Public – To be published on the Trust External website

Title: Safety and Risk Management Policy

(previously called **Harm Minimisation (Clinical Risk Assessment and Management) Policy**)

Ref: CLIN-0017-v9.1

Status: Ratified
Document type: Policy

Contents

1 Introduction

A key part of our work within mental health and learning disability services is to work with people who are at risk of harm, to themselves and/or others, and to minimise the likelihood of actual harm. To be able to do this the best way we can, we have to listen to people who are in distress, or who are in unsafe situations due to other people, and to understand the many factors that may be affecting a person so we can work together to help people to be as safe as possible.

To be able to do this, we need to approach conversations about harm and safeguarding in an informed way, to have an open mind to be able to listen and think. We need to have the right support and guidance to help us to be able to hear the deep levels of distress and vulnerability that people experience. Every member of staff who works in clinical services requires the skill, expertise and support to embrace the responsibility and duty of care for people who use our services.

This policy is therefore designed to provide guidelines for staff within the Trust who are providing direct support to people who are at risk of harm (either self-harm, or at risk of harm from others), and for senior clinical staff and managers within clinical services. Guidance is provided for all disciplines of staff, and for when staff teams are working together to support people who use our services and their families/ carers. Guidance is provided to support where there are high levels of distress and vulnerability and when there is no option to avoid harm, whereby the guidance helps to support decision making to ensure harm is minimised.

The guidance recognises that working with people who experience high levels of distress, who want to harm themselves and who do not want to be alive, is unsettling and stressful for staff. The guidance therefore describes the best approach to staff support with this aspect of their roles. It reinforces how this support is needed by all staff working in clinical settings, irrespective of role or seniority.

The evidence shows that the best way to support people in distress is by forming a trusting, working alliance. The guidance includes further information on how to approach this and to get best quality information to inform safety planning for people who use our services.

This policy is critical to the delivery of Our Journey To Change (OJTC) and our ambition to co-create safe and personalised care that improves the lives of people with mental health needs, a learning disability or autism. It helps us deliver our three strategic goals as follows:

This policy supports the Trust to co-create a great experience for all patients, carers and families from its diverse population by ensuring that care is co-produced, needs led and person centred.

This policy supports the Trust to co-create a great experience for our colleagues by ensuring that staff can focus on delivering the care and treatment that the people we serve need.

This policy supports the Trust to be a great partner, so we will work collaboratively at place, within our health and care system to deliver the best possible outcomes for our population.

2 Why we need this policy

2.1 Purpose

This policy outlines the organisations approach to prioritising the safety, well-being, and autonomy of people, working towards reduced harm, improved quality of life, and better mental health outcomes. This is not always easy, and this policy has been written to help you to work through this process, with the people who use our services, family and carers and teams and you work with.

This policy will support us to embed the principle that harm minimisation is a proactive and recovery orientated approach to supporting people in our care. The policy advocates a collaborative approach involving everyone from mental health professionals to family members, and of course the person. Recognising that people are also part of a wider system, wider communities and a range of other services. The approach of harm minimisation looks at doing with rather than doing to people; it is about having conversations about why we do what we do, and the impact of it, as well as considering supporting people to autonomously thrive whilst supporting and maintaining their safety.

2.2 Objectives

- To provide support to staff that will enable them to make well considered decisions with people who use our services, and their families and carers.
- To ensure that staff demonstrate the rationale and clinical judgement by which decisions were arrived at, and how the potential risk of each harm was balanced in that decision making.

3 Scope

3.1 Who this policy applies to

Harm minimisation requires a whole systems approach, these principles will guide all staff groups working with people in our care and across all services.

All clinical staff, where competency in clinical risk assessment, formulation and management is required in their role are required to implement the policy's standards and procedures.

Patient safety events, both within the Trust, and learning from external incidents are reviewed and increase learning and awareness, particularly in preventing harm or managing risk. This process can highlight emerging themes or areas of concern or development required.

Within the Trust these learning themes feed into the organisational learning group, and ultimately may provide further insight and learning through the learning library, alerts or fundamental standards.

3.2 Roles and responsibilities

Role	Responsibility
Chief Executive and Trust Board	• Promoting a culture whereby the interrelationship between trauma informed care, personal recovery and wellbeing, and balancing risks of harm in support of that recovery are understood • Ensuring there are effective arrangements for staff to be trained, supervised and supported in the way they assess risk of harm, intervene to manage the risk and demonstrate that process in the clinical record
Chief Nurse	• Developing, monitoring and reviewing this policy and practice standards • Providing appropriate mandatory foundation training and education to support the standards
Speciality Clinical Director	• Identifying, developing and authorising the most appropriate clinical risk assessment tools and risk management processes in their clinical areas via the Specialty Clinical Networks

Director of Therapies, Executive Medical Director, Chief Nurse, Care Group Managing Directors.	• Implementing and monitoring the adherence to this policy in their areas of responsibility • Ensuring that systems and processes are in place and monitored to meet the requirements outlined in this policy • Providing appropriate specialist training and education to support the policy standards including the use of agreed assessment tools • Ensuring that all appropriate employees undertake relevant training with updates as required • Implementing the systems and processes that are in place to monitor compliance with the policy
All clinical staff where competency in clinical risk assessment, formulation and management is required in their role	• Implementing the policy's standards and procedures • Maintaining their individual competence in clinical risk assessment, management and undertaking training as required by their roles
Chief Pharmacist	• Oversight of pharmacy professionals' implementation and monitoring policy
Patient Safety and Clinical Effectiveness Groups	• Ensuring that the services delivered are safe, effective and reflect current approaches to clinical effectiveness, safety and experience of people who use our services.

4 How to approach clinical risk assessment and harm minimisation

4.1 The purpose of assessing risk

The purpose of any risk assessment is to support people in their recovery and wellbeing through minimising the risk of harm to themselves or others. The most effective risk assessments are dynamic and co-produced with people, their families and others involved in their care. We do this most effectively when we have taken time to build trusting and safe relationships both with people and within teams. Harm does not happen in isolation, it is created systemically, and we can only work effectively to reduce it when compassion, psychological and social safety are evident throughout the system.

Risk assessment is a collaborative process and should be completed with the person, their family, carer or any professional involved, individually or collectively. This should be considered at every point of contact with our services.

Cocreating an understanding of potential harms through a strength-based conversation, allows for open discussion, and professional curiosity when considering how we develop a shared awareness of strengths, risks, and how to support the minimisation of harm.

4.2 Assessing Risk

Risk should be assessed at every direct contact with a person. At every direct contact, we should ensure that there is a safety plan in place. At the first direct contact this plan may be limited, but over time this is expected to grow and develop to meet their needs.

