NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST

BOARD OF DIRECTORS MEETING

Meeting Date: 25 February 2015

Title and Author of Paper: Clinical Risk Assessment and Management Strategy
Dr Rajesh Nadkarni

Paper for Debate, Decision or Information: Information and Decision

Key Points to Note:

The Trust has been working on developing this strategy for the past year. It has been highlighted as a developmental need in previous Internal Audit reports, and risk assessment and management as a theme has been raised in previous Independent Inquiries.

This strategy sets out the Trust's requirements relating to mental health staff working with service uses and carers and other service providers to assess and manage risk. It provides a useful framework to assist clinicians in their practice.

The aims and purpose of this Strategy are as follows:

- Promote service user safety;
- Promote staff safety;
- Promote a systematic approach to risk assessment and management at individual practitioner, team and organisational levels;
- Minimise clinical risk within the Trust, to the community and to the public;
- Support members of staff in developing safety focussed care plans with service users to assess and manage risk;
- Promote positive risk taking;
- Outline the responsibilities of the Trust, teams and individuals in assessing and managing risk and recording risk information.

Outcome required: Approval by the Board of Directors

Northumberland, Tyne and Wear NHS
NHS Foundation Trust

Clinical Risk Assessment and Management Strategy

Applies to:	ALL directly employed and agency staff ALL Contractors when working for NTW
Lead Officer	**Executive Director of Nursing and Operations** **Medical Director**
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Review and Amendment Log	**Version**	**Type of change**	**Date**	**Description of change**
	V01	NEW	Mar 15	NEW Document

Clinical Risk Assessment and Management Strategy

1 Introduction

1.1 The Trust Board recognises that risk assessment and management, including positive risk taking is an integral part of good clinical practice and, to be most effective, should be part of the culture of the Trust. It is committed to ensuring that responsibility for implementation is accepted at all levels in the organisation.

1.2 Safety is at the centre of all good health care. This is particularly important in mental health but it is also more sensitive and challenging. Patient autonomy has to be considered alongside public safety. A good therapeutic relationship must include both sympathetic support and objective assessment of risk and an understanding of the benefits of positive risk taking.

1.3 Risk assessment and management is often viewed in a negative light; the connotation of risk management being that professionals are responsible for controlling the whole of a person's life. As a consequence of this risk management is often seen as a punitive process with practitioners focussing on possible negative outcomes and their avoidance. Northumberland, Tyne and Wear NHS Foundation Trust (the Trust/NTW) takes the stance that risk should be managed in the least restrictive way possible and should take into account and balance the benefits that a person may gain from taking a risk with the possible negative consequences.

