Clinical Risk Management

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Explanation of terms used in this policy

**Care Co-ordinator** - Health worker allocated to patients living in the community. They are responsible for co-ordinating the patient/service user’s care

**Care Programme Approach (CPA)** - The care planning process used in mental health services which includes a risk assessment element

**Clinical Risk Assessment** - Clinical risk assessment is the process used to determine risk management priorities for patient care by evaluating and comparing the level of risk against organisational standards, predetermined target risk levels or other criteria. The focus should always be on patient safety

**Clinical Risk Assessment Tool** - Forms or formats specifically designed to inform systematic clinical risk management decision making and practice

**Clinical Risk Management** - Mechanism for managing exposure to risk and enabling efficient recognition of those activities or events that may result in unfortunate or damaging consequences

**Multi-disciplinary Team (MDT)** - A team of health/social care workers who work with the patient/service user and their family/carers and contribute to their care and treatment. This could include, medical staff, nursing staff, psychologist, occupational therapists, social workers, speech and language therapists and physiotherapists

**Named Nurse** - Nurse allocated to patient on admission to in-patient setting responsible for coordinating the patient’s/service user’s care during his/her stay

**Patient/Service User** - The terms 'patient' and 'service user' are used interchangeably throughout the document

**Person Centred** - The patient/service user is central to the risk management process and be involved as much as possible

**Positive Risk Taking** - All comprehensive risk management plans should incorporate positive risk taking. This may have a stepped approach to increasing exposure to risk through the risk management review process. This allows opportunities and freedoms are increased but risks are closely managed

**Risk** - The chance of something happening that will have an impact upon the objectives of care and/or recovery of the patient
1.0 Introduction and Overview
Safety is at the centre of all good health care. Clinical risk management is integral to the co-ordination and delivery of effective and safe care. The Black Country Partnership NHS Foundation Trust expects the principles of best practice in clinical risk management to be used in all of its service areas.

It is acknowledged that risk cannot be completely eliminated; indeed some risks are difficult or even impossible to predict, the Trust however advocates a systematic approach to clinical risk management which is underpinned by effective communication and record keeping skills thereby maximising the chances of managing risk.

This policy gives clinical staff working with patients/service users’ clear guidance on conducting risk assessments and the formulation of risk management plans. This policy provides guidance to clinical staff where there is a perceived or known risk. This includes the use of risk assessment tools, processes and escalation used by practitioners that have been formally approved by the Trust as part of its governance and risk management arrangements.

It recognises that risk management also involves consideration of positive risk taking to promote independence, choice and responsibility, once the potential benefits and harm to that individual and others have been thoroughly assessed.

This policy supports frontline staff working with adults in mental health, learning disability and children and young people.

2.0 Purpose
This policy is intended to guide practitioners who work with service users to manage the risk of harm. It sets out the principles and standards required that should underpin best practice across all health settings.

3.0 Objectives
- Provide an agreed trust-wide structure for assessing clinical risks
- Ensure that staff are aware of their responsibilities in relation to risk management
- Ensure that patients/service users and their carers are involved in the risk management process
- Outline a clear process for risk management including timescales
- Ensure the tools that are authorised for use in clinical risk assessment are evidence based and fall within the divisions clinically agreed framework
- Promote the importance of accurate and clear recording of identified risks and associated management

Part One: Best Practice Recommendations for Risk Assessment and Management:

4.0 Process
4.1 Clinical Risk Management Process
In 2007 the Department of Health published guidance documentation on Clinical Risk Management (‘Best Practice in Managing Risk’). This 2007 document was updated in 2009
with additional information relating to the implementation of the previous guidance. Specifically, in both documents, the DoH recommends that 16 best practice points are followed as a framework for effective risk assessment and management. This policy incorporates these 16 best practice points for guiding staff through the clinical risk process. Although the DoH documents relate to Mental Health services specifically, the principles described are broad and applicable across clinical areas and services provided by the Trust.

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

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

Risk assessment and management should be based on physical, procedural and relational security (DoH, March 2010). Relational security is the knowledge and understanding staff have of a service user and of the physical and social environment and the translation of that information into appropriate responses and care (e.g. See, Think, Act (date)).

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

The following best practice points should form the basis of the risk assessment and management process:

1. Best practice involves making decisions based on knowledge of the research evidence, knowledge of the individual service user and their social context, knowledge of the service users own experience, and clinical judgement. The most effective risk management plans involve good clinical judgement, involvement of the patient, their carer, family and other professionals working with the individual.

4.1.1 Fundamentals

2. Positive risk management as part of a carefully constructed plan is a required competence for all practitioners. All staff should ensure that care plans are in place to support positive risk management.

3. Risk management should be conducted in a spirit of collaboration and based on a relationship between workers, the service user and their carers that is as trusting as possible. Ideally, this will involve clear and comprehensive sharing of information between all parties. Where there are complexities in relation to the sharing of such information (e.g. where the service user does not consent to this information being shared or where they withdraw consent) then such issues should be discussed and, if possible, resolved in as transparent a way as possible.

4. Risk management plans should be constructed with full involvement of the patient and carers taking into account the age of the patient and the mental capacity act. They should be provided with information in an accessible format which meets the requirement of Accessible Information Standard (AIS).