To assess risk, support recovery, and reduce harm, we need to consider several factors. This will include, what's going well in a person's life, what they may be struggling with and what others may perceive as strengths and concerns. Questions to be considered include but may not be limited to: -

- What's going well in your life?
- Is there anything that you are struggling with or worried about?
- Is there anything that your family and carers are struggling with or worried about?
- Does anything make you feel unsafe?
- How likely is it to happen?
- What makes you feel safe?

To respond to information gathered, we need to consider the context of the harms identified and apply our clinical knowledge of factors that increase risk of harm to the person, for example:

- The wider social determinants of health such as housing, poverty, employment, and education.

- Understanding historical information, what has been helpful, or unhelpful in the past

- Discussion with people regarding options available to them. Including potential outcomes, helping them to make informed decisions about their care.

A strengths-based approach focusing on a person's strengths and social and community networks is holistic and multidisciplinary and works with the person to promote their wellbeing and can be used as building blocks to harm minimisation.

There are five broad areas these are:

1. **Harm to self** - This section should identify any intention or risks of harm to self from self. This should not include unintentional risks to self, such as a fall but should consider unintentional consequences as a result of potentially harmful behaviour.

2. **Harm from others** - This is the section that will identify risks to people using our services from any other person but does not include risks from service intervention (iatrogenic harm).

3. **Harm to others** - This is the section that will identify risks to others from the person.

4. **Harm from service** - Iatrogenic harm refers to the harm caused inadvertently by the process of treatment. This may manifest as uncertainty and anxiety caused to people using our services by a failure of staff to provide them with important information regarding diagnosis, treatment, or discharge planning; adverse reactions to drugs; negligence; or unnecessary treatment resulting from a clinician's decision.

5. **Other harms and risks** – for example physical health, loss of trust.

Sometimes there may appear to be a conflict in our duty of care to keep people safe and the balance of their human rights and autonomy such as right to privacy. Multi-disciplinary discussions and escalation needs to be considered for such cases.

Staff must carefully consider the rationale for the use of any restrictive practice and ensure it is the least restrictive for the shortest time possible.

Blanket restrictions should be avoided unless they can be justified as necessary and proportionate responses to risks identified for particular individuals.

Where blanket restrictions are justified staff should acknowledge and ensure that appropriate safeguards are used and that they are reviewed within a regular time frame.

Whenever a child or adult is at risk, a Safeguarding referral must be made. All considerations must be documented within the electronic care record. Please refer to the Safeguarding Adults Policy or the Safeguarding Children Policy for further guidance. Staff should adopt a whole family approach when developing an understanding of risk, including the consideration of the impact of parental mental health on the family network (PAMIC).

Triangulation of all information gathered will support the process of risk formulation. This will aid understanding and recognition of escalating and cumulative risk.

It is important that this process is not the sole responsibility of one professional. A multi-disciplinary approach should be applied and utilised. This may be through the use of huddles, supervision, MDT meetings, case discussion etc.

Staff should clearly document the views of all involved and show what has been considered with evidence of how decisions were made. This should be recorded in the persons electronic care record.

A variety of bespoke tools should be used to support formulation and understanding of risk, and many of these have been incorporated into electronic patient records. Speciality clinical networks will guide on appropriate tools to be implemented as evidence develops and updates.

4.2.1 People not requiring a safety plan

Everyone who has had a direct contact needs a safety plan, but for those where a service has not identified risk and/or a full plan is not applicable any immediate mitigations will be documented as a minimum in the plan, along with those who can support.

For patients who have not yet had a clinically meaningful direct contact, information from the referral form and/or triage conversations will be included in the safety plan which will be monitored/updated via keeping in touch processes.

4.2.2 Crisis Teams

All patients referred to a Crisis Resolution Home Treatment Team (CRHT) are triaged by registered staff using the UK Mental Health Triage Tool. This helps determine clinical priority, needs, risk factors and services/agencies to support. For those contacting the CRHT’s and triaged in categories D-G (lower level, routine needs which may be best met by alternative agencies, services, and alternatives) of the UK Mental Health Triage Tool, the Safety Summary and Safety Plan is not expected to be fully completed – unless pertinent information is provided at the time of contact.

⚠ **This does not apply to those in Triaged in Categories A-C (Emergency, Very Urgent, Urgent clinical priority) of the UK Mental Health Triage Tool, and/or any subsequent assessment and/or period of Home-based Treatment.**

4.2.3 Commenting on Mental State

Reasons for doing mental state assessment.

Good practice and professional guidance encourage and expect us all to be actively noticing and documenting how people are presenting. In essence, it's about being curious in every encounter and acting on this, remembering that we strive to coproduce care and documentation.

For a mental state assessment, staff should take note of a person’s presentation and draw meaning from this so that the most appropriate course of action is taken, ensuring the persons needs are met and risks are addressed. That is, noticing and documenting through the lens of your professional role or task, and the level of detail expected will therefore vary accordingly.

The domains that are assessed when completing a full Mental State Examination (MSE) are useful as an aide memoire even if a full MSE is not the expectation. The domains can include, for example: - Appearance, Behaviour, Mood, Affect, Thinking, Motor Activity, Speech, Cognition, Perception & Insight. (Appendix 4, and Accessible Version Appendix 5).

4.3 Other considerations

We know that clinicians typically underestimate the breadth of potential harm compared to the harms a person might perceive (Sykes, Brabban, & Reilly, 2015) so it is important to think carefully with the person using our services about these. Harder to define harm may include loss of freedom, privacy, control, self-determination, hope, dignity, confidence, or aspiration. It may also include the loss of opportunity to learn from difficult experiences.

Both short-term and long-term harms, especially the harder to define harms, may only become apparent in the long-term.

Harm may arise as a result of our interventions, especially if they are not compatible with the person’s aspirations and life goals. An example would be adverse effects from medication which may impede the person’s ability to live a full and meaningful life. Similarly restrictive interventions such as restraint can be both traumatising and retraumatising. Not returning phone calls or turning up when we said we would, can create or perpetuate an experience of rejection.

In some cases, the decisions the person wishes to take will develop into an advanced decision-making process and we will work with the person to develop and adhere to advance decisions and statements. (Advance decisions to refuse treatment and statements made in advance Ref CLIN-0011).

When there is a real and immediate risk to human life we must take action. We need to be clear that our response is necessary and is proportionate and related to these immediate risks. Our responses should be developed through collective conversations with the person themselves if at all possible. It is important to include multidisciplinary contributions and other support outside the team if needed.

When a team focuses on harm alone, it can lead to a disproportionate response; it is vital to consider the rights that the person has under the Human Rights Act. The two absolute rights that are most relevant in the context of the work that we do are **the right to life and the right to not be tortured or treated in an inhuman or degrading way**. We should hold in mind the right to life does not ‘outweigh’ the right to be free of inhuman or degrading treatment. A team may need to access extra expert help if decisions were touching on this balance.