2 Scope

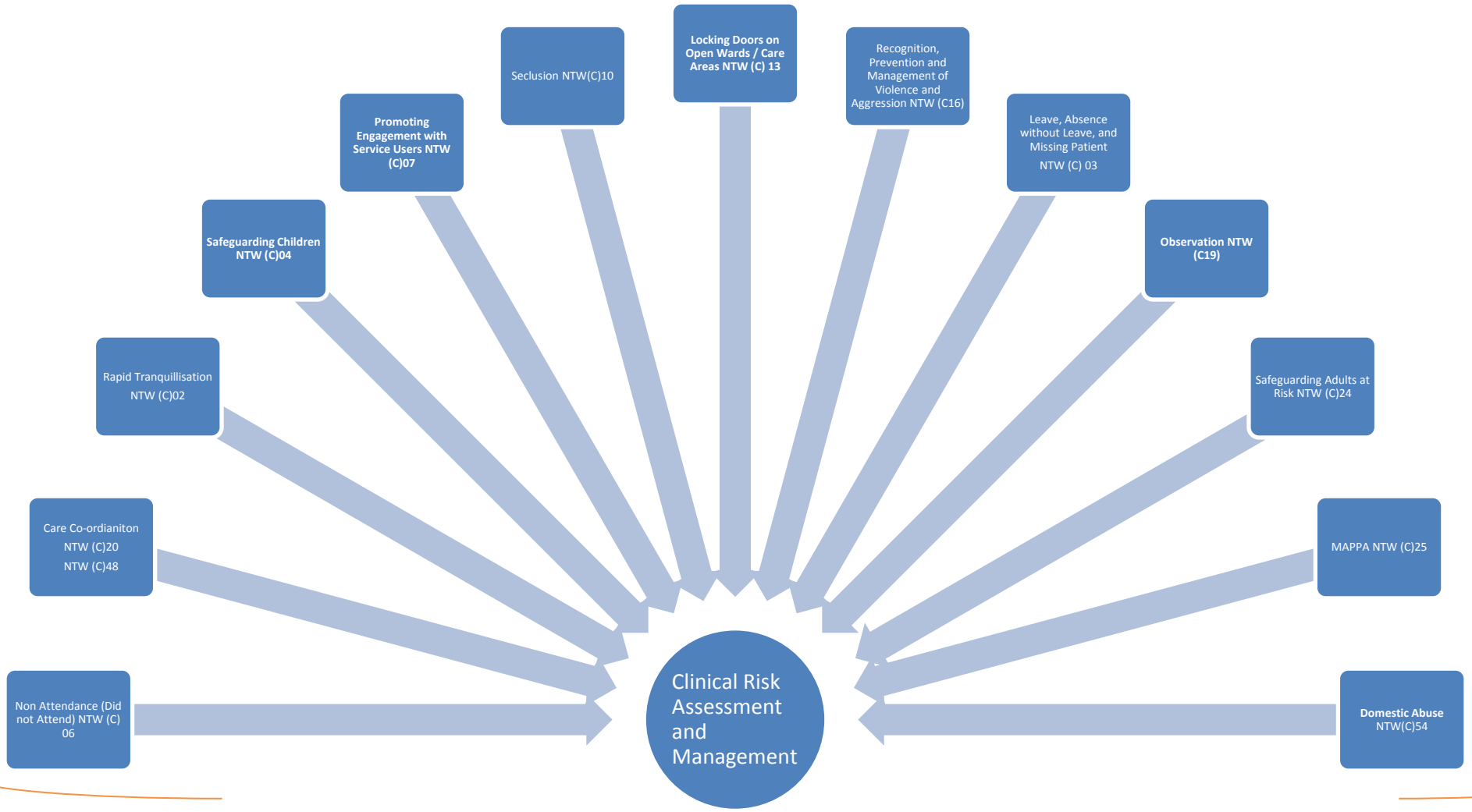
2.1 This Strategy sets out the Trust's requirements relating to mental health staff working with service uses and carers and other service providers to assess and manage risk.

2.2 The aims and purpose of this Strategy are as follows:

- Promote service user safety
- Promote staff safety
- Promote a systematic approach to risk assessment and management at individual practitioner, team and organisational levels
- Minimise clinical risk within the Trust, to the community and to the public
- Support members of staff in developing safety focussed care plans with service users to assess and manage risk
- Promote and support positive risk taking
- Outline the responsibilities of the Trust, teams and individuals in assessing and managing risk and recording risk information

2.3 Risk assessment and management is an integral part of good clinical practice. As such it is integrated into a number of Trust policies and practice guidance notes. These set standards and requirements for Risk assessment and management in the context of the stage of the service users pathway.