5. Risk management must be built on recognition of the service users strengths and should emphasise recovery. However not all patients will be ‘recovering’ and risk management
may be in place to improve and maintain positive health and well being

6. Risk management requires an organisational strategy as well as efforts by the individual practitioner. Risk management is everyone’s responsibility

4.1.2 Basic Ideas in Risk Management

7. To reduce the risk of harm to patients, a good risk management plan should take into account both general and patient specific risks. If risk cannot be removed then it should be minimised

8. Knowledge and understanding of mental health legislation is an important component of risk management

9. Risk management plans should include the following:
   - A holistic approach to risk
   - A summary of the risk
   - Summary of what situations may increase risk
   - Action that the patient and practitioners will take if a crisis happens

“The governing principle behind good approaches to choice and risk is that people have the right to live their lives to the full as long as that does not stop others from doing the same. Fear of supporting people to take reasonable risks in their daily lives can prevent them from doing the things that most people take for granted. What needs to be considered is the consequence of an action and the likelihood of any harm from it. By taking account of the benefits in terms of independence, well-being and choice, it should be possible for a person to have a support plan which enables them to manage identified risks and to live their lives in ways which best suit them.”(DOH, 2007)

10. Risk assessment and management should be based on the structured clinical judgement approach.

11. Risk assessment tools should consider a range of factors when addressing risk (e.g. dynamic, static, stable and future factors) (HQIP 2018)

12. Risk tools and scales have little place on their own in the prevention of risks such as suicide. Risk should not be regarded as a number and risk assessment is not a checklist. Where tools are used these need to be simple, accessible and should be considered as part of a wider assessment process. (HQIP 2018)

13. Risk assessment tools should be viewed as a way to enable candid conversations about risk to take place and to develop the relationship between patient / client and worker (HQIP 2018)

14. The emphasis in risk assessment should be on building relationships and gathering good quality information on (i) the current situation (ii) past history and (iii) social factors to inform a collaborative approach to management (HQIP 2018)

15. Risk management is the basis for developing the right kind of intervention for the service user. The risk management plan should include a summary of all risks identified, formulations of the situation in which identified risks may occur, and actions to be taken by
practitioners and the service user in response to crisis. (DOH 2009).

16. The risk management plan should be personalised to the patient and result from an individualised formulation of the patients history, current circumstances and coping

4.1.3 Working with Service Users and Carers

17. All staff involved in risk management must be capable of demonstrating sensitivity and competency in relation to diversity in race, faith, age, gender, disability, individuals communication needs and sexual orientation

18. Risk management must always be based on the awareness of the capacity for the service users risk level to change over time, and recognition that each service user requires a consistent and individual approach. Levels of risk must be constantly reviewed and risk management plans changed accordingly this should be reflected in a reviewed care plan

19. Risk assessment and management needs to be personalised to take into account the dynamic nature of life situations and how individuals manage them (HQIP 2018).

4.1.4 Individual Practice and Team Working

20. Risk management plans are the responsibility of all members of the multidisciplinary and multi-agency teams. Risk management plans should be developed by teams in an open, democratic and transparent culture that embraces reflective practice. These should be shared with MDT as clinically appropriate

21. A risk management plan is only as good as the time and effort into communicating its findings to others. All risk assessments, management plans, and discussions should be clearly documented and communicated to all involved and relevant parties, including the service user, carer, and other agencies if appropriate. Risk management plans must comply with the NHS Accessible Information Standard (2016)

22. All staff involved in risk management should evidence competence in utilising risk management tools and receive relevant training required for their practice via appraisal and supervision process

23. Risk assessment and management plans should be developed and reviewed in line with local policies, and whenever new relevant information becomes available or there is a change in the service user’s clinical presentation or circumstances including:
   - Admission, discharge or leave of absence from inpatient care
   - Transition between services
   - Change of care co-coordinator or other key staff
   In the face of any significant life changes or event
Part Two: A Process Model for Robust Risk Assessment and Management:

Model
Clinical risk assessment is the process used to determine risk management priorities for patient care by evaluating and comparing the level of risk against organisational standards, predetermined target risk levels or other criteria. The focus should always be on patient safety and outcomes. By utilising standardised Clinical Risk Assessment Tools along with an agreed Clinical Risk Management process, our primary focus is to manage risks of individuals and those who we support. The process for clinical risk management is determined by the nature and requirements of the service. The Trust acknowledges that specialist practitioners may use specialist tools for clinical risk assessments and that it is not practical to have one single assessment tool because the services the Trust provides are so diverse. Nonetheless, every assessment and care planning process will have common risk assessment elements with an evidence based holistic risk screen incorporated into it, which follows the model of risk management described below:

- Initial clinical risk assessment/Screening (face to face and/or telephone)
- Initial risk management plan if indicated
- Comprehensive risk assessment if indicated
- Collaborative risk management plan and positive risk taking
- Risk review

4.2 Initial Clinical Risk Assessment / Screening
Initial clinical risk assessment (or risk screening) would be conducted on first contact with services (or within 24 hours of an in-patient admission). The nature of the initial risk screen will depend on the service specifications and contracts. Such variations in service design may result in some initial risk screens being conducted in a face-to-face setting whereas others are conducted via telephone. The assessment of risk via telephone may be aided by the use of additional IT facilities such as Skype or face time, thus providing additional visual data for the assessor. Services may benefit from local consideration of how their risk screening processes provide relatively more or less risk data dependant on the way in which information is initially collected.

