risk Assessment is undertaken at the beginning of each new episode of care.
- All staff undertaking risk assessments and management plans are trained.
- Risk reviews are conducted in a timely way and are current.
- Risk assessments for detained service users are reviewed and explicitly agreed by the RC or deputy.
- The Risk Management Plan must be integrated and form an essential part of the service user’s Care Plan/CPA Care Plan and reflected in the progress notes.
- Transitions are managed sensitively and collaboratively.

13.3 All audits will be conducted annually and be led by the Divisional Professional Lead.
Appendix 1

Training Needs Analysis

If there are any training implications in your policy, please complete the form below and make an appointment with the LEaD department (Louise Hartland, Quality, Governance and Compliance Manager or Sharon Gomez, Essential Training Lead on 02380 874091) before the policy goes through the Trust policy approval process.

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<tr>
<th>Training Programme</th>
<th>Frequency</th>
<th>Course Length</th>
<th>Delivery Method</th>
<th>Facilitators</th>
<th>Recording Attendance</th>
<th>Strategic &amp; Operational Responsibility</th>
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<td>Assessment and Positive Risk</td>
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<td>Face to face</td>
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<tr>
<th>Directorate</th>
<th>Service</th>
<th>Target Audience</th>
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| MH/LD/OPMH | Adult Mental Health | All qualified practitioners, assistant/associate practitioners, therapists and trainee practitioners who work in the following services; East ECT; Hawthorns ward, PICU and MOD unit; South Outpatients, Saxon ward, Hamtun Ward, Trinity ward, South Fast Stream Rehab (Forest Lodge), South OT, Abbey ward. Mother & Baby Unit; Kinsley ward, Melbury OT. All art therapists that work in North Psychological Therapies.  
All qualified practitioners, assistant/associate practitioners, therapists and trainee practitioners, support workers, technical instructors/technicians who work in the following services; CQUIN Psychiatric Liaison; Liaison Psychiatry; AMH Management; Division Bed Management; West Medical Expansion; New Forest Teaching CTR; Homeless Team; Liaison & Diversion and the Perinatal Community Team. |
| MH/LD/OPMH | Specialised Services | All qualified practitioners, assistant/associate practitioners, therapists and trainee practitioners who work in the following services; Leigh House; Ravenswood House (Athurst, Lyndhurst, Malcolm Faulk, Mary Graham, Mean Valley wards and RSU community), RSU Therapies, RSU Psychology, Clinical Risk & Security and RSU Management); Southfield, Southfield OT & Southfield Psychology; Bluebird House (Bluebird Nursing & Security, Bluebird House OT and Bluebird House Psychology, Hill, Moss & Stewart wards) and Personality Disordered Offender team. Cypress and Ashford. |
| MH/LD/OPMH | Learning Disabilities | All qualified practitioners, assistant/associate practitioners, therapists and trainee practitioners who work in the following services; Willow ward;; Evenlode; House 2 Step Down; Ridgeway centre.  
All qualified practitioners, assistant/associate practitioners, therapists and trainee practitioners, support workers, technical instructors/technicians who work in the following services; Community Learning Disability Teams including management; Psychology teams; Autistic Spectrum Disorder team. |
| MH/LD/OPMH | Older Persons Mental Health | All qualified practitioners, assistant/associate practitioners, therapists and trainee practitioners who work in the following in-patient services; Gosport War Memorial Hospital (Dryad & Daedalus wards); Melbury Lodge (Stefano Olivieri ward); Parklands Hospital (Beechwood, Elmwood wards & North Inpatient Therapies ); Western Community Hospital (Beaulieu, Berrywood & Minstead wards & Western Inpatient Therapies)  
All qualified practitioners, assistant/associate practitioners, therapists and trainee practitioners, support workers, technical instructors/technicians who work in the following community services; Community mental health teams (CMHT); Western/West Psychology; Western Management; Dementia Advisors; OPMH-Sift; ECT & Clinics; Aerodrome; East Management; St. Waleric and Newtown House. |

ISD’s | Adults | Not Applicable |
ISD’s | Childrens Services | Not Applicable |
Corporate | All | Not Applicable |
## Appendix 1

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<tr>
<td>Team Based Reflective Practice: Risk Training</td>
<td>E-assessment – once only</td>
<td>Staff are required to complete the Positive Risk Taking e-assessment and participate in a minimum of 2 team based reflective practice sessions (1 hour minimum duration per session)</td>
<td>E-assessment and team based facilitated sessions (minimum of one hour duration)</td>
<td>A central register of facilitators will be maintained by the Head of Nursing, AHP and Quality-Mental Health</td>
<td>e-assessment via LEaD Staff will e-verify compliance with team based reflective practice risk training requirements via the LEaD website.</td>
<td>Strategically – Head of Nursing, AHP and Quality for MH. Operationally – Team Managers/Modern Matrons</td>
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<th>Target Audience</th>
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<td>MH/LD.OPMH</td>
<td>Adult Mental Health</td>
<td>All qualified practitioners, assistant/associate practitioners, therapists and trainee practitioners, support workers, technical instructors/technicians who work in the following services; Eating Disorders Service, Hampshire IAPT, all community treatment teams (CTT’s), access and assessment teams, early intervention in psychosis teams (EIP), crisis and hospital at home teams, assertive outreach teams, psychology teams, enablement team, Elmleigh (inpatients &amp; PICU) and Hollybank. (Exception art therapists).</td>
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Appendix 2

Southern Health NHS Foundation Trust:
Equality Impact Analysis Screening Tool

Equality Impact Assessment (or ‘Equality Analysis’) is a process of systematically analysing a new or existing policy/practice or service to identify what impact or likely impact it will have on protected groups.