Violence Prevention Strategy

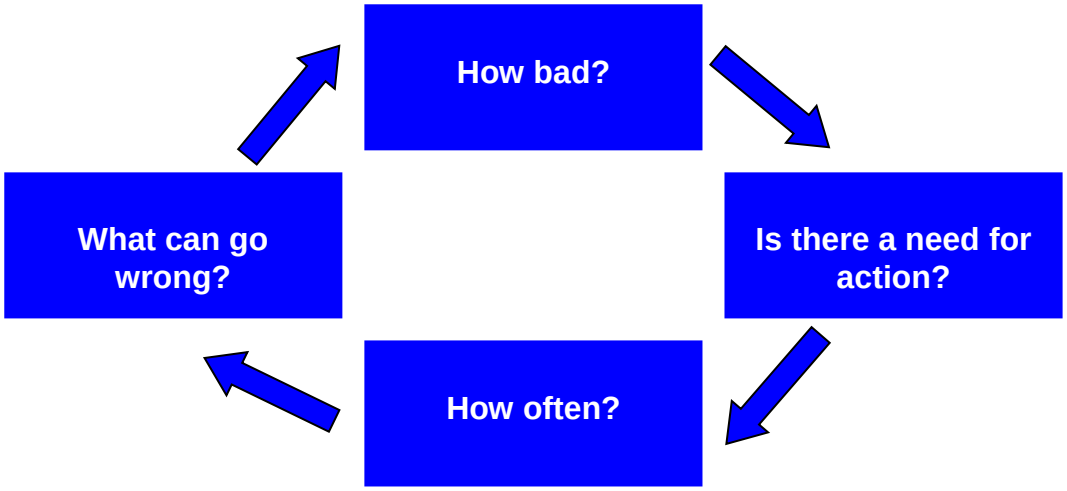


3 Definition of Clinical Risk and Management

3.1 Clinical risk assessment is:

"The process of assessing whether or not, and in what circumstances, a person may harm themselves or others (or be harmed). This assessment involves chance, uncertainty and unpredictability. It is about assessing the likely occurrence of a future event, the likely impact of that event, upon whom or what and with what consequences.

3.2 A clinical risk assessment seeks to answer four related questions;



3.3 It is not usually possible to eliminate all risks but healthcare staff have a duty to protect patients as far as 'reasonably practicable'. This means one must avoid any unnecessary risk. It is best to focus on the risks that really matter – those with the potential to cause harm. Keep risk assessment simple – do not use techniques that are overly complex for the type of risk being assessed.

3.4 Clinical risk management is:

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

3.4.2 While this definition is helpful in supporting staff to consider risk management options NTW believes that service user's strengths and aspirations lie at the heart of reducing risk. Staff should focus their expertise on identifying major risks such as the risk of harm to self and others while recognising that helping service users meet their needs and aspirations (e.g. housing, finances, relationships, psychological recovery and employment) in order to build a meaningful life may at times be the most effective way to reduce these risks.

3.4.3 The emphasis of the risk assessment and management process should be to support and enable service users to recognise their role in developing strategies to maximise recovery and their safety and that of others. Focussing on engagement and developing a therapeutic relationship which promotes trust is possibly the most powerful tool in enabling mutual risk assessment and effective risk reduction.

3.4.4 There are times where actions must be taken by staff to reduce risk and any intervention to manage risk must be proportionate to the seriousness of potential harm and the likelihood or imminence of that harm occurring. Any risk management plan must balance the wishes of the individual with consideration of their wellbeing, their human rights and the need to minimise risk.

4 Duties

4.1 Chief Executive

4.1.1 The Chief Executive is responsible for ensuring effective clinical risk management within NTW in conjunction with partner Directors of Social Services.

4.2 Accountable Directors

4.2.1 Executive Medical Director:

- The Medical Director is responsible for the development of this strategy and for ensuring the effective management of clinical risk within NTW. This responsibility is delegated to Group Directors, Managers and Clinicians and is monitored via approved committee structures. The Medical Director is the Chair of the Safety Programme Board. The Medical Director is also responsible for ensuring effective risk management practice within the medical work force.

4.2.2 Executive Director of Nursing and Operations:

- The Director of Nursing and Operations is chair of the Group Business Meeting (GBM). This group is responsible for overseeing clinical risk management across the trust. Safety and Safeguarding Groups meet monthly to ensure that lessons learnt from incidents are shared across the organisation and embedded in practice. The Director of Nursing and Operations is also responsible for ensuring effective risk management practice within the nursing and allied health professional work force.

4.3 Group Directors

- It is the responsibility of Group Triumvirates to ensure that staff members are made aware of this strategy, are sufficiently trained in risk assessment and management and that this strategy is implemented in their services. This is monitored via the monthly safety audit and via reported compliance with mandatory training, clinical supervision and Appraisals.

- Each group has in place a Safety and Safeguarding Committee to oversee, monitor and manage risk within the service lines.

5 The Assessment of Risk

5.1 The term risk assessment often causes anxiety for practitioners, and is surrounded by an aura of mystique which it does not deserve.

5.2 Best practice in risk assessment and management involves making decisions based on knowledge of the research evidence, knowledge of the individual service user's experience, their social context, and clinical judgement.

5.3 The cornerstone of good risk assessment and management is the completion, recording and appropriate sharing of a comprehensive clinical assessment which any multidisciplinary team should be able to undertake.