- This screening assessment provides a record of the information and evidence available at the time of the assessment and demonstrates that a systematic assessment has taken place
- Potential sources of information include - clinical interviews with patient/service user, Mental Capacity assessment, observations, information from clinical risk scales (e.g. Beck Hopelessness scale)), information from others including other professionals/family and history as recorded in the notes
- In some circumstances the initial screening assessment and the initial risk management plan may be completed by a single practitioner. (e.g. admitting nurse to an inpatient setting or a health visitor in family home)
- This information would support the development of the initial risk management plan as indicated
- In some instances the initial risk screen would inform a triage process for the client, indicating which follow on service the client requires referral to.
- The Trust may benefit from the development of local SOPS (Standard Operating Procedures) that inform risk related processes such as ‘Risk assessment of waiting list clients’ and ‘Inpatient Discharge’.
4.3 Initial Risk Management Plan
This would be devised following the initial screening assessment:

- The initial plan will be devised following initial risk assessment detailing any risks, highlighting the need for further detailed risk assessment and, where appropriate, specifying the escalation process. The escalation response will depend on the nature of the risk and urgency of response required
- The aim of this plan is to ensure the safety of the individual and others during the initial episode of care

4.4 Comprehensive Risk Assessment
If identified from initial risk screening or as required by specific service specifications, this would be completed within 7 days of contact with service and is a more comprehensive process:

- This assessment would cover key areas pertinent to the service area (e.g. using the tool authorised by the specific division)
- In most circumstances the comprehensive risk assessment and management plan would be led by a named professional who will ensure that there is a coordinated plan. They will be supported by the MDT and the patient/service user and /or family

4.5 Comprehensive Risk Management Plan
This would be devised following the completion of the comprehensive risk assessment.

- The management plan would reflect all of the risk indicators identified through the assessment process
- It would include short and long term risk management options. Short term options should include crisis and reactive strategies
- It would ensure that the person’s wishes are considered as far ‘as they are able to’ in the context of a capacity assessment as defined by The Mental Capacity Act (2005)
- It would ensure that responsibilities enshrined in a duty of care take into account both individual and public safety at all times. This would be balanced with the need to enable the person to have as much freedom to act as possible in the circumstances with the least restrictive options (MCA and MHA)

4.6 Exceptions
The initial assessment and initial risk management plan may be sufficient for the clinical need - this may include; specific clinical interventions, or if an episode of care was so short that there would be no need to do a more comprehensive assessment

4.7 Positive Risk Management and Positive Risk taking
All comprehensive risk management plans should incorporate positive risk taking. This means following a process which takes as a starting point identifying the potential benefit or harm of an action. The aim is to help people develop and support positive risk taking to achieve personal growth or positive change (West Midlands Joint Improvement Partnership, 2011). Logan (2006) clarifies that over-defensive practice is bad practice and any risk-related decision is likely to be acceptable if it conforms to relevant guidelines; is based on the best information available; is clearly documented and the relevant people are informed. As long as a decision is based on the
best evidence, information and clinical judgement available, it will be the best decision that can be made at the time.

This means acknowledging that we can never eliminate all risks. This will be reflected in the risk management plans having to include agreed decisions that will have some risk as part of the plan. This plan may have a stepped approach to increasing exposure to risk through the risk management review process. This should be explicit in the decision making process and should be discussed openly with the service user and/or their carer.

Positive risk management (DOH, 2009) includes:

- Working with the service user to identify what is likely to work – and what is not;
- Paying attention to the views of carers and others around the service user when finally deciding a plan of action;
- Weighing up the potential costs and benefits of choosing one action over another;
- Being willing to take a decision that involves an element of risk because the potential positive benefits outweigh the risk;
- Developing plans and actions that support the positive potentials and priorities stated by the service user, and minimising the risks to the service user or others;
- Being clear to all involved about the potential benefits and the potential risks; and
- Ensuring that the service user, carer and others who might be affected are fully informed of the decision, the reasons for it and the associated plans.

4.8 Risk Management Review

The named professional would be responsible for ensuring the regular review of the risk management plan, involving both the patient/service user and the MDT as appropriate. The management plan would require review whenever risk changes, for example; following an incident, decrease in risk behaviour, increase in risk behaviour, new risk behaviour:

- At regular intervals for individuals as determined by their management plan (e.g. a plan may specify a daily review)
- At regular intervals as defined by the service (e.g. weekly ward round for inpatients)
- At significant point in care pathway (e.g. CPA review, or Mental Health Tribunal)
- When transferring from one service/team / worker to another
- When being discharged from a service

Part Three: Clinical Risk Tools:

4.9 Clinical Risk Tools

A number of risk tools exist for the purposes of both screening and more comprehensive assessment. Some tools assess risk in a broad number of areas whilst others focus explicitly on risks in one domain (e.g. suicide or violence). Some tools are designed specifically to assess risks within particular client groups. The rationale for the use of specific tools will develop and fluctuate over time in each clinical area but, below is a description of the various risk tools that are available for use within BCPFT as of March 2019. Each Clinical Division should have agreement on which tools are in use in their areas and the rationale for this. Tools should be applied consistently and the findings from such tools should be discussed and communicated as widely as necessary to ensure robust risk management and safety planning. All staff should be trained in the use of these assessment tools so that they can meet the requirements of their
roles.

**Steve Morgan Working with Risk**
An evidenced based initial risk assessment screening tool to develop an initial risk management plan from and highlight further areas that may require more in depth risk assessment.

**Connecting With People**
Evidence based risk assessment and management framework for specifically addressing risks of suicide and self-harm. Connecting with People aims to increase empathy and compassion towards people who have thoughts of harm to self and has been coproduced between people with lived experience and professionals. Connecting with People makes use of the SAFE tool and aims to coproduce safety plans.

**Threshold Assessment Grid (TAG)**
TAG is an initial screening tool to be used on first contact with services; this identifies initial management risks and helps the clinician decide whether a more comprehensive assessment is required.

**Sainsbury’s Clinical Risk Tool**
A fuller, in-depth assessment, where participation of a patient/service user is incorporated into the assessment, findings are recorded, and contingency/action plans devised. Sainsbury’s should be completed within 7 days of contact with services.

**Historical Clinical Risk- 20 (HCR-20)**
A clinical risk tool that assesses violence of individuals with mental or personality disorders. This tool is used by forensic services within the Trust and can only be used by those with specialist training in its use.