It involves using equality information, and the results of engagement with protected groups and others, to understand the actual effect or the potential effect of your functions, policies or decisions. The form is a written record that demonstrates that you have shown due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations with respect to the characteristics protected by equality law.

For guidance and support in completing this form please contact a member of the Equality and Diversity team

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<th>Name of policy/service/project/plan:</th>
<th>The Assessment and Management of Clinical Risk Policy</th>
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</tr>
<tr>
<td>Department:</td>
<td>Mental Health Division</td>
</tr>
<tr>
<td>Lead officer for assessment:</td>
<td>Liz Durrant</td>
</tr>
<tr>
<td>Date Assessment Carried Out:</td>
<td>December 2015</td>
</tr>
</tbody>
</table>

1. Identify the aims of the policy and how it is implemented.

<table>
<thead>
<tr>
<th>Key questions</th>
<th>Answers / Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Briefly describe purpose of the policy including</td>
<td>This policy describes the processes Southern Health NHS Foundation Trust (SHFT) uses to ensure risks relating to the clinical presentation of service users and their care and support are assessed and managed.</td>
</tr>
<tr>
<td>▪ How the policy is delivered and by whom</td>
<td>Intended policy outcomes:</td>
</tr>
<tr>
<td>▪ Intended outcomes</td>
<td>• <strong>support clinicians</strong> in the assessment and management of clinical risk</td>
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<tr>
<td></td>
<td>• <strong>ensure that the Trust</strong> has an agreed process for clinical risk assessment and management</td>
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<tr>
<td></td>
<td>• <strong>ensure that the Trust</strong> can demonstrate that it complies with all national and commissioner guidance on clinical risk management.</td>
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</table>
2. Consideration of available data, research and information

Monitoring data and other information involves using equality information, and the results of engagement with protected groups and others, to understand the actual effect or the potential effect of your functions, policies or decisions. It can help you to identify practical steps to tackle any negative effects or discrimination, to advance equality and to foster good relations.

Please consider the availability of the following as potential sources:

- **Demographic** data and other statistics, including census findings
- Recent research findings (local and national)
- Results from consultation or engagement you have undertaken
- Service user monitoring data
- Information from relevant groups or agencies, for example trade unions and voluntary/community organisations
- Analysis of records of enquiries about your service, or complaints or compliments about them
- Recommendations of external inspections or audit reports

<table>
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<tr>
<th>Key questions</th>
<th>Data, research and information that you can refer to</th>
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<tr>
<td>2.1 What is the equalities profile of the team delivering the service/policy?</td>
<td>The Equality and Diversity team will report on Workforce data on an annual basis.</td>
</tr>
<tr>
<td>2.2 What equalities training have staff received?</td>
<td>All Trust staff have a requirement to undertake Equality and Diversity training as part of Organisational Induction (Respect and Values) and E-Assessment</td>
</tr>
<tr>
<td>2.3 What is the equalities profile of service users?</td>
<td>The Trust Equality and Diversity team report on Trust patient equality data profiling on an annual basis</td>
</tr>
<tr>
<td>2.4 What other data do you have in terms of service users or staff? (e.g results of customer satisfaction surveys, consultation findings). Are there any gaps?</td>
<td>The Trust is preparing to implement the Equality Delivery System which will allow a robust examination of Trust performance on Equality, Diversity and Human Rights. This will be based on 4 key objectives that include:</td>
</tr>
</tbody>
</table>
1. Better health outcomes for all  
2. Improved patient access and experience  
3. Empowered, engaged and included staff  
4. Inclusive leadership

| 2.5 | What internal engagement or consultation has been undertaken as part of this EIA and with whom? What were the results? Service users/carers/Staff |
| 2.6 | What external engagement or consultation has been undertaken as part of this EIA and with whom? What were the results? General Public/Commissioners/Local Authority/Voluntary Organisations |
In the table below, please describe how the proposals will have a positive impact on service users or staff. Please also record any potential negative impact on equality of opportunity for the target:

In the case of negative impact, please indicate any measures planned to mitigate against this:

<table>
<thead>
<tr>
<th>Positive impact</th>
<th>Negative Impact</th>
<th>Action Plan to address negative impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>As people grow older, they are more likely to be diagnosed with conditions such as cancer, heart disease and arthritis. A patient’s relative need for a range of health interventions, including surgical treatment, therefore increases with age.</td>
<td>Actions to overcome problem/barrier</td>
</tr>
<tr>
<td>Disability</td>
<td>Use of Interpreters or other appropriate communication services such as sign language, may be required to ensure full involvement of service users in clinical risk assessment.</td>
<td>People with severe and enduring mental health problems are more likely to have co-existing physical health problems, have poor social functioning and be stigmatised.</td>
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<tr>
<td>Gender Reassignment</td>
<td>Throughout the process of gender reassignment all treatments, procedures, access criteria, associated risks and expectations should be clarified with the patient. An individualised programme of information provision, services, treatment, and surgery as appropriate to the person's individual needs and situation should be discussed and agreed.</td>
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</table>

| Marriage and Civil Partnership | No negative impacts identified at this stage of screening |

| Pregnancy and Maternity | No negative impacts identified at this stage of screening |

| Race | Use of Interpreters or Interpreting and |
other appropriate communication services such as sign language, may be required to ensure full involvement of service users in clinical risk assessment.

<table>
<thead>
<tr>
<th>Religion or Belief</th>
<th>No negative impacts identified at this stage of screening</th>
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<tbody>
<tr>
<td>Sex</td>
<td>No negative impacts identified at this stage of screening</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>National Institute for Mental Health England (2007) Mental disorders suicide and deliberate self-harm in lesbian, gay and bisexual people, London: NIHME. “Our findings show that LGB people are at significantly higher risk of mental disorder, suicidal ideation, substance misuse, and DSH than heterosexual people”</td>
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