5.1 Risk factors

5.1.1 The Department of Health (DOH) guide Best Practice in Managing Risk identifies a risk factor as:

5.1.2 A personal characteristic or circumstance that is linked to a negative event, and that either causes or facilitates the event to occur.

5.1.3 Risk factors can help us to predict what types of risks are potentially present and may be categorised as follows:

5.1.4 **Static factors**: Factors that are known to be correlated with increased risk, which do not change. These include historical indicators for example a history of suicide attempts, violence or childhood abuse. These factors will always be present although their relevance will vary across individuals and over time.

5.1.5 **Dynamic factors**: Factors which change over time. They may be aspects of the individual or of their environment and social context or indeed all of these. Examples of these are: attitude and beliefs of carers, alcohol or substance misuse, financial status, current mental state and social deprivation. These factors may change over time and are therefore more amenable to management. Dynamic factors may change slowly (stable factors) or rapidly (acute factors) and the impact of these factors on the level of risk may be short lived or longer term.

5.2 Types of risk assessment

5.2.1 The Best Practice in Managing Risk guide identifies three types of risk assessment and management.

5.2.2 **Unstructured clinical approach**: this type of approach would take the form of an unstructured conversation, it is not systematic and therefore less reliable; this method is not recommended.

5.2.3 **Actuarial approach**: this approach focuses on static factors known to be associated with increased risk. For example; statistically people who have self-harmed in the past are at a higher risk of suicide. Actuarial risk assessment (applying a mathematical model to known risk factors) is of value in placing people in risk categories for the likelihood of an adverse event happening. They do not however predict that the event will or will not occur in an individual case.

5.2.4 **Structured clinical**: this approach combines the use of a structured method of assessing risk with the use of actuarial information to assess clearly defined risk factors, risk triggers and ameliorants of risk and makes use of:

- Clinical experience and knowledge of the service users
- The service user's view
- Takes into account views of carers and other professionals

5.2.5 **The structured clinical approach is the process which NTW Trust staff should practice and is explained in the accompanying PGN, CRS-PGN-01 - The context, approach and stages of clinical risk formulation**

6. Gathering Information

6.1 The key to effective risk assessment is obtaining information via interview and collateral history from various sources. Interview with the service user is the basis of an initial risk assessment, however this is seldom sufficient and in all cases, when possible, risk related information must be collected from informants, e.g. referral source, GP, community team, family, social or criminal justice services.

6.2 A clear record must be made of the sources of information on which any risk assessment is based. Past records both from within and outside of NTW must always be sought in the preparation of an initial risk assessment including when a service user is re-referred or admitted to a ward. Historical information must always be taken into account when assessing risk. Prior interventions that proved effective will also help inform the risk management plan.

7. When to assess risk

7.1 Risk must be assessed at certain key points in a service user's care pathway.

- As part of initial assessment / ongoing assessment / reassessment

- When admitting and discharging from hospital, informing observation levels and as part of planning and agreeing leave

- As part of community or inpatient care coordination or MDT reviews

- When there are major changes to presentation / personal circumstances or following an incident

- When a known major event is imminent that may affect the individual such as appearance in court or an anniversary of a significant event e.g. death of a close relative / loved one

- When alerted by carers / relatives to their concerns. e.g. about changes to presentation / personal circumstances / an incident

- When referring service users to other professionals teams/service providers to ensure that there is a shared understanding of current risks to inform the referral process

- When transferring service users to other teams/service providers to ensure that there is a shared understanding of current risks to inform the transfer process.

- When alerted by other members of the care team about major changes to presentation / personal circumstances / an incident

7.2 **Care Co-ordination**

7.2.1 Clinical Risk assessment and management is an integral part of the Trust's approach to assessment and care planning for all service users. Within the Care co-ordination process clinical risk assessment is an integral part of deciding if a service users need are complex / enhanced (CPA).

8. Essential components of clinical risk assessment and management

8.1 Essential components of clinical risk assessment and clinical risk management include engagement, good history taking, and formulation of risk.

8.2 **Risk formulation**

8.2.1 **Formulation should try to answer:**

- How serious is the risk?
- Is the risk specific or general?
- How immediate is the risk?
- How volatile is the risk?
- What specific treatment or management plan might reduce the risk?