If you need further support please contact the Equality, Diversity and Human Rights team on 0191 3336267 or tewv.eandd@nhs.net

4.4 Working together to understand the risks of harm/s

Collaborative working with people who use our services and other services/partners is essential to minimise the risk of harm. It is important to be aware that risks cannot ever be completely eliminated and may change within moments or hours depending on multiple external factors. Care and safety plans at times may include decisions in which there are no risk-free options. These complex decisions should be explored as part of multi-agency, person centred discussions.

An important principle to consider is that the people who use our services have the right to make individual decisions or choices about their own recovery and how to minimise harm to ensure their wellbeing. This includes the right to make decisions that we may not agree with, and we should be trying, wherever possible, to reach a shared understanding with the person and their families or carers when assessing potential risks of harm and how these should be managed. This involves shared decision making and supporting people who use our services and their significant others in their own decisions. By fully involving people in their risk assessment and safety planning, we minimise the risk of unintended harms being caused. A needs-led comprehensive assessment that takes account of a person's individual circumstances: be that life history, the social, financial and cultural context, as well as sexual orientation, gender identity, physical and mental disabilities, neurodiversity, religion and spirituality, age, and any connection with armed forces is required.

When working in collaboration with other organisations in the wider system, such as third sector, Integrated Care Board's (ICB), social care and any other agencies, consideration must be given to accurately record respective roles and responsibilities within care planning, risk management and safety planning. This information needs to consider IT systems that may not integrate or communicate the same view or information, what verbal communication may need to happen, and how this is agreed, shared and documented.

Examples of this can be: -

- Agreed multi agency huddles.
- Joint case reviews
- Identified attendance at discharge meetings for other services.
- Mutual understanding of risk thresholds between agencies, and escalation routes where this may pose a concern.
- Integrated contingency planning
- Interoperability plan during interventions and care planning discussions.

The safety summary is a useful tool to make sure that each person who is involved in the decision, including the person themselves, can have the space to think about the potential impacts. It is particularly useful to use a framework like this when emotions are running high or there is a divide in the approach that is being advocated.

4.4.1 Formulating

Developing a collaborative understanding (formulating) of the person is an essential part of developing a good therapeutic relationship. A good therapeutic relationship is key to help someone feel safe enough to tell us about their life; feeling heard and understood minimises the likelihood of harm.

Formulating is the process we use to help make sense of someone's life story; of their current distress, and why they have come to feel how they do. Through conversation we gather information and try to help the person understand why they may feel or cope the way they do. Gathering this information, together with an understanding of what has been useful and positive for people helps us to shape a plan that will be the best way forward. In order to do this well, being able to listen, reflect and be curious about the person is essential.

As well as understanding someone's story, it is also necessary to help the person identify potential vulnerabilities and distress in the context of their life experiences. We are also trying to understand any strategies the person may have developed to cope with their experiences. Together, this should help us to understand what may heighten or reduce someone's risks and enable us to provide the correct support.

If someone has experienced interpersonal trauma -i.e. being hurt by another person, then they will experience you as a potential source of harm, therefore modelling a trustworthy approach to your interactions would be imperative. Given the high levels of interpersonal trauma experienced by people who need our services, it is good practice to maintain high levels of trustworthiness at all times.

We must consider how we adjust our communication for people (e.g. those with a learning disability, autistic people, people with dementia and including consideration of a person's developmental age etc). Consider the language you are using and listen to people's responses to check if you have been properly understood and that you are understanding the person. Consider that the persons first language may not be English and include the use of interpreters. Take advice from family who are familiar with the persons communication style and pattern of behaviours, but do not use the family as interpreters. Be particularly aware of not introducing risk through the risk assessment discussion. Use listening and consideration of change in presentation rather than the conversational content to assess levels of risk.

When we talk with people, and we develop an understanding which helps to make sense of someone's story. For this to be a helpful process, our listening and understanding is the most important element. Enquiring, listening and reflecting are key skills.

Our knowledge of people means that we are able to identify what would be a significant change for someone that would either heighten or reduce their risks and vulnerabilities. An individualised formulation, produced together and shared with the person, provides a detailed understanding of potential factors that contribute towards the risk of harms occurring and makes it more likely that decisions are made about what would be most likely to help when someone is in acute distress.

There are different formulation models that may be useful; one of which is the ‘5P’ which considers 5 areas to summarise different factors that help us to understand people.

1. Current issues. What’s happening now? What I am struggling with at the moment (Presenting),
2. Past experiences (what has happened to me and how this has affected how I think about myself, other people, and my future; how vulnerable I feel; Predisposing),
3. Why am I currently experiencing issues? What has triggered my distress/ vulnerability now; (Precipitating),
4. What is keeping things stuck? What are the blocks to change? (Perpetuating) and
5. What has helped me, what are my values, skills and strengths, who is on my side and has helped and supported me? (Positives).

When I’m feeling ok and calm what is helpful for me to keep feeling ok? What can I do, what is helpful for others to do?

When I’m starting to become distressed, or unsettled, what do I notice, what would others notice? And what do I find helpful? what can others do to support me?

When I’m in crisis and in need of help to keep me safe what is the best way to help me to feeling ok again? What can I do? What can others do? What are the signs that this is working?

4.5 Interventions to reduce the risk of harm/s

4.5.1 Working with people where there are no risk-free options

The Trust supports us working with people who use our services to do things that may carry some risks if this is well thought through with people, their families and carers (where appropriate) and with colleagues; and is supportive of the person's recovery and wellbeing. It is recognised that in some situations with people, there are no risk-free options.

One of the most difficult conversations we will be involved in is how to protect someone from harm whilst also enabling them to do things that help them live life to the full. This can be very complicated and sometimes harm may occur even when care has been good, well considered and approached collaboratively. It is therefore vital to document the decision-making process as well as the plan that is agreed. Making a clear record of the decision-making process and the current plan, ensures that everyone takes time to understand the nuance, detail and inter-relating factors that have been considered.

It is important to appreciate that something that may reduce harm in one way, may increase the risk of another. For example, people tell us that some of the ways we try to support them can also lead to loss of confidence or autonomy, can harm their identity, or lead to loss of hope. Where this is a possibility, it is important that this is considered and recorded as part of the decision-making process.

In these situations, it is important to take time for these conversations to think together with people and their families/ carers (where appropriate) and with colleagues to consider whether we are preventing someone from doing things that enhance their life but make us nervous. Also, if we are trying to encourage people to do things that they don't want to or are not ready for, we need to make sure we do this with care and support and be prepared to change our minds. We need to think about how we support an increase in safety for the person whilst limiting any restrictions.

Conversations which focus on the person's own wellbeing could include: -

Doing more of these

- ✓ Doing something that you have chosen.
- ✓ Doing something, no matter how small it might seem to you or other people, that feels a bit out of your comfort zone.

- ✓ Doing what you think is important.
- ✓ Doing something that is very clearly linked to what you want to be different.
- ✓ Involving other people – change can be daunting, and we all need help.