Risk tools provide a means to systematically identify potential risk and protective factors. For the majority of service users, they should be used more as an aid to formulation and risk management planning than a means of prediction. The choice of tools will be dependent on the local clinical risk framework and the type of risk being assessed. Some tools will assess specific risks but a range of tools will also assess multiple risks.

Any new tools that are introduced should be evidence based and have been approved by the Divisional Quality and Safety Group.

**Part Four: Implementation and Maintenance of this Policy:**

The Black Country Partnership Foundation Trust expects that best practice principles in clinical risk management are used in its services. In this context, on the basis of service specifications and requirements, clinical areas should ascertain service risk management approaches and implement a clinical risk strategy on that basis. This would enable recommendations to be formulated that would highlight current best practice, and identify improvements needed to meet the BCPFT Clinical Risk Management policy. It would also ensure CQC inspection requirements demonstrate consistent and transparent risk management across all the Clinical areas.

Once a clinical risk strategy plan is agreed, an audit plan will be implemented to identify improvements required to meet and maintain the BCPFT Clinical Risk Management policy.
Part Five: Learning from Risk Incidents and Near Misses:

In order to capitalise on lessons learned from previous risk incidents and near misses, this Policy recommends that learning from risk incidents (as outlined in Root Cause Analysis (RCA) and 72 hour Assurance Reports) is shared with Trust clinical teams in a timely manner. The way in which such information is shared should be determined by Divisional risk and safety groups but could include, for example, the use of ‘lessons learned’ bulletins, regular workshops or Quality Improvement events or via local team meetings and reflective practice forums. Feedback should include positive reinforcement of successful risk assessment and management practices as well as feedback on where and how risk management could be improved or strengthened.

Part Six: Training Recommendations:

There will be significant locality/divisionally based clinical risk training resources already available to build on existing good practice. It is recommended that each division scopes these resources in order to share good practice. In addition:

- The policy would recommend that all staff joining the trust receive training on clinical risk management principles reflected in the policy.
- All staffs have a mandatory annual update on clinical risk management principles reflected in this policy.

Part Seven: Procedures Connected to This Policy:

5.0 Procedures connected to this Policy
Risk Management (Clinical) - SOP 01 - Relocation of Patients’ Accommodation Disruption to Ward Environment

6.0 Links to Relevant Legislation

Mental Health Act 1983 (amended 2007)
The Mental Health Act (2007) amended the Mental Health Act (MHA) of 1983. The main purpose of the legislation is to ensure that ‘people with serious mental disorders, which threaten their health or safety or the safety of other people can be treated irrespective of their consent where it is necessary to prevent them from harming themselves or others’. The amended act introduced:

- A new broad definition of ‘mental disorder’ to encompass ‘any disorder or disability of the mind’
- An ‘appropriate treatment test’, preventing patients from being compulsorily detained unless appropriate medical treatment is available
- Community Treatment Orders to supervise the treatment of certain patients in the community
- New safeguards including a provision for Independent Mental Health Advisors to provide information and help people understand and exercise their rights
- New roles to replace the roles of approved social worker and responsible
medical officer

- Provision for powers to reduce the time limits for the automatic referral of some patients to the Mental Health Review Tribunal

**Mental Capacity Act 2005**
The Mental Capacity Act provides a statutory framework to empower and protect vulnerable people who are unable to make their own decisions. It aims to ensure that people are given the opportunity to participate in decisions about their care and treatment to the best of their capacity. It covers all aspects of health and social care. The Act creates a new statutory service, the Independent Mental Capacity Advocate (IMCA) Service. Its purpose is to help vulnerable people who lack mental capacity who are facing important decisions about serious medical treatment and changes of residence.

The Act also created a new criminal offence of ill treatment or neglect of a vulnerable adult. 1 April 2009 saw the implementation of the Deprivation of Liberty Safeguards under the Mental Capacity Act. These safeguards were created to create legal protection for adults who lack capacity to consent to care or treatment in a hospital or care home and that care or treatment constitutes a deprivation of their liberty. These safeguards are not an alternative to the Mental Health Act but instead provide a legal framework for people who cannot legally be made subject to the Mental Health Act (i.e. they are not eligible for some reason).

**Gillick and Fraser competence**

Gillick Competence is a term originating in England and is used in medical law to decide whether a child/young person under the age of 16 has the maturity to consent to his or her own medical treatment, and understand the implications of those decisions, without the need for parental permission or knowledge. For further information, there is training on ESR 000 Adolescent Health 03: Legal Framework that covers Gillick competence.

Fraser Guidelines are used specifically to decide if a child/young person should receive contraception and contraceptive advice without the need for parental permission or knowledge.

**Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)**

These regulations introduce the new fundamental standards, which describe requirements that reflect the recommendations made by Sir Robert Francis following his inquiry into care at Mid Staffordshire NHS Foundation Trust. They enable the Care Quality Commission to pinpoint more clearly the fundamental standards below which the provision of regulated activities and the care provided to people must not fall, and to take appropriate enforcement action where we find it does.

Part 3 has two sections: Section 1 describes the requirements relating to persons carrying on or managing a regulated activity.

Section 2 introduces the fundamental standards below which the provision of regulated activities and the care people receive must never fall. They came into force for all health and adult social care services on 1 April 2015.

Regulation 8: General
Regulation 9: Person-centred care
Regulation 10: Dignity and respect
Regulation 11: Need for consent
Data Protection Act 2018
The Data Protection Act 2018 became law on the 23rd May 2018. It sets standards that must be satisfied when obtaining, recording, holding, using or disposing of personal data. The Act controls how your personal information is used by organisations, businesses or the government. The Act is the UK's implementation of the General Data Protection Regulation (GDPR). It ensures personal information kept is used fairly, lawfully and transparently.

The Act introduces new offences for knowingly or recklessly obtaining or disclosing personal data without the consent of the data controller, procuring such disclosure, or retaining the data obtained without consent. The Act also implements the EU Law Enforcement Directive; it implements those parts of the GDPR which 'are to be determined by Member State law' and creates a framework similar to the GDPR for the processing of personal data which is outs

6.1 Links to Relevant National Standards
CQC Regulation 9: Person-Centred Care
The intention of this regulation is to make sure that people using a service have care or treatment that is personalised specifically for them. This regulation describes the action that providers must take to make sure that each person receives appropriate person-centred care and treatment that is based on an assessment of their needs and preferences.

Providers must work in partnership with the person, make any reasonable adjustments and provide support to help them understand and make informed decisions about their care and treatment options, including the extent to which they may wish to manage these options themselves.

Providers must make sure that they take into account people's capacity and ability to consent, and that either they, or a person lawfully acting on their behalf, must be involved in the planning, management and review of their care and treatment. Providers must make sure that decisions are made by those with the legal authority or responsibility to do so, but they must work within the requirements of the Mental Capacity Act 2005, which includes the duty to consult others such as carers, families and/or advocates where appropriate.

Safer Services Toolkit (Dec 2017):
The National Confidential Enquiry into Suicide and Homicide by People with Mental Illness (NCISH) has made recommendations to improve the safety of mental health care. The Safer Services Toolkit represents a list of key elements of safer care in mental health services. The toolkit is intended for use as a basis for self-assessment by
specialist mental health providers and covers the following areas:

- Safer wards
- Care planning and early follow up on discharge from hospital to community
- ‘Out-of-area’ admissions
- 24 hour crisis resolution teams
- Community outreach teams
- Specialised services for patients with comorbid mental health and addiction difficulties
- Multidisciplinary review (working with carers)
- Implementing NICE guidance on depression and self-harm
- Personalised risk management, without routine checks
- Low turnover of non-medical staff
- Psychosocial assessment of self-harm patients
- Safer prescribing of opiates and antidepressants
- Diagnosis and treatment of mental health problems in primary care
- Additional measures for men with mental ill health

The ‘personalised risk management, without routine checks’ recommendations state that:

- There is a comprehensive management plan based on assessment of individual / personalised risks, and not on the completion of a checklist
- There is a guide in place on the effective communication of personalised risk management between different agencies, services and professionals involved with the patient, including their family.

Adherence to the recommendations in this Policy would meet the requirements of the Safer Services Toolkit (2017).

**Working with families**

In order to improve the outcomes for children and their families it is essential that we focus on those problems faced by parents/carers which have an impact on entire families.

*Practitioners should be mindful of any children in the household, their ages and the impact the parental mental health may have on those children*.

A ‘think family’ approach is essential in order to ensure that services and professionals can identify problems and intervene earlier to meet the needs of children and their parents/carers.

Safeguarding Children

All of those who come into contact with children and families in their everyday work, including practitioners who do not have a specific role in relation to safeguarding children, have a duty to safeguard and promote the welfare of children.

Safeguarding Adults

Living a life that is free from harm and abuse is a fundamental right of every person. However, when abuse does take place, it needs to be dealt with swiftly, effectively and in ways which are proportionate to the issues, where the adult in need of protection stays as much in control of the decision-making as is reasonably possible. The right of the individual to be heard throughout this process is a critical element in the drive towards a more personalised care and support. It remains the job of BCPFT Adult Safeguarding Team to make sure all the teams within the organisation work together to prevent abuse and also to protect people if they are harmed or exploited.

http://luna.smhsct.local/trust/safeguarding-team

6.2 Links to other key policy/s

- Health Records Policy
- Risk Management Policy
- Violence and Aggression Policy
- Incident Reporting and Investigating Policy
- Incidents, Complaints and Claims – Analysis, Improvement and sharing Lessons Learnt Policy
- Lone Working Policy
- Safeguarding Children Policy
- Safeguarding Adults at Risk Policy
- Dysphagia Policy
- DNA Policy
- Resuscitation and Management of Deteriorating Patient Policy
- Physical Health – Adult Services Policy
- Pressure Ulcers Policy
- Medical Devices Policy
- Clinical Falls Policy
- Care Programme Approach Policy
- Nutrition and Hydration Policy
- Insulin Management Policy
- End of Life Policy
- Safe and Effective Use of Bedrails Policy
- Ligature Risk Assessment Policy
- Supervision Policy
- Capability Policy
- Disciplinary Policy

6.3 References

Department of Health (2007) Best Practice in Managing Risks: principles and guidance for best practice in the assessment and management of risk to self and others in mental health
services
Hooper, J. (1999): Health needs Assessment; helping change happen. Community Practitioner 72(9), 286-88
Health Child Programme, department of Health (2009)
University of Manchester website lists all the National Confidential Inquiries into Suicide and Homicide by People with Mental Illness (NCI/NCISH): www.medicine.manchester.ac.uk
NHS Litigation Authority’s Risk Management Standards 2012-13 Threshold Assessment Grid (TAG). Kings College London
### 7.0 Roles and Responsibilities for this Policy

<table>
<thead>
<tr>
<th>Title</th>
<th>Role</th>
<th>Responsibilities</th>
</tr>
</thead>
</table>
| All Clinical Staff                         | Adherence | - Ensure they familiarise themselves with this policy and adhere to its principles in order to be able to respond to the immediate needs of patients and service users  
- Attend training applicable to their role  
- Promote the well-being and dignity of the patient at all times  
- Comply with all Trust policies – this is a condition of employment and a breach of this policy may result in disciplinary action  
- Ensure any errors or incidents relating to this policy and area of practice are reported on DATIX, the Trust’s electronic incident reporting system  
- Raise any concerns about the way this policy is being implemented or about this area of practice in general with their line manager or lead clinician/service manager. If they feel unable to raise the matter with them, they may write to an Executive Director. If they feel unable to raise the matter with an Executive Director, they may write to the Chairman or a Non-Executive Director. If they are unsure about raising a concern or require independent advice or support, they may contact:  
  - Trade Union representative  
  - the relevant professional body  
  - the NHS Whistleblowing Helpline - 08000 724 725 |
| Ward Managers/ Team Leaders/ Matrons       | Operational | - Ensure all staff are aware of their role under the policy  
- Ensure staff have received sufficient training and/or are competent to implement the policy  
- Ensure records are kept as specified  
- Ensure that all incidents/issues relating to this policy and area of practice are reported |
| Service Managers                           | Implementation | - Ensure they are familiar with this policy and be responsible for staff adhering to the procedures referred to  
- Ensure staff attend training applicable to their role  
- Implement the guidance across their areas of responsibility  
- Ensure staff work to the standards set out in this policy |
| Divisional Quality and Safety Groups       | Monitoring | - Monitor and review all incidents, complaints and claims relating to this area of practice and policy within their Division  
- Receive the results and recommendations of all related completed audits and be responsible for monitoring action plans to implement changes to current practice until completion |
| Quality and Safety Steering Group          | Scrutiny and Performance | - Scrutinise the implementation of a systematic and consistent approach to this policy in all service areas  
- Provide exception and progress reports to the Quality and Safety Committee |
| Clinical Directors/ Divisional Directors/ Head of Nursing | Trust Leads | - Lead discussions around this topic area and policy at Divisional Quality and Safety Group meetings  
- Oversee the completion of audits in respect of this topic area and policy  
- Provide updates on this area of practice and policy within their division to the Quality and Safety Steering Group |
| Divisional Managers                        | Strategic | - Provide support and guidance regarding resources to enable this policy to be implemented  
- Ensure systems are put in place to enable this policy to be implemented within their service areas  
- Ensure all managers are aware of the policy and promote good practice |
<table>
<thead>
<tr>
<th>Title</th>
<th>Role</th>
<th>Responsibilities</th>
</tr>
</thead>
</table>
| Executive Director of Nursing and AHPs and Governance                | Executive Lead        | - Lead responsibility for the implementation of this policy  
- Lead on strategies and innovations to improve current practice  
- Ensure any serious concerns regarding the implementation of this policy are brought to the attention of the Board of Directors |

### 8.0 Training

<table>
<thead>
<tr>
<th>What aspect(s) of this policy will require staff training?</th>
<th>Which staff groups require this training?</th>
<th>Is this training covered in the Trust’s Mandatory &amp; Specialist Mandatory Training Needs Analysis document?</th>
<th>If no, how will the training be delivered?</th>
<th>Who will deliver the training?</th>
<th>How often will staff require training?</th>
<th>Who will ensure and monitor that staff have this training?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mandatory Training in relation to Children and Adult Safeguarding</td>
<td>All staff groups</td>
<td>Yes</td>
<td>Learning and Development Team</td>
<td>On induction and Annually thereafter</td>
<td>Workforce and Development Group</td>
<td></td>
</tr>
<tr>
<td>Level 2 and 3 Children and Adult Safeguarding Training</td>
<td>All clinical staff groups</td>
<td>No, staff will receive specific training in relation to this policy where it is identified in their individual training needs analysis as part of their development for their particular role and responsibilities</td>
<td>Internally</td>
<td>Strategic Lead for Safeguarding Children and Adults</td>
<td>Every three years</td>
<td>Service Managers/ Team Managers</td>
</tr>
<tr>
<td>MAPA (including Rapid Tranquilisation)</td>
<td>All inpatient qualified nurses and HCSWs in MH &amp; LD</td>
<td>Yes</td>
<td>MAPA® Certified Instructors</td>
<td>Annually</td>
<td>Workforce Development Group</td>
<td></td>
</tr>
<tr>
<td>Promoting Safer and Therapeutic Services (PSTS) and Conflict Resolution</td>
<td>All patient facing staff working in MH &amp; LD services (except those who require MAPA) and All patient facing staff working in Dudley Children’s services</td>
<td>Yes</td>
<td>Learning and Development Team</td>
<td>Three Yearly</td>
<td>Workforce Development Group</td>
<td></td>
</tr>
<tr>
<td>What aspect(s) of this policy will require staff training?</td>
<td>Which staff groups require this training?</td>
<td>Is this training covered in the Trust’s Mandatory &amp; Specialist Mandatory Training Needs Analysis document?</td>
<td>If no, how will the training be delivered?</td>
<td>Who will deliver the training?</td>
<td>How often will staff require training?</td>
<td>Who will ensure and monitor that staff have this training?</td>
</tr>
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</tr>
<tr>
<td>Infection Prevention &amp; Control (including Hand Hygiene &amp; Inoculation Incidents)</td>
<td>All Trust staff</td>
<td>Yes</td>
<td>Learning and Development Team</td>
<td>On induction and annually thereafter</td>
<td>Workforce Committee</td>
<td></td>
</tr>
<tr>
<td>Infection Prevention &amp; Control Champions acting as a local resource and point of contact for infection prevention and control issues</td>
<td>Infection Prevention &amp; Control Champions</td>
<td>No, champions will receive specific training and educational sessions in relation to their role and responsibilities</td>
<td>Internally</td>
<td>Infection Prevention &amp; Control Team</td>
<td>Quarterly</td>
<td>Infection Prevention &amp; Control Team</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control Educational sessions as per service needs</td>
<td>All clinical staff</td>
<td>No, staff will receive specific training in relation to this policy where it is identified in their individual training needs analysis as part of their development for their particular role and responsibilities</td>
<td>Internally</td>
<td>Infection Prevention &amp; Control Team</td>
<td>As and when required to meet service need</td>
<td>Service Managers/ Matrons</td>
</tr>
<tr>
<td>Immediate Life Support (ILS)</td>
<td>Registered Nurses/ Inpatient staff</td>
<td>Yes</td>
<td>External training provider</td>
<td>Annually</td>
<td>Workforce Committee</td>
<td></td>
</tr>
<tr>
<td>Basic Life Support (BLS)</td>
<td>Non-Clinical Staff</td>
<td>Yes</td>
<td>Learning and Development Team</td>
<td>Annually</td>
<td>Workforce Committee</td>
<td></td>
</tr>
<tr>
<td>What aspect(s) of this policy will require staff training?</td>
<td>Which staff groups require this training?</td>
<td>Is this training covered in the Trust’s Mandatory &amp; Specialist Mandatory Training Needs Analysis document?</td>
<td>If no, how will the training be delivered?</td>
<td>Who will deliver the training?</td>
<td>How often will staff require training</td>
<td>Who will ensure and monitor that staff have this training?</td>
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</tr>
<tr>
<td>ELS</td>
<td>Registered Nurses OP/ Inpatient HCA/ Other Clinical Staff</td>
<td>This should be in the mandatory training</td>
<td>External training provider</td>
<td>Annually</td>
<td>Workforce Committee</td>
<td></td>
</tr>
<tr>
<td>FallSafe Awareness Training</td>
<td>Nominated Staff Leads</td>
<td>No, staff will receive specific training in relation to this policy where it is identified in their individual training needs analysis as part of their development for their particular role and responsibilities</td>
<td>In house</td>
<td>Physical Health Matron AHP Trust Professional Lead Practice Development Nurse</td>
<td>Staff becoming fallsafe leads</td>
<td>Physical Health Matron AHP Trust Professional Lead/ Practice Development Nurse</td>
</tr>
<tr>
<td>FallSafe E-learning</td>
<td>All qualified staff And Health Care Support Workers with an interest in falls</td>
<td>No, staff will receive specific training in relation to this policy where it is identified in their individual training needs analysis as part of their development for their particular role and responsibilities</td>
<td>Online</td>
<td>N/A</td>
<td>One off</td>
<td>Physical Health Matron AHP Trust Professional Lead/ Practice Development Nurse</td>
</tr>
<tr>
<td>Diabetes Awareness Training</td>
<td>Health Care Assistants (HCAs) Qualified staff</td>
<td>No, staff will receive specific training in relation to this policy where it is identified in their individual training needs analysis as part of their development for their particular role and responsibilities</td>
<td>Internally, face-to-face</td>
<td>Learning and Development Team</td>
<td>3 yearly</td>
<td>Workforce Committee</td>
</tr>
<tr>
<td>Safe Administration of Insulin</td>
<td>Qualified Staff only</td>
<td>No, staff will receive specific training in relation to this policy where it is identified in their individual training needs analysis as part of their development for their particular role and responsibilities</td>
<td>Electronically via E-Learning (Diabetes on the NET – CPD Module)</td>
<td>n/a</td>
<td>Annually</td>
<td>Workforce Committee</td>
</tr>
</tbody>
</table>
9.0 Equality Impact Assessment
Black Country Partnership NHS Foundation Trust is committed to ensuring that the way we provide services and the way we recruit and treat staff reflects individual needs, promotes equality and does not discriminate unfairly against any particular individual or group. The Equality Impact Assessment for this policy has been completed and is readily available on the Intranet. If you require this in a different format e.g. larger print, Braille, different languages or audio tape, please contact the Equality & Diversity Team on Ext. 8067 or email bcpft.equalityimpactassessment@nhs.net

10.0 Data Protection and Freedom of Information
Data Protection Act provides controls for the way information is handled and to gives legal rights to individuals in relation to the use of their data. It sets out strict rules for people who use or store data about individuals and gives rights to those people whose data has been collected. The law applies to all personal data held including electronic and manual records. The Information Commissioner’s Office has powers to enforce the Data Protection Act and can do this through the use of compulsory audits, warrants, notices and monetary penalties which can be up to €20million or 4% of the Trusts annual turnover for serious breaches of the Data Protection Act. In addition to this the Information Commissioner can limit or stop data processing activities where there has been a serious breach of the Act and there remains a risk to the data.

The Freedom of Information Act provides public access to information held by public authorities. The main principle behind freedom of information legislation is that people have a right to know about the activities of public authorities; unless there is a good reason for them not to. The Freedom of Information Act applies to corporate data and personal data generally cannot be released under this Act.

All staffs have a responsibility to ensure that they do not disclose information about the Trust's activities; this includes information about service users in its care, staff members and corporate documentation to unauthorised individuals. This responsibility applies whether you are currently employed or after your employment ends and in certain aspects of your personal life e.g. use of social networking sites etc. The Trust seeks to ensure a high level of transparency in all its business activities but reserves the right not to disclose information where relevant legislation applies. The Information Governance Team provides a central point for release of information under Data Protection and Freedom of Information following formal requests for information; any queries about the disclosure of information can be forwarded to the Information Governance Team.
### 11.0 Monitoring this policy is working in practice

<table>
<thead>
<tr>
<th>What key elements will be monitored? (measurable policy objectives)</th>
<th>Where described in policy?</th>
<th>How will they be monitored? (method + sample size)</th>
<th>Who will undertake this monitoring?</th>
<th>How Frequently?</th>
<th>Group/Committee that will receive and review results</th>
<th>Group/Committee to ensure actions are completed</th>
<th>Evidence this has happened</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Management Plans are in place</td>
<td>4.0 Process</td>
<td>Record Keeping Audit</td>
<td>Ward Managers/Team Leaders/Matrons</td>
<td>Annually</td>
<td>Information Governance Steering Group</td>
<td>Group Quality and Safety Groups</td>
<td>Minutes of meetings/action plan signed off</td>
</tr>
<tr>
<td>Physical assessment of patients when they are admitted to a service including timeframes</td>
<td></td>
<td>Audit - A detailed review of practice including compliance with frequency of screening, use of authorised tools, patient assessment within given timescales, MDT working</td>
<td>Physical Health Matron</td>
<td>Annually</td>
<td>Quality and Safety Steering Group</td>
<td>Quality and Safety Steering Group</td>
<td>Audit outcomes and sign off of action plans</td>
</tr>
<tr>
<td>Ongoing assessment of physical needs for all patients including timeframes</td>
<td></td>
<td>Audit - A detailed audit review of practice</td>
<td>Physical Health Matron</td>
<td>Annually</td>
<td>Quality and Safety Steering Group</td>
<td>Quality and Safety Steering Group</td>
<td>Audit outcomes and sign off of action plans</td>
</tr>
<tr>
<td>Physical Health Booklet</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compliance with the Annual Infection Prevention and Control Audit Programme</td>
<td>n/a</td>
<td>All Inpatient Units will be audited</td>
<td>Infection Prevention &amp; Control Team</td>
<td>Annually</td>
<td>Infection Prevention &amp; Control Committee</td>
<td>Infection Prevention &amp; Control Committee</td>
<td>Detailed in Infection Prevention &amp; Control Team's annual report and exception report</td>
</tr>
<tr>
<td>What key elements will be monitored? (measurable policy objectives)</td>
<td>Where described in policy?</td>
<td>How will they be monitored? (method + sample size)</td>
<td>Who will undertake this monitoring?</td>
<td>How Frequently?</td>
<td>Group/Committee that will receive and review results</td>
<td>Group/Committee to ensure actions are completed</td>
<td>Evidence this has happened</td>
</tr>
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</tr>
<tr>
<td>Other Clinical Services will submit a Self-Assessment Audit</td>
<td></td>
<td>Self-Assessment submitted to Infection Prevention &amp; Control Team</td>
<td></td>
<td>Annually</td>
<td>Infection Prevention &amp; Control Committee</td>
<td>Infection Prevention &amp; Control Committee</td>
<td>Detailed in Infection Prevention &amp; Control Team's annual report and exception report</td>
</tr>
<tr>
<td>How the organisation raises awareness about preventing and reducing the number of falls within inpatient areas</td>
<td>Audit of FallSafe care bundle completion</td>
<td>Falls Leads on each ward</td>
<td>Monthly</td>
<td>Falls Steering Group</td>
<td>Group Quality &amp; Safety Steering Groups</td>
<td>Group Quality &amp; Safety Steering Groups</td>
<td>Completed audits signed off/completed action plans signed off/minutes of meetings</td>
</tr>
<tr>
<td>Initiation of resuscitation, including the system for summoning help</td>
<td>Audit - Simulation and reviews</td>
<td>Deputy Director of Nursing</td>
<td>Quarterly</td>
<td>Resuscitation Sub-Group of Nursing Board</td>
<td>Nursing Board</td>
<td>Nursing Board</td>
<td>Minutes of meetings/Action plan signed off</td>
</tr>
</tbody>
</table>
## Policy Details

<table>
<thead>
<tr>
<th>Title of Policy</th>
<th>Clinical Risk Management Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique Identifier for this policy is</td>
<td>BCPFT-CLIN-POL-16</td>
</tr>
<tr>
<td>State if policy is New or Revised</td>
<td>Revised</td>
</tr>
<tr>
<td>Previous Policy Title where applicable</td>
<td>n/a</td>
</tr>
<tr>
<td>Policy Category Clinical, HR, H&amp;S, Infection Control, Finance etc.</td>
<td>Clinical</td>
</tr>
<tr>
<td>Executive Director whose portfolio this policy comes under</td>
<td>Executive Director of Nursing, AHPs and Governance</td>
</tr>
<tr>
<td>Policy Lead/Author Job titles only</td>
<td>Head of Nursing – LD and CYPF</td>
</tr>
<tr>
<td>Committee/Group responsible for the approval of this policy</td>
<td>Nursing Board</td>
</tr>
<tr>
<td>Month/year consultation process completed *</td>
<td>July 2019</td>
</tr>
<tr>
<td>Month/year policy approved</td>
<td>October 2019</td>
</tr>
<tr>
<td>Month/year policy ratified and issued</td>
<td>November 2019</td>
</tr>
<tr>
<td>Next review date</td>
<td>November 2022</td>
</tr>
<tr>
<td>Implementation Plan completed *</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality Impact Assessment completed *</td>
<td>Yes</td>
</tr>
<tr>
<td>Previous version(s) archived *</td>
<td>Yes</td>
</tr>
<tr>
<td>Disclosure status</td>
<td>‘B’ can be disclosed to patients and the public</td>
</tr>
</tbody>
</table>

* For more information on the consultation process, implementation plan, equality impact assessment, or archiving arrangements, please contact Corporate Governance

## Review and Amendment History

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Details of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.0</td>
<td>Mar 2019</td>
<td>Full policy review - Section 4.0 Process updated to reflect current practice and legislation updated.</td>
</tr>
<tr>
<td>2.0</td>
<td>Oct 2016</td>
<td>Full policy review and new policy template</td>
</tr>
<tr>
<td>1.0</td>
<td>Nov 2012</td>
<td>New policy for BCPFT</td>
</tr>
</tbody>
</table>