8.2.2 **A risk formulation should:**

- Summarise dynamic and static risk factors and protective factors
- Try to give an idea of how much impact individual risk factors have and what the precipitating event that has increased risk *now* is
- Discuss the summary of risk with the patient and get their views to incorporate in the formulation
- Together, look at what outcome the patient would like and what can be done to modify individual risk factors to minimise (not eliminate) risk
- Incorporate contingency planning and how the patient can seek help if things change in the formulation
- Note down names and roles of all people involved in the discussion about risk management in the formulation
- Be recorded around specific scenarios and in what situation these risks would be precipitated

8.3 The role of the care plan in risk management

8.3.1 The care (including crisis and risk management) plan should:

- Outline risk areas identified
- Indicate the likelihood and severity of risk
- Identify any potential harm / benefits from risk
- Identify trigger and protective factors
- Outline a risk management plan

8.3.2 The plan should be constructed and agreed with the service users and carers. It may reflect what they feel would be most effective in reducing the risk particularly in respect of crisis and contingency plans. It is also helpful to be clear with the service users as to what are the identified antecedents or causal links to their risky behaviour (as far as possible) so everyone can be aware of the potential consequences. Some service users may not wish to participate in this process and the plan may represent more of a service response; this should be recorded in the management plan. Copies of the plan should be given to service users and carers as per the Care Co-ordination policy.

8.3.3 If an intervention is indicated to reduce risk (e.g. increased medication, access to psychological therapies, monitoring by staff, access to supported housing) and is not available, this should be clearly recorded in the management plan and / or fed back to the service manager. A realistic management plan within the resources available still needs to be made, recognising that treatment options may be limited. This should be fed back to the service users.

8.4 Decision making

8.4.1 Any risk-related decision is likely to be the best decision that can be made at the time and will be acceptable if:

- It conforms with legislation
- It conforms with relevant guidelines
- It is based on the best information available
- It is documented
- The relevant people are informed

8.4.2 The rationale for any decisions must be recorded. This record must note:

- The persons /agencies involved in the decision making process
- The recognition of the risks identified
- Action taken to reduce the risk
- The contingency plan in place to support the individual

8.4.3 This information must be clearly documented and shared with the relevant individuals.

9. Recording risk information

9.1 Risk assessment should be recorded in the electronic patient record (RiO). At initial assessment this will be recorded on the narrative risk tool or the FACE risk profile as appropriate to the service user's complexity of need.

9.2 Reassessment at other key points in a service user's care pathway where there is a change to the previously recorded risk assessment should be recorded on the narrative risk tool or the appropriate FACE risk profile. Where there is no change to assessed risk this should be recorded in the electronic patient record, as set out in the Care co-ordination policy / PGNs.

9.3 The navigation screen on the service user's electronic patient record (RiO) identifies completed risk assessment tools and the last completion date.

9.4 In community services the electronic patient record (RiO) should be completed no later than three working days **unless** there is any issue of risk or concern, in which case the entry should be made as soon as practicable and on the same day as the patient is seen and consideration should be given to use the urgent entry process.

9.5 In Inpatient and crisis teams the electronic patient record (RiO) should be completed as soon as possible following patient contact, **no later** than the end of shift. If there is an issue of risk or concern, the entry should be made as soon as practicable but no later than the end of shift and consideration should be given to use the urgent entry process.

9.6 **Urgent entry process**

9.6.1 Where clinical judgment indicates that there is the need to update the record urgently and where there is no immediate access to the electronic patient record (RiO) entry must be made by another member of NTW staff in an un-validated progress note with originator on the note changed as appropriate. Each team must ensure this facility is in place within their team e.g. through Duty system or administrator arrangements. These entries must be made immediately onto the electronic patient record (RiO).