Doing less of these

- ✗ Being made to do something you don't want to do.
- ✗ Doing something just because it frightens you/ only choosing 'big' things to take on.
- ✗ Doing something that someone else thinks is important for you.
- ✗ Doing something that has no clear relationship with your personal goals for growth.
- ✗ Being coerced to do something risky while everyone else washes their hands of the situation.

4.6 Documenting and communicating the decisions that have been made

All people will have their identified risks individually formulated into safety plans in collaboration with any significant others or relevant services. These will be documented on the appropriate electronic care record in accordance with organisational procedures and practice. A safety plan can be simple, reflecting detail such as support mechanisms, how to access the services and contact details if deemed clinically appropriate within collaborative and mutual discussions. The agreed safety plan will clearly identify the interventions and resources, including how, when and by whom this will be delivered and reviewed. Key people identified in plans (such as family and other services), should have been involved in the production of the plan. Alerts on the electronic patient record system should be utilised to highlight areas of significant risk.

Developing and sharing the formulation and safety plans with the person, involved clinical practitioners and significant others involved in the care of the people who use our services, significantly lowers risk. Some aspects of this may need to be sensitively approached e.g., if there is a trauma history. What is shared needs to be necessary and justifiable.

During multidisciplinary/ multi agency reviews it is the lead practitioner's responsibility to ensure that the necessary elements of the assessment, formulation and clinical management (safety) plans are communicated. However, each professional is responsible for assessing and communicating risks that they have noted during their own work and ensuring this is integrated into the safety plan.

We expect that, in most cases, the family and carers will have been involved in discussions while developing the formulation about risk of harms. It is also important to consider what formal information needs to be shared with carers and families through this process. In most cases this will be in agreement with the person, but in exceptional circumstances the duty to share will override the duty to maintain confidentiality (the Caldicott Principle '*The duty to share information can be as important as the duty to protect service user confidentiality*' is actively supported by the Trust). This must be reviewed on an individual basis by the multi-disciplinary team, considering and documenting the wishes of the person and the reason why it is believed confidentiality should be breached. Wherever possible that reason should be shared with the person. Further information can be found in the Trust Patient and Carer Leaflet Common Sense Confidentiality

⚠ Where a person has a Gender Recognition Certificate we must seek advice before disclosing this protected information, which can only be shared if an exemption applies.

4.7 Timely reviews

The factors affecting risk levels are often dynamic and so risks are fluid and may fluctuate rapidly. Assessing the risk of harm and managing those risks to minimise that risk of harm is a continuous, proactive process to be collaboratively undertaken by all involved in the person's care.

People should expect that the risks of clinically related harms will be approached with professional curiosity, formulated in partnership and regularly reviewed as often as necessary.

A Safety Summary should be undertaken as clinical need indicates and, as a minimum, with every formal review, but needs to incorporate historical and dynamic factors that may present an evolving picture over time. This can also apply to protective factors or relationships. Minimum standards for the frequency of review of the safety summary in the community will, at the very least, be annual but should take place whenever the situation changes. In inpatient services it would be envisaged that these reviews would be more frequent and related to the changing needs of person using our services.

4.8 Support and training

All clinical practitioners will have access to training on how to assess identify and reduce the risk of harm/s. Staff should be reviewing their work with people who use our services on a regular basis within a supervisory setting, utilising peer supervision, huddles and professional development forums to enhance their knowledge and perspectives

The Trust is committed to providing basic training in harm minimisation and risk formulation as part of the mandatory training programme. The principles of harm minimisation are also incorporated into other training requirements, including the Positive Approaches Training and Safeguarding.

Core mandatory training will be available to all staff, however specialities or regulated professions may have their own training packages in relation to reducing harm, in such instances this needs to be triangulated with the Trusts approach to ensure consistency.

A key responsibility of staff is to ensure that they regularly discuss risks and harm minimisation within clinical supervision. There is an expectation that staff receive caseload management supervision monthly, which provides the forum to discuss and review some cases that may be complex, require other reflections and a sample of others that may or may not demonstrate any significant change.

A record of any supervisory discussion regarding the clinical risk management of a person using our services should be recorded in the contemporaneous clinical record of that person (guidance can be found in the Trust's Clinical and Professional Supervision Policy). All those involved in responding to risk of harm will have knowledge of the legal frameworks that they are working within and where to turn to resolve uncertainties (See section 10 - References).

5 Specific circumstances to consider

5.1 Suicide risk mitigation

Good clinical risk assessment and management has a well-documented role in reducing the risk of suicide. All clinical practitioners should ensure they are familiar with contemporary information about risk factors associated with suicide for the communities and settings that they are working within. Inpatient units should be aware of themes of incidents across wards in order to review risk mitigation for their people to identify goals and aspirations, in a way that fosters hope and optimism and recognises a person's desire to be listened to and respected.

Although people may present to services at times of crisis and perceived hopelessness, it is important that all staff respond in a manner which promotes the possibility of recovery from the trauma of acute mental ill health and personal despair. The core values of recovery practices are compatible with addressing the needs of people at risk of suicide. (National Action Alliance for Suicide Prevention: Suicide Attempt Survivors Task Force, 2014).

Harm Minimisation applies to everyone. Staff should be aware of the risk of diagnostic overshadowing and ensure that they are retaining an individualised understanding of the person we are working with. Our role is to seek to understand the person's distress and work collaboratively with them to find ways to minimize that distress so that the harmful behaviours are able to reduce. The Trust recognises that for some people, self-harm and/or suicidal thinking is present for long periods of time. Their lifetime risk of death or injury is higher than for other groups and the situations are often complex. Therefore, decision making should be inclusive and thoughtful and revisited regularly.

When someone presents with a wide variety of suicidal and self-harm behaviours, these behaviours, thoughts, and feelings need to be separately assessed and described following detailed discussion with the person and clinical record searches. It is important that clinicians understand and document the actual and intended lethality of different behaviours. Some people may carry out unintentionally lethal self-harm behaviours, whilst others carry out non-lethal behaviours whilst fully intending to die.

For example, "He was feeling suicidal yesterday" is not enough. The following would be more helpful: -

> It would be more helpful if there was a description of what the person actually said, any actions they had taken (such as searching the internet regarding methods), and whether their thoughts had changed since.

It is important to note that families and carers play a significant role in the care and treatment of the people who use our services. They are key for information gathering with regards to the person. As part of the ongoing information gathering it is important to review the support available to people that use our service by families and carers and ensure that safety plans are shared with those who are included in the persons' support (Safety Plan 'what others can do' section).

5.2 Transitions between places of care / home

5.2.1 Transition

Transitions are periods in a person’s life where there are lots of changes. sometimes transitions will be positive, but we know that for some people times of transition can be highly stressful and distressing.