10. Risk assessment tools

10.1 Within the Trust and its partner agencies the minimum approved tools to record the outcome of risk assessment are:-

- FACE Risk Profile (Mental Health) for adult mental health services in Planned, Urgent and Specialist Group (excluding Neuro-rehabilitation and Neuro behavioural wards). Adult mental health SW staff in integrated teams Newcastle, Northumberland and North Tyneside and South Tyneside Local Authorities
- Gateshead Social Services Adult Social Care staff - Working with Risk 1; 2 and 3
- FACE Risk Profile (Neuro rehabilitation) - Neuro Rehabilitation Services within Specialist Group
- FACE Risk Profile (Neuro Psychiatry) - Neuro Psychiatry Services within Specialist Group
- FACE Risk Profile LD - Learning Disability services within Planned and Urgent Care groups and South Tyneside Local Authority
- FACE Forensic Risk Profile and HCR20 - Forensic Mental Health Services within Specialist Group
- FACE SAP Risk Profile Older People - Older People services within Planned and Urgent Care Groups and Older People SW staff in Newcastle and South Tyneside Local Authorities.
- Narrative risk tool (for service users who do not have enhanced needs) - Planned Care; and Community based Specialist Services (excluding Addictions). Crisis and Home Based Treatment Teams and Liaison Psychiatry.
- FACE risk profile for Children and Young Peoples Services.

11. Communicating an opinion of risk

11.1 An opinion of risk, whether based on a contemporary risk assessment or not, must be communicated to everyone who needs to be aware of it or act upon it. Issues of confidentiality and information sharing must be considered but may be overridden in order to prevent serious harm. Whilst such decisions are usually made by senior clinicians, any employee of the Trust who genuinely believes that disclosure of information will prevent serious harm and is unable to get a timely opinion from a senior, must act to minimise the risk of harm. Advice and support can be obtained from the Trust Caldicott and Legal Affairs Team.

12. Positive Risk-Taking

12.1 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.

12.2 Positive risk taking may be characterised by:

- 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

12.3 How to take positive risks

12.3.1 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).

12.3.2 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 and the pursuit of new ideas.

12.3.3 Through high-quality supervision and support, which are essential for discussing and refining ideas.

12.3.4 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.

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

12.3.6 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.

12.4 Guidelines For Positive Risk Taking

- Service-user experiences and understanding of risk.
- Carer experiences 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).
- Outcome of previous attempt(s) at this course of action.
- 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?

13. Training

13.1 The Trust requires all clinical staff to undertake Risk Assessment training every 3 years linked to care co-ordination. This includes the use of the FACE Risk Tool and training about the recording of risk. There are specific modules also delivered around Suicide Risk Assessment and Risk of Harm Assessment and Management. Details of the training and availability can be obtained from the training department.

14 References

- **North East Regional Suicide Prevention Steering Group A 5 Year Strategy for Suicide Reduction and Prevention: 2010 to 2015**

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- practice in supported decision making. Department of Health: London.

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- National Institute for Clinical Excellence, 2005. Violence. The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments. National Institute for Health and Clinical Excellence: London.

- University of Manchester (2006) Avoidable deaths: five year report of the national confidential inquiry into suicide and homicide by people with mental illness. University of Manchester: Manchester.

- Risk, Safety and Recovery

- Mental Health Network NHS Confederation/Centre for Mental Health, June 2014
  http://www.centreformentalhealth.org.uk/pdfs/ImROC-Briefing-Risk-Safety-and-Recovery.pdf

- Prevention and Management of Violence: Guidance for Mental Healthcare Professionals CR177 RCP
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- Special Report: Mental Health. Positive Risk |Taking-an idea whose time has come. Steve Morgan. October 2004.

'Strategy' Practice Guidance Note

Clinical Risk Strategy practice guidance note The context, approach and stages of clinical risk formulation – V01		
Date Issued	**Planned Review**	**PGN No:**
Issue 1 - Mar 2015	**March 2018**	**CRS-PGN-01** Part of - Clinical risk assessment and management strategy V01
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Contents

1 Introduction

1. This practice guidance note (PGN) refers to the context, approach and stages of clinical risk formulation within Northumberland, Tyne and Wear NHS Foundation Trust, (The Trust/NTW) and is a guide for clinicians working with all patients; sitting within the wider NTW Risk Strategy.

2. The requirements for when clinical risk is assessed and the associated recording requirements are set out in the Trusts policies;

   - NTW(C)20 - Care Coordination and Care Programme Approach
   - NTW(C)48 - Care Coordination and Care Programme Approach, Children and Young People

3. Risk assessment, formulation and management, including positive risk taking, is an essential part of providing a service to people. Clinicians are involved in making judgements of risk every working day.

2 Guidelines

2.1 Context

2.1.1 Risk is a term with broad meanings, in this context it means the clinical problems related to “risk to self” or “risk to others”, e.g. self-harm / suicide, and self-neglect and violence (including antisocial and offending behaviour). Positive risk taking is an informed decision to tolerate or manage some risk, with the aim of achieving a positive outcome for the service user.

2.1.2 It is not possible to devote the same degree of vigilance to all patients, so some services require to be more risk orientated than others in their day to day practice. Patients within a service should have similar risk formulation processes. Access to more expert risk assessment should be available, for example from Personality Disorder hubs, ACE or forensic services via consultation. Typically these services welcome contact from clinicians seeking advice and are funded for this.

2.1.3 The risk factors associated with suicide and serious violence in mental illness are well documented. Despite this, risk is often reported by clinicians as having been low before a suicide or homicide occurs. Risk formulations and management plans were the domains most likely to be judged unsatisfactory in both suicides and homicides. Risk is dynamic. Assessment of risk can only be based on what we know. It is also affected by social, organisational and cultural factors. An assessment that rates the risk as low where the patient subsequently kills themselves may be as accurate as is possible in the circumstance or may be as accurate as is possible but events changed. Risk tools focus on the ‘known knowns’. However, the “base rate” problem and the imperfection of clinical tests mean that even well conducted risk assessments can describe patients as low risk who then go on to have a risk event, and can falsely label patients as “high risk” who will never have an event. This is most true of the rarest events, e.g. homicide. Retrospective criticism of well conducted assessments can skew later clinician assessments, making them falsely pessimistic, leading to overly restrictive care. Events may occur which the assessor cannot have predicted. Nevertheless, it is desirable to be careful in the methodology of risk assessment, which increases the overall sensitivity and specificity of your risk assessment.

2.1.4 FACE profiles in use on the Trust provide a structure to inform risk assessment and clinical judgement with built in prompts for thinking about risk factors triggers and ameliorants. This supports and informs risk formulation; we as clinicians should not feel we have done a job of risk formulation by “doing the FACE risk form” in a mechanistic way. Similarly the narrative risk tool provides a structure to inform risk assessment clinical judgement and risk formulation.

2.1.5 Risk assessment needs to be given time. Clinicians should be encouraged to consider risk assessment in groups for difficult cases. Lone workers may not be

able to do this in real time, but would benefit from discussing risk formulations post hoc in their supervisions or with peers.

2.1.6 Where all of the options for management involve some risk, then "positive risk taking" is necessary – some criticise this phrase as separating risk out from the rest of the person. The trust recognises this but has decided that clinicians need the support of an endorsement of positive risk taking.

2.2 Clinical approaches

2.2.1 Risk must be assessed at certain key points in a service user's care pathway.

- Risk assessment is required:
    - As part of initial assessment/ongoing assessment / reassessment
    - When admitting and discharging from hospital, informing observation levels and as part of planning and agreeing leave
    - As part of community or inpatient care coordination or Multi-Disciplinary Team (MDT) reviews
    - When there are major changes to presentation/personal circumstances or following an incident
    - When a known major event is imminent that may affect the individual such as appearance in court or an anniversary of a significant event e.g. death of a close relative / loved one
    - When alerted by carers/relatives to their concerns. e.g. about changes to presentation/personal circumstances/an incident
    - When referring service users to other professionals teams/service providers to ensure that there is a shared understanding of current risks to inform the referral process.
    - When transferring service users to other teams/service providers to ensure that there is a shared understanding of current risks to inform the transfer process.
    - When alerted by other members of the care team about major changes to presentation / personal circumstances / an incident

2.2.2 Though "risk" or "dangerousness" is not a core symptom of mental disorder, all mental disorders are more or less associated with increased risks. Risk is similar to other patient problems such as unemployment all of which may be considered if we wish to bring a holistic approach. We formulate risk in order to manage it. Risk is best thought of as one of the presenting problems in a case. It is not a separate entity; that must be considered separately, after plans are made.

2.2.3 Risk should be formulated alongside the other problems associated with a service user or patient's mental disorder. Formulation is using a set of ideas, template, structure or plan to think about problems and how they arise. In clinical practice it is best to use "structured clinical judgment" which is a risk formulation based upon a pre-existing evidence-based structure, but also taking clinical judgement into account.