A period of transition and uncertainty can also be a time when people are at their most vulnerable and risks can increase.

These might include:

- Admission to an inpatient ward
- Discharge from an inpatient ward
- Life transitions (age, redundancy, moving house, bereavement etc)
- Transitions between teams/services (be mindful of re-referrals and the benefits of consistency of service)

We know transitions are particularly challenging for autistic people.

It is crucial that the risks associated with the period of transition, for both diagnosed and undiagnosed autistic people are recognised and there are several ways in which autistic children, young people and adults can be supported during the transition process including the provision of personalised reasonable adjustments.

Poorly coordinated transitions between different levels of care, such as from inpatient to community services, or from children and young people’s services to adult services, can result in fragmented support and restricted continuity of care. Inadequate planning and communication during these transitions can negatively impact autistic person’s wellbeing and impede their recovery (NHSE, 2023).

At around the age of 16–18 years, young people with mental health problems and those who are autistic are confronted with two simultaneous transitions: a situational transition (from CAMHS to AMHS) and a developmental transition (to adulthood).

5.2.2 Admission to an inpatient ward

The first few days of admission should be recognised as a period of high risk, as it is well established that admission to psychiatric inpatient care significantly increases suicide risk.

A number of studies have reported that the first week of admission is a time of particularly acute risk (Hunt et al, 2013), when around a quarter of suicides occur

(Meehan et al., 2006; Erlangsen et al., 2006). Established risk factors for inpatient suicide include chronic mental illness, mood disorders, previous self-harm, and intra-admission suicide attempts.

Careful risk assessment, formulation and safety planning is therefore needed. This should include discussions with the person, their family and carers, particularly when people have experienced recent illness onset or previous suicide attempts. Knowledge of recent life events or anniversaries experienced around admission should be incorporated into risk assessments and safety documentation.

On admission, leave and discharge the Engagement and Observations procedure, Privacy and Dignity Policy, and Oxehealth policy are important to consider, and services/staff need to refer to this procedure.

Careful planning and consideration with people and their families is required prior to agreeing to and going on time away from the ward or leave from the ward. Staff need to refer to both the Section 17 Leave for Detained Patients Policy (for detained patients and requiring a valid section 17 form) and Time Away from the Ward for Informal Patients Policy (for an informal patient).

5.2.3 Discharge from an inpatient ward

The highest risk of suicide is in the first 1-2 weeks after discharge (NCISH, 2019). Careful personalised care planning is therefore always required whenever anyone is discharged from hospital. Everyone should receive a follow up within 72 hours of discharge from hospital and the patient should be given the date of this meeting before leaving the ward.

⚠ The follow up should happen within **48 hours** if the person has self-harmed or disclosed suicidal thoughts. (NG225; NG53)

Clear communication between inpatient teams, crisis resolution and Intensive Home Treatment teams services/community teams is essential so each service can establish a clear role in the interventions that will be provided.

At the pre-discharge meeting a review will take place that will include comprehensive care plan discussion and a new care plan/safety plan will be agreed in collaboration with the person (and including their family and carers where appropriate), these should include a review of patient goals. These plans must be given to the person and/or carers and all parties involved must be aware of their role.

This meeting must include adherence to the standards described in the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) (2017): Safer services: A toolkit for specialist mental health services and primary care (see the link below):

The National Confidential Inquiry into Suicide and Safety in Mental Health

The care plan/safety plan must take into account the community living and support arrangements of the person upon discharge or when granting any leave leading up to discharge. The assessment must include risks of harm to children if the person may have or resume contact with children, especially if children have been implicated in any delusional or suicidal thinking.

5.3 When teams and organisations contribute to harm

We work with people at the times when they are experiencing periods of deep distress and are vulnerable. We need to be particularly careful to make sure the way we relate to other people is helpful and therapeutic.

Appendix 3 contains a useful brief guide on how to run meetings where people who use our services, families and carers are present in a way which reduces the risk of inadvertently causing harm (based on research in the Trust which showed the small things we can do to reduce the likelihood that we cause harm in meetings). This will be covered in further detail in the staff training.

6 Definitions

Term	Definition
Duty of care	Organisations must maintain an appropriate standard of care in their work and not be negligent. People who have mental capacity to make a decision and choose voluntarily to live within a level of risk, are entitled to do so. In this case the law considers the person to have consented to the risk and there is thus no breach of duty of care and the organisation or individual cannot be considered negligent.
Human rights	All public authorities and bodies have a duty not to act incompatibly with the European Convention of Human Rights. A balance needs to be struck between risk and the preservation of rights.

Health and safety	There is a legal duty on all employers to ensure, as far as reasonably practicable, the health, safety and welfare of their employees as well as the health and safety of those who use services. Health and Safety legislation should not block reasonable activity.
Mental capacity	This is concerned with a person's ability to make decisions for themselves and the principle enshrined in the Mental Capacity Act, 2005 is that they must be assumed to have capacity unless it is established that they do not. People with capacity may make unwise decisions. For those who lack capacity, decisions made on their behalf must be made in their best interests and with the least restriction.
Fluctuating mental states and neurological conditions such as but not restricted to dementia	The choices and wishes of people with fluctuating mental states and dementia must be respected and their risk agreements monitored and reviewed regularly. In these circumstances it is important to engage with families and carers.
Safeguarding	For people who are considered to be vulnerable there is a need to consider the factors of empowerment and safety, choice and risk. Practitioners need to consider when the need for protection overrides decisions to promote choice and empowerment.
The Mental Health Act 1983 (MHA)	There are five guiding principles which should be considered when making all decisions in relation to care, support or treatment provided under the Act: • Least restrictive option and maximising independence • Empowerment and involvement • Respect and dignity • Purpose and effectiveness • Efficiency and equity
Mental State Examination (MSE)	The mental state examination is a structured way of assessing a patient's current state of mind. As with any clinical examination, it is split into several domains. And is an important part of the clinical assessment and diagnostic processes in neurological and psychiatric practice.

Mental State Assessment	Regular appraisal of a person’s appearance, behaviour, mood, affect, thinking, motor activity, speech, cognition, perception & insight. It is actively noticing and documenting how people are presenting on a regular basis.

7 Related documents

- Human Rights Equality Diversity and Inclusion Policy
- The Care Programme Approach and Standard Care
- Privacy and Dignity Policy
- Engagement and Observation Procedure
- Supporting Behaviours that Challenge (BtC) Policy
- Information Governance Policy
- Sharing information and Confidentiality Policy
- Safeguarding Children Policy
- Clinical and Professional Supervision Policy
- Minimum Standards for Clinical Record Keeping
- Rapid Tranquillisation Policy
- Health and Safety Policy
- Individuals who decline treatment and or disengage with services
- Advance decisions to refuse treatment and statements made in advance
- Staff Development Policy
- Did Not Attend (DNA)/ Was Not Brought (WNB) Policy
- Admissions Transfer and Discharge Policy
- Safeguarding Adults Policy
- Safeguarding Children Policy
- Transition protocol from Child and Adolescent to Adult/Primary care services
- Joint Working Protocol for People with Mental Health and Learning Disabilities
- Communicating with service users best practice
- Interpreting and Translation Policy

8 How this policy will be implemented

- This policy will be published on the Trust’s intranet.

- Line managers will disseminate this policy to all Trust employees through a line management briefing.

8.1 Training needs analysis

The training required to effectively implement any specific model and tool identified for use by services and/or professions, will be provided by those services and professions where required.

The content, format and frequency of that training will be based upon the model and tool and the requirements of the service or professional group.

Staff/Professional Group	Type of Training	Duration	Frequency of Training
All clinical staff	Mandatory 'Harm Minimisation: Safety and Risk Management' e-learning	1.5 hours	For staff new to TEWV
All clinical staff where competency in clinical risk assessment, formulating and management is required in their role	Mandatory 'Harm Minimisation: Safety and Risk Management' face to face learning	3 hours	Every 3 years

Those services providing specific model/tool training will be responsible for monitoring that training and its implementation and provide updates to their relevant governance groups.

9 How the implementation of this policy will be monitored

Number	Auditable Standard/Key Performance Indicators	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually

			be via the relevant Governance Group).
1	85% of clinical staff will have completed mandatory training	Service Improvement Delivery Groups (SIDG) to monitor for compliance and exceptions on a monthly basis	SIDG and Care Group Boards to monitor
2	Completion of and adherence to safety plans is monitored in the Quality Assurance (QA) Schedule.	QA schedule results are reviewed monthly at Care Group Fundamental Standards groups.	Strategic Fundamental Standards Group and Quality Assurance Committee will monitor.

10 References

- Erlangsen et al., (2006): Physical, mental, and social wellbeing and their association with death by suicide and self-harm in older adults: a community-based cohort study: International Journal of Geriatric Psychiatry: 2021 May;36(5):647-656
- Hunt, I. M., Bickley, H., Windfuhr, K., Shaw, J., Appleby, L., & Kapur, N. (2013). Suicide in recently admitted psychiatric inpatients: a case-control study. *Journal of Affective Disorders*, *144*(1-2), 123-128.
- Meehan et al., (2006): Suicide in mental health in-patients and within 3 months of discharge. National clinical survey. Br J Psychiatry: 2006 Feb:188:129-34
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). (2017). *Safer Services: A Toolkit for Specialist Mental Health Services and Primary Care. 10 Key Elements to Improve Safety*. Retrieved from safer-services_a-toolkit-for-specialist-mental-health-services_updated-nov-2018.pdf (rcpsych.ac.uk)
- National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). (2019). Retrieved from http://documents.manchester.ac.uk/display.aspx?DocID=46558
- NHSE (2023): Meeting the needs of autistic adults in mental health services Guidance for integrated care boards, health organisations and wider system partners
- Sykes, M. J., Brabban, A., & Reilly, J. (2015). Balancing harms in support of recovery. *Journal of Mental Health*, *24*(3), 140-144.
- NHS England: Patient Safety Incident Response Framework (PSIRF)
- Freedom of Information Act 2000.

- NG 225: Self-harm: assessment, management and preventing recurrence
- NG 53 Transition between inpatient mental health settings and community or care home settings
- Mental Health Act 1983: Code of Practice.
- Mental Capacity Act 2005.
- Equality Act 2010.

11 Document control (external)

To be recorded on the policy register by Policy Coordinator

Required information type	**Information**
Date of approval	16 September 2025
Next review date	15 October 2027
This document replaces	CLIN-0017-v9 Safety and Risk Management Policy (Private document)
This document was approved by	Executive Clinical Leaders Sub-group
This document was approved	16 July 2025
This document was ratified by	Management Group (pending)
This document was ratified	16 September 2025 (pending)
An equality analysis was completed on this policy on	12 June 2024
Document type	**Public**
FOI Clause (Private documents only)	n/a

Change record

Version	**Date**	**Amendment details**	**Status**
v9	August 2024	Full review with major changes. Renamed to ‘Safety and Risk Management Policy’.	Withdrawn

		Updated terminology and approach to better reflect principles of personalising care planning, assessment of risk and to strengthen and clarify the expectation on staff to work collaboratively with the people who use our services in developing and devising their care. Updated against current NICE guidance.	
v9.1	16 Sept 2025	Minor change to remove description of harm. Please note that this revised version has been reviewed for harm and has been assessed as containing no harmful information. It is now a **public** document.	Ratified

Appendix 1 - Equality Impact Assessment Screening Form

Please note: The Equality Impact Assessment Policy and Equality Impact Assessment Guidance can be found on the policy pages of the intranet

Section 1	**Scope**
Name of service area/directorate/department	Trustwide
Title	Safety and Risk Management Policy (formerly known as Harm Minimisation Policy)
Type	Policy
Geographical area covered	Trustwide
Aims and objectives	To outline the organisations approach to prioritising the safety, well-being, and autonomy of people who use our services, working towards reduced harm, improved quality of life, and better mental health outcomes.
Start date of Equality Analysis Screening	30 May 2024.
End date of Equality Analysis Screening	12 June 2024.

Section 2	**Impacts**
Who does the Policy plan benefit?	The policy will benefit all those who access our services, their families and carers by ensuring a personalised and collaborative approach to care is taken when addressing issues of safety, care planning and recovery. The policy will benefit staff by providing them with a framework that will support them to offer personalised care planning that accounts for a person's safety and risk management in a holistic and collaborative manner.
Will the Policy impact negatively on any of the protected characteristic groups? Are there any Human Rights implications?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men and women) **NO** • **Gender reassignment** (Transgender and gender identity) **NO** • **Sexual Orientation** (Lesbian, Gay, Bisexual, Heterosexual, Pansexual and Asexual etc.) **NO** • **Age** (includes, young people, older people – people of all ages) **NO** • **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women / people who are breastfeeding, women / people accessing perinatal services, women / people on maternity leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Armed Forces** (includes serving armed forces personnel, reservists, veterans and their families) **NO** • **Human Rights Implications YES** (Human Rights - easy read)
Describe any negative impacts / Human Rights Implications	When people are very unwell, and where there may need to be detention for them under the Mental Health Act or the deprivations under the Mental Capacity Act then decision making can be complex. This could lead to unrealistic assessment of risk.
Describe any positive impacts / Human Rights Implications	The policy gives a framework for those complex conversations to be had between staff and people using our services, and outlines, with a human rights

	approach, that the decisions that are made and the plans that are out in place collaboratively: - Respect / what we do to prevent use of restrictions Protect / the safeguarding elements we have in place. Fulfil/ Procedural ways we review practice.

Section 3	**Research and involvement**
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	Research and national policy guidance. NICE guidance. MHS, MCA and Equality Act. Human Rights.
Have you engaged or consulted with people who use our services, carers, staff and other stakeholders including people from the protected groups?	We have engaged with staff from a wide range of professional backgrounds and across the specialties in the Trust and have consulted with experts by experience. We plan to target more specifically for consultation with our co-creation boards in both Care Groups.
If you answered Yes above, describe the engagement and involvement that has taken place	A series of working group meetings and communication by email.
If you answered No above, describe future plans that you may have to engage and involve people from different groups	

Section 4	**Training needs**
As part of this equality impact assessment have any training needs/service needs been identified?	Yes
Describe any training needs for Trust staff	Trust staff will need to be updated on how to best approach collaborative, personalised care planning that manages a person’s risk and minimises potential harms. Develop a clear understanding of ‘what good looks like’.
Describe any training needs for people who use our services.	None identified.
Describe any training needs for contractors or other outside agencies	None identified.

Check the information you have provided and ensure additional evidence can be provided if asked.

Appendix 2 – Approval checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

Title of document being reviewed:	Yes / No / Not applicable	Comments
1. Title		
Is the title clear and unambiguous?	Y	
Is it clear whether the document is a guideline, policy, protocol or standard?	Y	
2. Rationale		
Are reasons for development of the document stated?	Y	
3. Development Process		
Are people involved in the development identified?	Y	
Has relevant expertise has been sought/used?	Y	
Is there evidence of consultation with stakeholders and users?	Y	
Have any related documents or documents that are impacted by this change been identified and updated?	Y	
4. Content		
Is the objective of the document clear?	Y	
Is the target population clear and unambiguous?	Y	
Are the intended outcomes described?	Y	
Are the statements clear and unambiguous?	Y	
5. Evidence Base		
Is the type of evidence to support the document identified explicitly?	Y	
Are key references cited?	Y	

Are supporting documents referenced?	Y	
6. Training		
Have training needs been considered?	Y	
Are training needs included in the document?	Y	
7. Implementation and monitoring		
Does the document identify how it will be implemented and monitored?	Y	
8. Equality analysis		
Has an equality analysis been completed for the document?	Y	
Have Equality and Diversity reviewed and approved the equality analysis?	Y	
9. Approval		
Does the document identify which committee/group will approve it?	Y	
10. Publication		
Has the policy been reviewed for harm?	Y	No harm
Does the document identify whether it is private or public?	Y	Public
If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	N/A	
11. Accessibility (See intranet accessibility page for more information)		
Have you run the Microsoft Word Accessibility Checker? (Under the review tab, 'check accessibility'. You must remove all errors)	Y	
Do all pictures and tables have meaningful alternative text?	Y	
Do all hyperlinks have a meaningful description? (do not use something generic like 'click here')	Y	

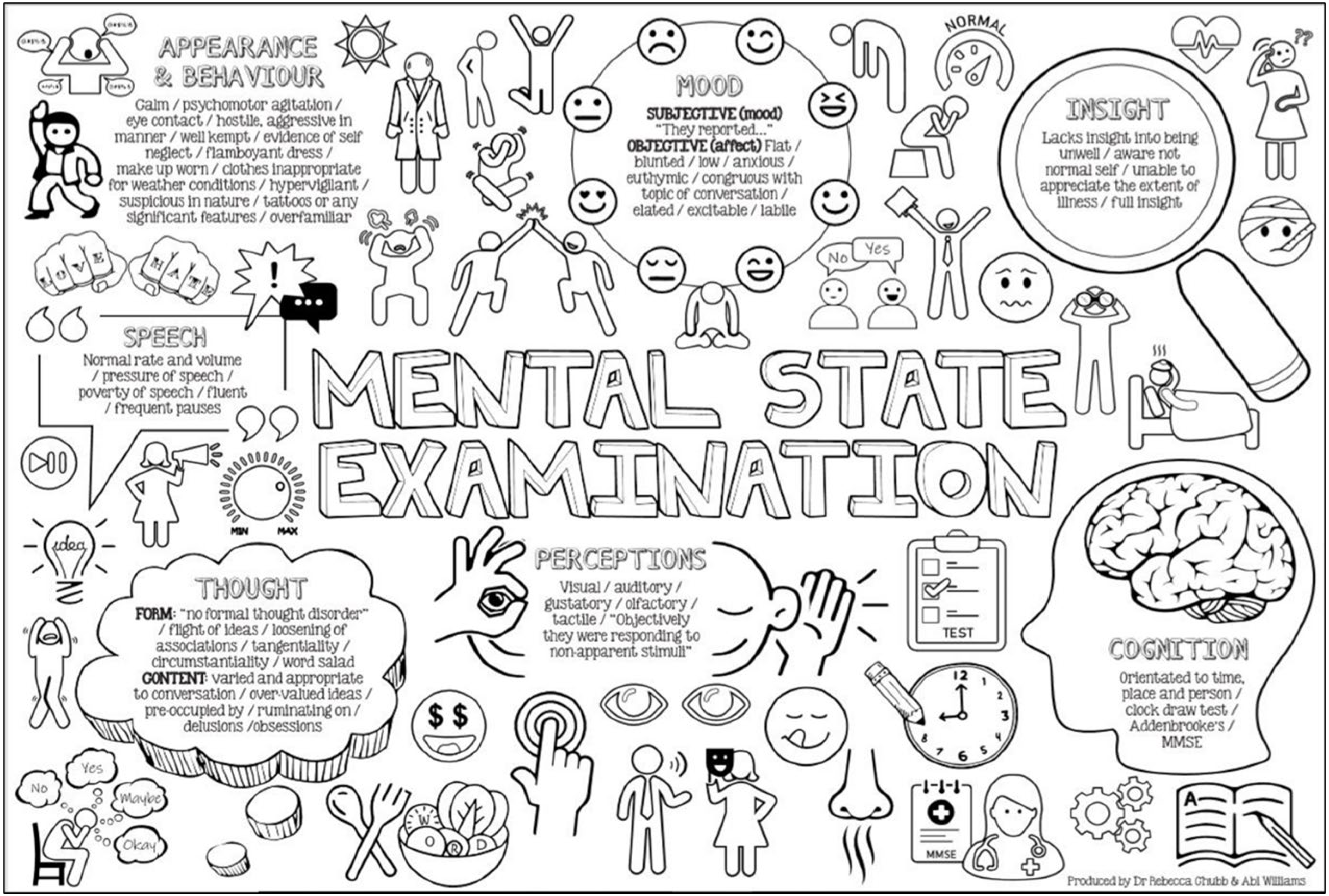
Appendix 3 – Brief guide on how to run meetings

Our learning about how meetings that involve a service user, can cause harm, and how to reduce the risk of that happening: -

- Make sure the room is confidential that there is a sign indicating not to be disturbed.
- Use a small preferably round table – you are aiming for safe and intimate not big and exposing.
- Don't have the staff sitting in there waiting for the service user to be 'brought in'. Try to arrive together.
- Keep the group small and relevant. Only people who have something to contribute should be there and the service user should have been involved in the discussion about the purpose of the meeting and who will be there. Make sure staff are briefed on what is expected of them before and during the session (especially that they are there to contribute not to 'watch').
- Make sure everyone has a drink (all the same – not that staff have tea and the patient has water unless that is their preference).
- At the start of the meeting make sure everyone is introduced and their role made clear.
- Make sure all the chairs are the same. The service user sitting on a small chair can feel vulnerable but sitting on a higher chair though can feel like being in court.

Appendix 4 – MSE Printable

Please see over page for Mental State Examination (MSE) Printable:



MENTAL STATE EXAMINATION

APPEARANCE & BEHAVIOUR

Calm / psychomotor agitation / eye contact / hostile, aggressive in manner / well kempt / evidence of self neglect / flamboyant dress / make up worn / clothes inappropriate for weather conditions / hypervigilant / suspicious in nature / tattoos or any significant features / overfamiliar

MOOD

SUBJECTIVE (mood) "They reported..."
OBJECTIVE (affect) Flat / blunted / low / anxious / euthymic / congruous with topic of conversation / elated / excitable / labile

INSIGHT

Lacks insight into being unwell / aware not normal self / unable to appreciate the extent of illness / full insight

SPEECH

Normal rate and volume / pressure of speech / poverty of speech / fluent / frequent pauses

THOUGHT

FORM: "no formal thought disorder" / flight of ideas / loosening of associations / tangentiality / circumstantiality / word salad
CONTENT: varied and appropriate to conversation / over-valued ideas / pre-occupied by / ruminating on / delusions /obsessions

PERCEPTIONS

Visual / auditory / gustatory / olfactory / tactile / "Objectively they were responding to non-apparent stimuli"

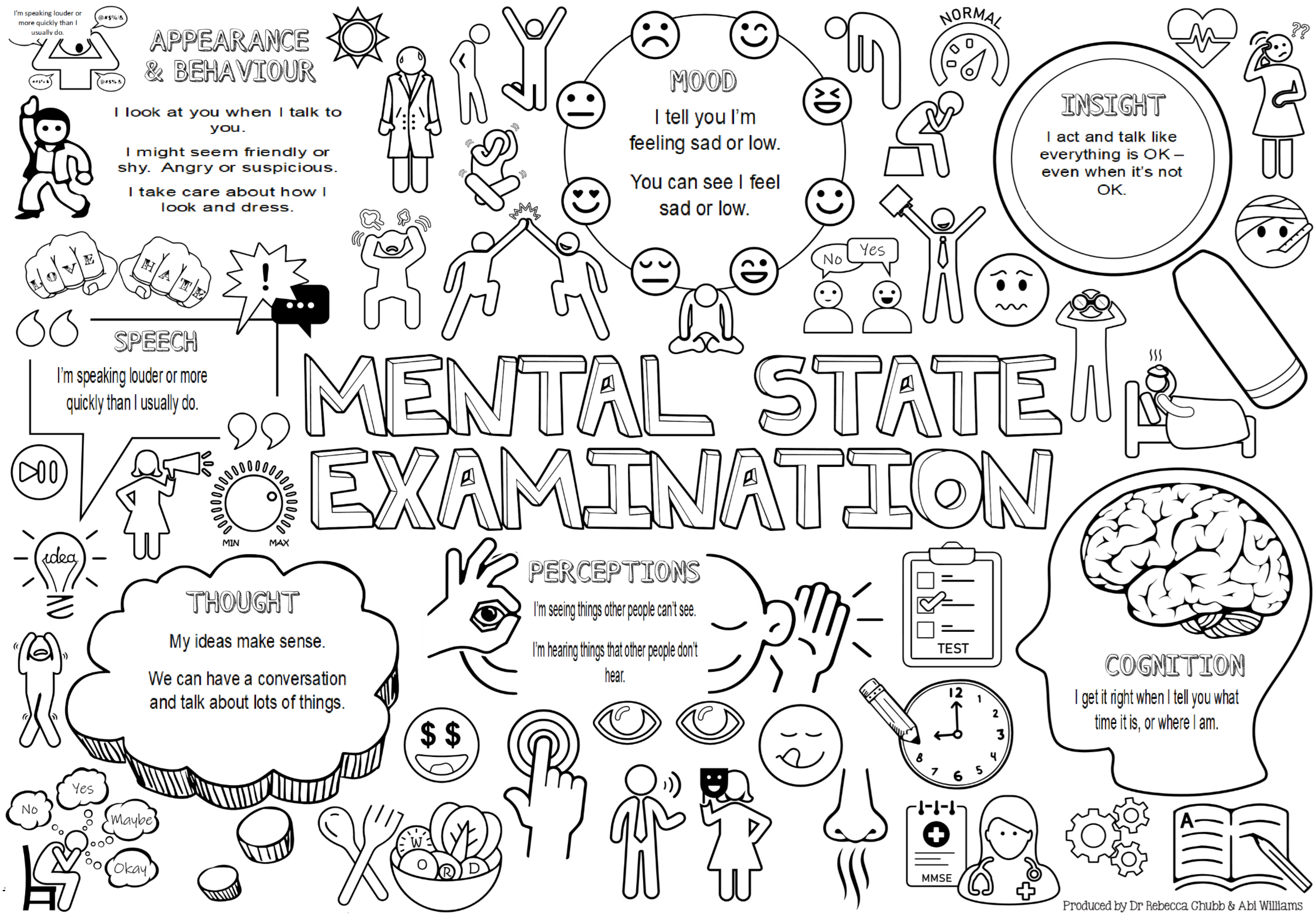
COGNITION

Orientated to time, place and person / clock draw test / Addenbrooke's / MMSE

Produced by Dr Rebecca Chubb & Abi Williams

Appendix 5 - MSE Accessible Printable

Please see over page for Mental State Examination (MSE) Accessible Printable:



MENTAL STATE EXAMINATION

APPEARANCE & BEHAVIOUR

I look at you when I talk to you.

I might seem friendly or shy. Angry or suspicious.

I take care about how I look and dress.

MOOD

I tell you I'm feeling sad or low.

You can see I feel sad or low.

INSIGHT

I act and talk like everything is OK – even when it's not OK.

SPEECH

I'm speaking louder or more quickly than I usually do.

THOUGHT

My ideas make sense.

We can have a conversation and talk about lots of things.

PERCEPTIONS

I'm seeing things other people can't see.

I'm hearing things that other people don't hear.

COGNITION

I get it right when I tell you what time it is, or where I am.

Produced by Dr Rebecca Chubb & Abi Williams

Blank page