2.2.4 Risk "prediction" is not really possible for individuals. But a good formulation will drive better management.

2.2.5 It is important to think clearly about how much of the risk in a case is related to mental disorder or is due to other things, which may or may not be able to be changed. This may inform the realism of plans.

2.2.6 We as a trust have a *duty to cooperate* with risk information sharing with those agencies in certain situations within the bounds of confidentiality and structures exist (MAPPA, child protection) to help this. This issues have their own policies, training and professional approaches.

2.3 Stages of clinical risk formulation

2.3.1 The risk formulation needs to have certain stages.

2.3.2 First, get broad sources of information, including the patient'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.

2.3.3 Second, for each type of risk (self-harm, violence, sexual risk, neglect, etc.), form some idea of the general level of reasonable vigilance for this patient. 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 your patient.

2.3.4 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. Anyone who has ever had ideas or actions around self-harm needs a formulation, however brief, of self-harm risk. The same is true for vulnerability, inappropriate sexual behaviour, and other domains of risk.

2.3.5 Third, the imminence of risk now, how soon a risk event might happen, should be considered. This should consider how the patient is now, their "clinical state". 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. These factors should be well known to clinicians and fluently available at the time of assessment because they guide the day to day monitoring and treatment of the health problems that lead to the risk.

2.3.6 Fourth, a plan should be drawn up for the comprehensive management of the patient 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.. This should be done as far as possible with patient's and families'/friends' inclusion. The plan should be all inclusive and see risk as part of the whole person. The plan should use terms that the patient and others can understand, keeping an open mind about what is important Try to be empathic and avoid malignant alienation.

2.3.7 Inclusion of patients in in planning important because:

i) it is ethically the most empowering thing to do

ii) it increases the chances of their using the plan

iii) discussion is likely to lead to the clinician being told practical details of the plan that might jeopardise its feasibility. In the case of suicide this may include e.g. exhaustion of the carers; or in violence, the ability of accommodation staff to monitor mental states such as psychosis

2.3.8 Fifth, the routine plan should be subjected to imagined or foreseeable tests of feasibility, life events, stressors, destabilisers, personal support and compliance of the patient. What might make the plan go wrong? It should be tweaked and then finalised, agreed on and communicated to patients, family and other agencies. Sometimes steps such as "target hardening" of potential victims through awareness, alarms and geographical separation can be considered and proposed to police, and these should obviously only be shared with those it is essential to share with. Advice from Safeguarding, MARAC and/or MAPPA should be considered for this, to guide the sharing of information.

2.3.9 Sixth, 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 patient 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 patient safe. Scenarios must not be discussed in a check-list fashion, or the process will not be helpful and may give false reassurance.

2.3.10 Seventh, contingency plans should be based on these risk signatures, and on realistic assumptions about the care that will be available.

2.3.11 It is conceptually important to see that there are two elements of planning overall – the standard plan and the contingency. The contingency plans should ideally be discussed with the patient too.

2.3.12 The risk formulation and management plan should be reviewed at clinical meetings such as Care Co-ordination (CPA) meetings, and also at other major changes to care such as admission, discharge and after perceived substantial changes in risk.

3 Final Section

3.1 Decision making and rationales

3.1.1 Any risk-related decision is likely to be the best decision that can be made at the time and will be acceptable if:

- it conforms with legislation
- it conforms with relevant guidelines
- it is based on the best information available
- it is documented
- the relevant people are informed

3.1.2 The rationale for any decisions must be recorded. This record must note:

- The persons /agencies involved in the decision making process
- The recognition of the risks identified
- Action taken to reduce the risk
- The contingency plan in place to support the individual

3.1.3 This information must be clearly documented and shared with the relevant individuals.

3.2 Positive Risk taking

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

3.2.2 Risk management often focuses on the more negative aspects of risk and often does not articulate the benefits of positive risk management,

3.2.3 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 became 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 working with a service user's strengths,
- having an agreed understanding of everyone involved

- having an understanding of peoples different perception 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
- the recording of the decision making process and the incorporation of appropriate actions within the risk management and risk contingency plans

4 References

- HCR-20

- Quality of Risk Assessment Prior to Suicide and Homicide: A pilot study, June 2013 - The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness