

CLINICAL POLICY

Safety Assessment in Mental Health and Learning Disability Clinical Practice

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Purpose:	This policy has been developed to provide a clear framework for safety assessment and safety management within the Trust. It outlines how these principles will be applied within the Trust, and will act as a benchmark for monitoring practice against standards
Consultation:	The policy has been shared with a range of clinical colleagues, those with lived experience of services, internal and external stakeholders
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Version History

Version	Date Issued	Reason for Change
V7.4	Sept 2011	Amendments to cover DASH service

V8	May 13	Format change
V9	Oct 2013	Full review
V10	March 2015	Amendments to cover service development of Mental Health Intermediate Care Services Gloucestershire – Agreed at Governance Committee
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V14.7	10/05/2024	Extension to review date – Policy confirmed as sufficient to meet the needs of existing practice by Associate Director of Patient Safety, Quality and Clinical Compliance
V14.8	10/12/2024	Extension to Policy of 12 months with under review statement added to top of the Policy
V15	02/09/2025	The risk policy has been reviewed and rewritten to align with national guidance on 'Staying Safe from Suicide' and to incorporate new approaches to safety assessment. The revised policy has been co-produced with key stakeholders. Title changed from 'Assessing and Managing Clinical Risk and Safety'

SUMMARY

Risk assessment is an integral part of the assessment, support and treatment of each service user when in contact with the Trust. This is not something that happens only once, or only at set times in a service user's journey towards recovery but is an on-going fluid process.

It is not possible to eliminate all risk, but through the use of safety assessment it is possible for the service user and their care team to understand and try to manage any identified safety concerns.

The cultural shift in mental health from 'risk' assessment to 'safety' assessment emphasises creating supportive environments that promote well-being and resilience. This approach focuses on identifying protective factors and strengths rather than categorising individuals by risk levels, fostering a more positive and proactive stance. By prioritising safety, mental health services can better support recovery, ensuring interventions are preventative, nurturing, and inclusive.

Safety assessment should be structured, evidenced-based and consistent across all the care

settings within the Trust.

TABLE OF CONTENTS

	Section	Page
1	<u>Introduction</u>	4-5
2	<u>Purpose - Why We Focus on Safety</u>	5-6
3	<u>Scope</u> <u>3.1 Primary and Entry Level Mental Health Services</u> <u>3.2 Secondary Mental Health Services</u> <u>3.3 Staff Responsibilities</u>	6 6-7 7 7
4	<u>Duties / General Roles, Responsibilities and Accountability</u>	7-8
5	<u>Mental Capacity Act Compliance</u>	8
6	<u>Policy Detail - Formulation Informed Management of Safety (FIMS) and Safety Assessment</u> <u>6.1 Introduction to FIMS</u> <u>6.2 Structure of FIMS in EPR</u> <u>6.3 Formulation</u> <u>6.4 Right Touch Approach</u> <u>6.5 Standards for Safety Assessment Process</u> <u>6.6 When Should you Carry out a Safety Assessment?</u> <u>6.7 Carrying Out a Safety Assessment</u> <u>6.8 Who Should Assess Safety Concerns?</u> <u>6.9 When to Carry out a Review of the Most Current Safety Assessment</u> <u>6.10 Additional Recording and Documenting of Incidences</u> <u>6.11 Escalation</u>	8-15 8-9 9 9-10 10-11 11 11-12 12-13 13 14 14 15
7	<u>Care Planning</u> <u>7.1 Mental Capacity and Co-production of Care and Treatment Plans</u> <u>7.2 Care Planning Around Safety and Documentation</u> <u>7.3 Key Components of a Safety Management Plan</u> <u>7.4 Principles of Good Care Planning</u>	15-18 15 15-16 16-17 17-18
8	<u>Debriefing Practices Following a Clinical Incident</u>	18-20
9	<u>Communication and Information Sharing</u>	20
10	<u>Therapeutic Safety Management (Positive Risk Taking)</u>	20
11	<u>Use of Risk Language in Safety Management</u>	20-22
12	<u>Working with Carers and Significant Others</u>	22
13	<u>Service-Specific Considerations</u> <u>13.1 Acute Services</u> <u>13.2 Learning Disability Services</u> <u>13.3 Forensic Services – Low Secure and Specialist Community Forensic Team</u>	22-24 22 22-23 23

	13.4 NHS Talking Therapies and Young Minds Matter 13.5 Mental Health Liaison Services	23-24 24
14	Safeguarding Children and Vulnerable Adults	24-25
15	Principles of Working Within Diversity	25
16	Criminal Justice and Safeguarding Considerations	25
17	Definitions	25-26
18	Process For Monitoring Compliance	26-27
19	Incident, Near Miss Reporting and Duty of Candour	27
20	Training	27
21	References	28-29
Appendices	Appendices Appendix 1: Safety Assessment Process Appendix 2: Quick Guide for Clinicians – FIMS Process Appendix 3: Care Planning Appendix 4: Positive Safety Management Appendix 5: NHS Talking Therapies - Safety Screening Appendix 6: FIMS Assessment EPR – Template Appendix 7: Low Secure Safety Assessment Formulation	30 31-32 33 34 35-40 41-47 48

ABBREVIATIONS

Abbreviation	Full Description
AMHP	Approved Mental Health Professional
CPA	Care Programme Approach
FIMS	Formulation Informed Management of Safety
FIRM	Formulation Informed Risk Management
GHC	Gloucestershire Health and Care NHS Foundation Trust
HCR-20	Historical Clinical and Risk Management-20
HONOS	Health of the Nation Outcome Scores
HQIP	Healthcare Quality Improvement Partnership
IAPT	Improving Access to Psychological Therapies
ICT	Intermediate Care Teams
LPA	Lasting Power of Attorney
MCA	Mental Capacity Act
MDT	Multidisciplinary Team
MHARS	Mental Health Acute Response Service
NCISH	National Confidential Inquiry into Suicide and Safety in Mental Health
NICE	National Institute for Health and Care Excellence
RAMP	Risk Assessment Management Plan

1. INTRODUCTION

An individualised safety assessment is crucial for providing safe and effective care, improving outcomes for those receiving mental health care from Gloucestershire Health and Care NHS Foundation Trust (GHC), and supporting their families, carers, and communities. Safety

assessments and plans should focus on individual needs, identifying situations where safety might be compromised and mitigating potential harm. Practitioners should foster a therapeutic relationship based on compassion, validation, and empathy, aiming for a shared understanding of safety with the person and, where possible, their family or carer.

According to NICE guidelines, risk prediction is ineffective, and categorising safety as low, medium, or high is inaccurate and impersonal. NICE advises shifting from a risk-focused culture to one centred on individual needs and safety. This policy should be used in conjunction with other personalised care tools, such as My Care Plan (MCP), Personal Safety Plan and the new Assessment, Care and Management Policy. Additionally, the safety assessment policy should be viewed as part of a broader strategy to support patients in managing their safety. Key areas from NCISH's "10 ways to safer services" include:

- Safer wards
- Early follow-up after discharge
- Reducing alcohol and drug misuse
- Low staff turnover
- Family involvement
- Personalised safety management
- Outreach teams
- 24-hour crisis teams.

These elements are essential in creating a comprehensive approach to patient safety.

Safety assessment is an ongoing, fluid process integral to the assessment, support, and treatment of each service user within the Trust. It should be structured, evidence-based, and consistent across all care settings. Best practice involves making decisions based on research evidence, the service user's individual context, their experiences, and clinical judgment.

Safety management often requires collaboration with other agencies or providers. However, the Trust retains responsibility for considering safety, even when the primary management of care rests with another service.

Any required **safety management plans**, such as care plans and Personal Safety Plans, should be documented and monitored. In **Learning Disability Services**, where safety management plans are held by outside agencies, these should also be documented and monitored. This applies regardless of which agency or provider is responsible for delivering key elements of the plan.

The individualised safety assessment is essential for providing safe, effective care by focusing on the specific needs of each person and their potential risks. Practitioners should build compassionate, empathetic relationships and develop shared safety plans with the individual and, where possible, their family or carers. Safety assessment is a continuous, evidence-based process that should be integrated across all care settings and considered a key part of a broader strategy for managing patient safety.

2. PURPOSE - Why We Focus on Safety

This policy has been written to provide a clear framework for safety assessment and safety management within the Trust. It outlines how these principles will be applied within the Trust and will act as a benchmark for monitoring practice against standards. This policy has been written to ensure that the Trust maintains a robust and effective process of assessing and managing safety.

Safety assessment is more than a task or a form, it's a therapeutic process rooted in compassion, collaboration, and trust. It supports recovery by helping people feel understood, valued, and safe. At its heart, it's about building a shared understanding of what safety means for the person in front of us, not simply identifying risks.

Historically, we've talked about 'risk assessment,' but research and lived experience tell us this approach can be overly focused on prediction and categorisation, often using language that feels clinical or impersonal. That's why we've adopted a 'safety' focus, supported by the FIMS model (Formulation Informed Management of Safety).

This approach helps us shift from:

- Predicting future harm → to understanding what safety looks like for each person.
- Labelling risk → to exploring context, strengths and protective factors.
- Generic forms and checklists → to collaborative formulation and meaningful planning.

What This Means in Practice:

- Every conversation about safety is a chance to build connection, not just collect information.
- Safety is dynamic. It changes as people grow, recover, or face new challenges.
- Not everyone needs the same level of assessment. Our job is to respond proportionately but never lose sight of our responsibility to consider and support safety.
- We use a blend of clinical knowledge, lived experience, carer insights, and professional judgement.

We recognise that we can't eliminate all risk but by focusing on shared safety, we can support people to live well, make informed choices, and feel secure in the care we provide.

This policy sets out a clear and compassionate framework for assessing and managing safety within the Trust. It promotes a shift away from traditional risk-focused approaches, instead supporting a person-centred, collaborative process using the FIMS model. Safety is seen as dynamic and individual, and the policy encourages proportionate, meaningful responses that build trust and promote recovery.

3. SCOPE

This section defines the scope of the policy and includes the following key points:

- **Applicability:** The policy applies to all Trust staff, encompassing those working within both primary and secondary mental health services.
- **Staff Responsibilities:** All staff members are responsible for adhering to and actively promoting the principles and practices outlined in the policy.
- **Variation Across Services:** The nature and extent of safety assessments will vary across different services and clinical settings, depending on the specific needs and circumstances of the patients being assessed.

3.1 Primary and Entry Level Mental Health Services

- **Initial Safety Assessments:** Staff working in primary or entry-level mental health services are expected to carry out and complete initial safety assessments during the initial / core assessment. These may be completed using a 'right touch' approach (see section for details)

or through an approved safety assessment tool specific to that service, such as those used in Talking Therapies or Young Minds Matter.

- Immediate Safety Concerns: These assessments should identify any immediate risks and determine the need for further intervention or referral to secondary services.

3.2 Secondary or Tertiary Mental Health Services

- All new referrals will have a safety assessment completed during the initial/core assessment.
- Comprehensive Assessments: Secondary mental health services may include Tertiary (highly specialised) mental health units, inpatient facilities, outpatient clinics, and certain community mental health services such as recovery and Assertive Outreach Teams (AOT).
- Detailed Evaluations: Safety assessments in these settings are typically more comprehensive and are conducted by appropriately qualified mental health professionals.
- Individualised Safety Management Plans: Safety management plans should be the outcome of a detailed formulation following comprehensive evaluation. These plans should be based on the individual's needs rather than a focus on 'risk'. They should reflect an understanding of the person's mental health history, current experiences, and any potential safety concerns. This includes the development of safety management plans, linked care plans, and the implementation of targeted interventions to address identified needs.

3.3 Staff Responsibilities

- Adherence to Policy: All Trust staff are expected to follow this policy and incorporate its principles into their daily practice.
- Training and Development: This includes participating in training and development activities to enhance their skills in conducting safety assessments and managing risks.
- Promoting a Culture of Safety: Staff are responsible for promoting a culture of safety within their teams and ensuring that safety assessments are conducted consistently and effectively across all services.
- By adhering to this policy, the Trust aims to provide a safe and supportive environment for all patients, ensuring that safety assessments are conducted with the highest standards of care and professionalism.

4. DUTIES

General Roles, Responsibilities and Accountability

Gloucestershire Health and Care NHS Foundation Trust (GHC) aims to take all reasonable steps to ensure the safety and independence of its patients and service users to make their own decisions about their care and treatment.

In addition, **GHC** will ensure that:

- All employees have access to up-to-date evidence-based policy documents.
- Appropriate training and updates are provided.
- Access to appropriate equipment that complies with safety and maintenance requirements is provided.

Managers and Heads of Service will ensure that:

- All staff are aware of and have access to policy documents.
- All staff access training and development as appropriate to individual employee needs.
- All staff participate in the appraisal process, including the review of competencies.

Employees (including bank, agency, and locum staff) must ensure that they:

- Practice within their level of competency and within the scope of their professional bodies where appropriate.
- Read and adhere to GHC policies and procedures.
- Identify any areas for skill update or training required.
- Participate in the appraisal process.
- Ensure that all care and consent complies with the Mental Capacity Act (2005) – see section on [MCA Compliance below](#).

5. MENTAL CAPACITY ACT COMPLIANCE

Where parts of this document relate to decisions about providing any form of care treatment or accommodation, staff using the document must do the following: -

- Establish if the person is able to consent to the care, treatment or accommodation that is proposed? (Consider the 5 principles of the Mental Capacity Act 2005 as outlined in section 1 of the Act. In particular principles 1,2 and 3) [Mental Capacity Act 2005 \(legislation.gov.uk\)](#).
- Where there are concerns that the person may not have mental capacity to make the specific decision, complete and record a formal mental capacity assessment.
- Where it has been evidenced that a person lacks the mental capacity to make the specific decision, complete and record a formal best interest decision making process using the best interest checklist as outlined in section 4 of the Mental Capacity Act 2005 [Mental Capacity Act 2005 \(legislation.gov.uk\)](#).
- Establish if there is an attorney under a relevant and registered Lasting Power of Attorney (LPA) or a deputy appointed by the Court of Protection to make specific decisions on behalf of the person (N.B. they will be the decision maker where a relevant best interest decision is required. The validity of an LPA or a court order can be checked with the Office of the Public Guardian) [Office of the Public Guardian - GOV.UK \(www.gov.uk\)](#).
- If a person lacks mental capacity, it is important to establish if there is a valid and applicable Advance Decision before medical treatment is given. The Advance Decision is legally binding if it complies with the MCA, is valid and applies to the specific situation. If these principles are met it takes precedence over decisions made in the person's best interests by other people. To be legally binding the person must have been over 18 when the Advance Decision was signed and had capacity to make, understand and communicate the decision. It must specifically state which medical treatments, and in which circumstances the person refuses and only these must be considered. If a patient is detained under the Mental Health Act 1983 treatment can be given for a psychiatric disorder.
- Where the decision relates to a child under the age of 16, the MCA does not apply. In these cases, the competence of the child must be considered under Gillick competence. If the child is deemed not to have the competence to make the decision, then those who hold Parental Responsibility will make the decision, assuming it falls within the Zone of Parental control. Where the decision relates to treatment which is life sustaining, or which will prevent significant long-term damage to a child under 18 their refusal to consent can be overridden even if they have capacity or competence to consent.

6. POLICY DETAIL

6.1 Formulation Informed Management of Safety (FIMS)

FIMS is our Trust's core model for understanding and supporting safety in mental health care. It has evolved from the Formulation Informed Risk Management (FIRM) framework to better reflect current national guidance (e.g. NICE, NCISH), research, and a wider shift in clinical culture—from predicting and managing “risk” to fostering collaborative, recovery-focused safety.

Unlike traditional risk models, FIMS doesn't rely on prediction or categorisation. It instead supports a structured, person-centred approach, encouraging staff to explore the meaning of safety for each individual and co-create practical responses based on that understanding.

Key principles include:

- Prioritising understanding, over scoring or labelling
- Recognising the complexity and changing nature of safety
- Valuing people's own perspectives and experiences
- Planning support that is tailored, strengths-based, and proportionate.

The Trust will support implementation of this approach through:

- Targeted clinical training
- Reflective practice spaces
- Updated documentation tools within EPR.

From this point forward, “FIMS” will be used throughout the policy to describe the Trust's safety-focused approach to assessment and care.

6.2 Structure of FIMS in EPR

The FIMS framework is structured as a single document under safety assessment on EPR, consisting of five sections:

- Safety assessment - current and historic safety concerns
- Safety assessment formulation
- Views of service user, carer or others
- Formulation and safety management plan.

Each section can be completed or updated independently, ensuring that the latest versions of each section are reflected when reviewing the overall safety assessment.

See [appendix 2](#) for quick guide for use on EPR.

6.3 Formulation

The ultimate goal of safety assessments is to prevent harmful outcomes and promote an individual's ability to maintain their own safety, while supporting improved or positive mental health. **Formulation Informed Management of Safety (FIMS)** Assessment provides a structured framework for creating a narrative that explains the underlying factors (problems, predisposing, precipitating, perpetuating, and protective) contributing to behaviours that may pose safety concerns. Recent reviews of safety management in clinical practice have recommended the broader use of safety formulations (Healthcare Quality Improvement Partnership [HQIP], 2017; NHS Resolutions, 2018).

Safety formulation involves developing an understanding and possible explanation of the safety

profile of the individual service user and the factors influencing their ability to maintain safety, including:

- What are the potential safety concerns? (What are the concerns? Who might they impact?)
- How likely are these to arise?
- If they arise, how serious could the impact be?
- When are these safety concerns most likely to occur?
- What might (or does) trigger safety challenges?
- How often do these challenges to an individual's safety occur?
- What indicators might suggest a safety concern?
- Is there any history of behaviours impacting safety?
- What are the person's strengths, skills, and resources that help them maintain their safety?
- What have been the most effective ways of supporting the person previously?
- What factors might increase challenges to safety?

Formulation will then lead to developing a personalised Care Plan and the Personal Safety Plan, which forms a core component of mental healthcare and the Care Management Approach. Formulating risk can be helped by considering potential scenarios (possible futures, posing the question, 'if...').

6.4 Right Touch Approach

There is evidence supporting a streamlined or "right touch" approach to safety assessment in services addressing populations with predominantly lower levels of need. This approach ensures assessments are appropriately tailored to the clinical setting and the individual's presenting concerns, prioritising efficiency without compromising thoroughness.

Research advocates for **proportionate** assessment methods that focus on identifying key areas for immediate support while maintaining flexibility for more comprehensive evaluations if required. In "right-touch" scenarios, it is essential that clinicians evidence their consideration of safety, even if concerns are minimal, to ensure a robust record that safety has been addressed. Additionally, robust escalation processes should be in place to address any emerging concerns swiftly and effectively.

To support this approach, staff should be provided with sufficient training and supervision to ensure they understand how to identify, document, and escalate safety concerns appropriately. These safeguards both service users and practitioners by ensuring assessments are meaningful, proportionate, and well-supported within the broader service context.

- **Centre for Mental Health (2018)** – Briefing on effective mental health care practices and proportionate approaches in lower-need populations.
- **Department of Health and Social Care (2019)** – *Right Touch Regulation in Health and Care: Guidance on proportionality in professional judgment and assessment.*

6.4.1 Right Touch Approach and Evidencing Safety Considerations

In alignment with the **Right Touch Approach**, the Trust recognises that a full safety assessment is not always required at every clinical contact. Service users are seen at different stages of treatment and along different care pathways, such as triage, stable cases reviewed annually, or those receiving ongoing intervention. However, safety concerns should be adequately considered and documented.

Clinicians should ensure that they have **reviewed the domains and factors within the FIMS Framework** during their contact with the service user. While not all safety considerations will require documentation within a full safety assessment, it is important to record where these considerations have been documented (e.g. medical clinic letters, progress notes, or other relevant records).

If a full safety assessment is not required, clinicians **should complete the relevant section in the safety form ([Appendix 2](#))** to confirm that safety has been considered and to indicate where this information has been recorded.

6.5 Standards for Safety Assessment Process

All new referrals will undergo a **safety assessment** as part of the initial/core assessment, in alignment with the **Right Touch Approach ([appendix 6 – section 4](#))**. This approach ensures that safety concerns are considered appropriately without overburdening service users with unnecessary assessments.

The safety assessment should be completed and recorded in the **Service User's Health and Social Care Notes** by a **registered practitioner** whose role includes conducting core and safety assessments.

For referrals to the **Mental Health Acute Response Service (MHARS)**, **Mental Health Intermediate Care Teams (ICT - Primary Mental Health Service)**, and **NHS Talking Therapy service (Gloucestershire)**, an **initial Safety Screen** will be conducted. In MHARS and IAPT services within ICT Gloucestershire, this screening will be undertaken by practitioners at **Band 4 or above**.

- If **no significant safety concerns** are identified, no further safety assessment is required at that stage.
- If **safety concerns are identified**, a **full safety assessment** should be completed by a **Band 5 practitioner or above ([Appendix 5](#))**.

Exception: Online direct psycho-educational course bookings do not require safety screening or assessment.

A Band 4 practitioner or Student Practitioner may assist in drafting a safety assessment or review, but it must be checked and validated by their practice supervisor (as per the Assessment and Care Management Policy).

6.6 When Should you Carry out a Safety Assessment?

Within GHC Mental Health Services, a clinical safety assessment and/or review should be carried out in the following circumstances. While this list sets out key situations, it is not exhaustive, and best clinical judgement should always be applied.

- **At Initial Contact or Referral**
 - When a service user is first referred or contacts the service, particularly if there are any indications of safety concerns, vulnerabilities, or potential risks.
- **During Triage or Assessment**

- At the point of triage, to screen for any immediate safety concerns or risks.
- During an initial comprehensive assessment to identify current and historical factors that may influence the service user's safety.
- **When Concerns Are Raised**
 - If a service user, their family, or other professionals raise concerns about safety or wellbeing.
- **Following a Significant Event**
 - After a crisis, incident of self-harm, suicide attempt, or any other significant event that may affect the service user's mental health or safety. **It is recognised that in some environments, the frequency of such incidents may be high; this list is not exhaustive, and best clinical judgement should always be used in assessing and addressing each situation.**
- **During Regular Reviews**
 - As part of routine care plan reviews, ensuring that any changes in the service user's situation, presentation, or environment are considered.
- **At Transition Points, which can include, although not exclusive to:**
 - If there is a notable change in the service user's presentation, such as worsening symptoms, increased distress, or new stressors (e.g., life events or environmental factors).
 - If there is a transition in care, such as discharge from hospital or transfer to another team or service.
 - A change in member of staff providing key interventions
 - Involvement of an additional specialist internal service
 - A change of team, locality, trust or services (i.e. CAMHS transition)
 - An admission to hospital (prior to admission, as soon as possible after admission, following safety (risk events and following any MDT care / case review meeting
 - Prior to discharge from any service.
- **Before Key Decisions**
 - Prior to significant decisions, such as changing treatment plans, reducing support levels, or discharging the service user from care.
- **As Part of a Dynamic Process**
 - Clinical risk assessments are not one-off tasks; they should be revisited and updated whenever new information becomes available, or circumstances change.

6.7 Carrying Out a Safety Assessment

Safety assessments must be carried out using the **Formulation Informed Management of Safety (FIMS)** framework on EPR. Where alternative or specific safety tools are used, they must be co-produced and formally approved through a recognised governance route. These tools should also be supported by a Standard Operating Procedure (SOP) to ensure consistency in documentation and staff access to key safety information.

Key Steps in Conducting a Safety Assessment

1) Use Multiple Sources to Build a Robust Safety Picture

Staff should apply professional judgment and clinical knowledge, drawing on a range of information sources to ensure the assessment is accurate and person-centred. This includes:

- **Core Information:**
 - Referrer's details and concerns
 - Direct input from the service user
 - Review of the service user's safety history in clinical records.
- **Additional Insight:**
 - **Personal networks** – carers, family, friends (with consent)
 - **Professional networks** – Trust teams, social care, police, or partner agencies.

Cross-check and evaluate all information for reliability and relevance. Key safety information should be summarised clearly and made easily accessible for staff involved in the service user's care, especially during times of crisis or change.

2) Consider Broad Safety Domains

The safety domains within the new Safety Assessment remain the same as those outlined in the previous Risk Assessment Policy, as they continue to be clinically sound and relevant. However, the form itself has been updated to better support and encourage formulation-based practice.

The following areas should be reviewed and, where relevant, recorded in the EPR Safety Assessment:

- Concerns related to suicide
- Harm to self
- Harm from others
- Harm to others
- Accidental injury or unintentional harm
- Other behaviours that impact personal safety or the safety of others.

This process supports a comprehensive, reliable, and dynamic understanding of the person's safety needs, forming a foundation for meaningful formulation and collaborative care planning.

Safety assessments should be completed using the **FIMS framework** on EPR. Clinicians must use professional judgment and draw on core information (referral, service user input, clinical history) and, where appropriate, input from carers and professionals. Assessments should cover key domains including self-harm, harm to/from others, accidental injury, physical health, substance use, safeguarding, and environmental risks. All safety information should be summarised clearly and made accessible to support safe, person-centred care. Assessments must be regularly reviewed and updated.

6.8 Who Should Assess Safety Concerns?

- All qualified staff with a clinical role who, through accreditation or practice are deemed capable at their local induction/orientation.
- Staff who have completed the Trust's Clinical Risk Management training and are deemed

competent. All clinical staff are expected to adhere to the agreed training schedule, including participation in refresher training as required.

Supervision is key to clinical practice and assuring competence. Line Managers should ensure that safety assessment and management is part of regular supervision. Through supervision, staff will be supported to develop their individual skills, and this will facilitate a learning environment. Line Managers and Clinical Leads have a key role in ensuring that staff share learning in their clinical environment.

6.9 When to Carry out a Review of the Most Current Safety Assessment

A patient's ability to maintain their safety can change rapidly and unpredictably. Therefore, safety assessments should be reviewed regularly as an integral part of clinical practice.

A review involves evaluating the current safety assessment and ensuring that care and personal safety plans align with the Service User's present needs. Reviews should take place (as a minimum):

- On referral
- When there are changes in presentation
- If safety concerns increase
- On discharge from the service or transfer to another service.

These reviews should follow the guidance outlined in section 6.6, ensuring they are conducted at key points in care, including during assessments, following significant events, and before key decisions.

Each review should be documented on EPR, including an updated overall safety formulation. Reviews should be conducted collaboratively with the Service User and, where possible, their care team, including family/carers, to ensure care and safety planning reflects their current situation.

However, if the clinical presentation remains stable, a minimum standard is that safety assessments are reviewed at least **annually**, in conjunction with the routine care review.

This ensures that the documentation remains current, relevant, and responsive to any subtle **changes that may have occurred**.

In all instances, the findings of the safety assessment or review should be clearly documented, ensuring they include evidence of consideration of safety concerns, historical context, and any actions taken to manage or mitigate presenting risks.

6.10 Additional Recording and Documenting of Incidences

All incidents must be recorded in the Risk Incident section (the language within this area cannot be changed within EPR) of the Health and Social Care Notes to form a chronology of safety related incidence. Each incident should include the incident date, an incident heading and reference the date when the progress notes detailing the event was completed.

There is also the ability to select 'add to risk history' at the bottom of progress notes at time of writing.

6.11 Escalation

There may be occasions when there is a need to escalate your concerns to a senior clinician or manager e.g. in an emergency or to manage a situation that is unfamiliar or having no experience in managing a certain situation.

Staff should be aware of their local arrangements for escalation to senior clinicians and managers. It is best practice in those situations to remain calm and seek support from a colleague in the first instance; escalation procedures can then be activated. Regular supervision is also a key opportunity for continued professional development, reflection, and support in managing difficult or complex situations.

7. CARE PLANNING

Purpose:

To support the person and those around them in recognising and responding effectively to challenging situations, whether sudden or developing, by outlining agreed actions, helpful strategies, and key contacts. The aim is to promote safety (long and short term), continuity, and early intervention.

Safety planning is a central part of the FIMS approach and goes far beyond completing a form, it is a **dynamic, collaborative, and person-centred process**. A well-developed safety plan aims not only to prevent harm but also to promote wellbeing, autonomy, and recovery.

7.1 Mental Capacity and Co-production of Care and Treatment Plans

Where the patient does not have mental capacity to engage in co-production, decisions need to be made on their behalf, following the best interest process, as outlined in s4 of the MCA 2005. The best interest decision maker needs to be identified. This will be any attorney under a Lasting Power Attorney or any court appointed deputy or in the absence of either, the practitioner most involved in the patient's care and treatment. In addition to involving the best interest decision maker in discussions about the safety plan the following should be consulted: -

- Any interested parties such as family members or informal carers
- Any Independent Mental Capacity Advocate
- Other practitioners involved in the person's care.

Although the patient may lack capacity to help make the safety plan, they should still be part of the process so that their views and wishes can be considered.

If it is identified that the patient poses a risk of harm to others, decisions about the safety plan may need to go beyond just what is in the best interests of the patient and may need to consider the safety of others.

7.2 Care Planning Around Safety and Documentation

1) Use *My Care Plan (MCP)* as the Primary Care Planning Tool

MCP should be the central document for co-producing care plans with the patient. Where applicable; however, we recognise that not all services use MCP as their primary care planning tool. All steps should be taken to ensure that the following standards are adhered

to:

- It supports a personalised, collaborative approach to safety and wellbeing.
- Use this space to clearly document safety-related interventions and strategies, including how the individual's strengths, needs, and coping approaches will be supported.
- Outline roles, responsibilities, and crisis responses where safety concerns are identified.

2) Create a *Bespoke Care Plan* if Co-production is Not Clinically Possible

- In situations where safety concerns prevent full co-production, a separate bespoke care plan may be needed outside of MCP.
- Clearly document specific safety-related actions, responsibilities, and crisis plans within this document.
- These bespoke plans should be reviewed regularly, with the aim of returning to MCP as soon as clinically appropriate.
- Bespoke care plans are co-produced (where possible) for patients under the Specialist Community Forensic Team, and where deemed appropriate by the MDT, will include aspects of My Shared Pathway.

3) **My Shared Pathway** is the framework used by Inpatient Secure Services used to ensure that each patient has a unique care plan which focuses on their pathway through secure care, formulation, health outcomes and special arrangements. This supports the patient to understand all aspects of their care.

4) Complete a *Personal Safety Plan* as Part of Contingency Planning

- Co-produce this plan with the patient to guide care during crisis or relapse.
- Include effective coping strategies, which may be revealed at different points along the care pathway.
- All staff are responsible for contributing to and maintaining the relevance of this plan over time.

5) Collaborate with the Wider Support Network

- Engage the patient meaningfully throughout the planning process.
- Involve carers or family (with consent) and the wider multidisciplinary team.
- Ensure all plans are realistic, safe, person-centred, and achievable.

7.3 Key Components of a Safety Management Plan

A well-developed safety management plan brings together personalised care planning and collaborative crisis planning. It should be co-produced wherever possible, centring the individual's voice, preferences, and strengths.

Understanding the Person

- Describe how the person typically presents when struggling, in crisis, or when early warning signs of deterioration appear.
- Include known triggers, patterns, or scenarios that could increase safety concerns (e.g.,

- sudden changes in support, relapse indicators).
- Outline the context in which safety concerns arise, supported by a clear formulation.

What Helps

- Specify strategies, environments, communication styles, or interventions the person finds helpful or calming.
- Identify protective factors and personal strengths that support stability and resilience.
- Clearly note the preferred communication approach and types of support the person finds most acceptable and effective.

Response Planning

- Provide clear, practical steps for different situations—what the person can do, what carers or professionals should do, and how to respond safely and consistently.
- Include harm reduction strategies where full prevention isn't possible, and guidance on what to do if the person disengages from services.
- Detail immediate and alternative support options (e.g., crisis teams, helplines) and how to access them.

Coordination and Responsibility

- Assign clear roles and responsibilities for carrying out each part of the plan—who does what, and when.
- Include key contacts for different scenarios, with escalation pathways where needed.
- Set a review date and include criteria for earlier review if circumstances change.

7.4 Principles of Good Care Planning

Effective care planning—especially when addressing safety—should be grounded in values that support collaboration, personalisation, and clinical flexibility. The following principles guide the development and review of high-quality care plans:

1) Personalised

Plans must reflect the individual's unique experiences, identity, preferences, values, and goals. Wherever possible, language should be written in the first person to amplify the individual's voice and promote ownership of their care. A personalised plan recognises that people are experts in their own lives and should be partners in decision-making.

2) Collaborative and Co-produced

Care planning should be a shared process between the individual, their carers (with consent), and professionals involved in their care. Co-production ensures that plans are more meaningful, relevant, and likely to be followed in practice.

3) Strengths-Based

Rather than focusing solely on risks or problems, a good care plan identifies what is going well. It builds on the person's skills, support networks, coping strategies, and inner resources, using these as foundations for safety and wellbeing.

4) Flexible and Dynamic

A care plan should not be static. It needs to evolve in response to changes in the person's mental or physical health, social circumstances, preferences, or engagement with services. Regular reviews ensure the plan stays relevant and responsive.

5) Proportionate

The level of detail and the type of intervention should match the person's current needs and level of concern. Overly complex plans can be overwhelming or impractical, while underdeveloped plans may miss essential support. The plan should strike a balance that feels appropriate and achievable.

6) Actionable

A strong plan clearly outlines what needs to be done, by whom, and when. This includes specific actions to take in crisis or challenging scenarios and clarifies roles and responsibilities for everyone involved. Actionable plans reduce confusion and enable a timely, coordinated response.

7) Holistic and Integrated

Care planning should take into account all aspects of a person's life—mental and physical health, social connections, housing, employment, and substance use—so that support is joined-up and consistent across services and settings.

8) Trauma-Informed

The plan should be sensitive to past experiences of trauma. It should avoid retraumatizing practices, promote psychological safety, and recognise the need for trust, choice, and empowerment throughout the care planning process.

Safety planning is a shared process. It's not just about minimising harm—it's about supporting people to make informed choices, take positive risks, and feel safer in their care and in their lives.

8. DEBRIEFING PRACTICES FOR SERVICE USER FOLLOWING A CLINICAL INCIDENT

“Following an incident where I was not offered a debrief, I felt abandoned and confused. This also caused me to feel resentment and impacted my ability to trust certain staff members.”

Toby – Lived Experience

In the aftermath of a clinical incident, which, in a mental health setting, might involve distressing events such as a self-harm episode, use of restraint, or an escalation in behaviour, it can be helpful to offer opportunities for debriefing in a way that is sensitive to individual needs and preferences. Guided by trauma-informed care principles, this means avoiding assumptions about what may or may not be helpful, recognising that some individuals may find debriefing supportive,

while others may not wish to engage. A personalised, compassionate approach helps to promote emotional safety and contributes to a caring, empathetic environment.

- 1) **Safety First:** Ensure the physical and emotional safety of the service user during the debriefing session. Create a calm and secure environment to help them feel safe and reduce anxiety.
- 2) **Trust and Transparency:** Communicate openly and honestly with the service user. Explain the purpose of the debriefing and the steps involved to build trust and reduce feelings of uncertainty.
- 3) **Empowerment and Choice:** Offer the service user choices whenever possible. Empowering them to participate in the debriefing process can help restore a sense of control and autonomy.
- 4) **Collaboration and Mutuality:** Work collaboratively with the service user and their support network, including family members and carers. Involve them in the debriefing process to ensure their perspectives and needs are considered.
- 5) **Cultural, Historical, and Gender Issues:** Be mindful of the service user's cultural background, personal history, and gender. Tailor debriefing strategies to respect and accommodate these factors.
- 6) **Peer Support:** Encourage the involvement of peer support workers who have lived experiences similar to the service user. Peer support can provide valuable empathy and understanding, helping to facilitate the debriefing process effectively.
- 7) **Emotional Regulation:** Use techniques to help the service user regulate their emotions during the debriefing session. This can include deep breathing exercises, grounding techniques, or other calming strategies that they find helpful.
- 8) **Validation and Empathy:** Acknowledge the service user's feelings and experiences. Show empathy and validate their emotions to help them feel heard and understood.
- 9) **Reflective Learning:** Encourage the service user to reflect on the incident and identify any lessons learned. This can help them gain insights and develop strategies for coping with similar situations in the future and help services working with them to better support them in navigating difficult situations. This is also a good opportunity to review their Personal Safety Plan — to identify what worked well and what could be done differently.
- 10) **Follow-Up and Support:** Provide ongoing support and follow-up after the debriefing session. Ensure that the service user has access to additional resources and support if needed.

By integrating these trauma-informed care principles into debriefing practices, we can create a more compassionate and effective approach to managing clinical incidents, ultimately promoting healing and recovery for the service user.

“The times I got offered a debrief following an incident helped me feel less anxious and paranoid but also made me feel safe and listened to. This helped me form trust and a rapport with those staff members.”

Toby – Lived Experience

Debriefing after a clinical incident should follow trauma-informed care principles to prioritise the service user's emotional and psychological well-being. Key considerations include ensuring **safety**, fostering **trust and transparency**, and offering **choice** to empower the individual. Collaboration with **families, carers, and peer support** enhances the process, while being mindful of **cultural, historical, and gender factors** ensures a personalised approach.

Techniques for **emotional regulation, validation, and empathy** help the service user feel heard and supported. Encouraging **reflective learning** and providing **ongoing follow-up** further promote recovery and resilience.

9. COMMUNICATION AND INFORMATION SHARING

Effective communication with carers is essential to support patient care while respecting confidentiality. Staff should ensure carers receive sufficient general information to enable effective care, such as details about the patient's condition, associated behaviours, managing crises, and understanding care plans and medication. Sharing practical advice, contact details of care co-ordinators, and resources such as local and national support organisations does not breach confidentiality and helps carers feel informed and supported.

There are some circumstances where the disclosure of confidential information is allowed without the permission of the service user:

- Where a child is believed to be at risk of harm (Children's Act, 1989);
- Where there is evidence of risk of harm either to the individual or somebody else;
- For the prevention, detection and prosecution of serious crime;
- When instructed by a Court; and
- In certain circumstances under the Mental Health Act (1983).

Carers should be involved in care planning and decision-making wherever possible, with their role acknowledged and supported. Staff should document patient preferences, discuss confidentiality early, and provide resources, including referrals to the Gloucestershire Carers Hub.

Please refer to the Trust's Common-Sense Confidentiality: *A Guide for Staff, Carers, Family and Friends*, for more comprehensive guidance.

10. THERAPEUTIC SAFETY MANAGEMENT (POSITIVE RISK TAKING)

The Trust is committed to a positive approach to safety management, ensuring that service users are supported to make informed choices about their care while balancing safety and recovery. In line with NHS guidance, therapeutic risk-taking is recognised as a vital part of person-centred care, enabling service users to develop independence and resilience while minimising harm.

Staff should work collaboratively with service users and carers to co-produce care plans, ensuring clear communication, shared decision-making, and adherence to legal and ethical standards on consent and capacity. All decisions should be based on a structured assessment of benefits and harms, with appropriate safeguards in place. Best practice guidance from NHS England, NICE, and other relevant frameworks should be followed to ensure a proportionate and evidence-based approach.

Further details on therapeutic safety management, including supporting references, can be found in the [Appendix 4](#).

11. USE OF RISK LANGUAGE IN SAFETY MANAGEMENT

In certain circumstances, the use of risk language is necessary and unavoidable. This includes situations where there is an imminent danger to others, such as the presence of known firearms in the household or risks associated with Multi-Agency Public Protection Arrangements (MAPPA) processes. In these instances, all safety management processes should be followed rigorously.

However, it is understood that these are mitigating circumstances that may require language that does not fully align with the therapeutic and person-centred approach outlined in this policy.

Imminent Danger and Risk Management

When there is an imminent danger to others, it is crucial to prioritise safety and take immediate action. This includes:

- Conducting a thorough safety assessment to identify potential threats and vulnerabilities.
- Implementing appropriate safety measures to mitigate identified risks.
- Collaborating with relevant agencies and stakeholders to ensure a coordinated response.

MAPPA Processes

MAPPA processes involve the assessment and management of risks posed by certain individuals to the public. In these cases, the use of risk language is essential to accurately communicate the level of threat and the necessary interventions. This includes:

- Detailed documentation of risk factors and management plans.
- Regular reviews and updates to ensure the effectiveness of safety measures.
- Clear communication with all involved parties to maintain a shared understanding of the risks and management strategies.

Documentation and Communication

In situations where risk language is used, it is essential to ensure that this information is clearly communicated to all relevant staff. This includes:

- **Adding an 'Alert' on the EPR system to highlight known risks. This ensures that the information is accessible and clear to all staff members who may be involved in the individual's care.**
- Ensuring that all safety management plans are documented in detail and regularly reviewed.

References to Risk Management in Mental Health

The necessity of using risk language in certain situations is supported by best practices in risk management within mental health services. According to the National Institute for Health and Care Excellence (NICE) guidelines, effective risk management involves a comprehensive assessment of potential risks and the implementation of appropriate safety measures. Additionally, the Mental Health Commission's Quality Framework emphasises the importance of a systematic approach to risk assessment and management to protect patients and others from harm.

By acknowledging the need for risk language in specific circumstances, this policy ensures that safety remains the top priority while maintaining a person-centred approach to care.

In summary, while this policy prioritises a person-centred, therapeutic approach to safety management, the use of risk language is sometimes necessary in situations involving imminent danger or MAPPA processes. In such cases, rigorous safety management procedures should be followed, including thorough safety assessments (via the Safety Assessment Form), clear documentation, and collaboration with relevant agencies. Effective communication, including system alerts and regular plan reviews, ensures that all staff remain informed and prepared to

respond appropriately while upholding best practices in mental health risk management.

12. WORKING WITH CARERS AND SIGNIFICANT OTHERS

Carers and significant others often play a crucial role in supporting service users and can be instrumental in identifying, formulating, and managing safety concerns. Gathering collateral information from those involved in the service user's life is essential for a comprehensive formulation, and staff should make concerted efforts to obtain this information where appropriate.

With the service user's agreement, carers should be included in care planning and management. Verbal consent should be sought, and staff should adhere to the Trust's Information Governance and Consent policies when sharing information. While confidentiality should be respected, it should not be a barrier to meaningful engagement with carers. In line with the Trust's Common Sense Confidentiality Guidance (2024), efforts should be made to provide carers with general, non-confidential information that supports them in their role, such as understanding the service user's condition, care plans, and available support services.

This approach aligns with the Trust's shift to Formulation Informed Safety Management, which emphasises collaborative care planning over safety-focused discussions.

13. SERVICE-SPECIFIC CONSIDERATIONS

13.1 Acute Services

- A safety assessment, including an initial formulation and safety management care plan should be completed within the first 24 hours of admission, with a more comprehensive formulation completed within 28 days in conjunction with completing My Care Plan. See section 10.0 for fuller details on care planning.
- For admissions to inpatient services, the assessing team is responsible for completing and/or updating the safety Assessment tool.
- If an inpatient admission has not been gatekept by the Crisis Home Treatment Team (e.g., following a Mental Health Act Assessment), the Safety Assessment tool may not have been completed. In this case, ward staff should complete or update the Safety Assessment as part of the admission process. However, the referring service should ensure that any relevant historical factors and current safety concerns are communicated effectively to support a comprehensive assessment.
- For inpatient services where the service user has an existing Safety Assessment, the Formulation, relevant care plans and Personal Safety Plan should be reviewed by the multidisciplinary team (MDT – within inpatient services) in collaboration with the service user, community care-coordinator, carer, or next of kin to support a safe admission and discharge.

13.2 Learning Disability Services:

- A safety assessment should be documented within 24 hours of the first planned contact with the service user.
- If there are no current risks or concerns the risk assessment and management plan may be recorded in, HCP Care Plan or Comprehensive Assessment.

- In instances where GHC are not the 'owner' of any existing safety management plan (i.e. where it is sat with supported accommodation) steps needs to be taken to ensure that any identified safety concerns are communicated between provider and GHC services.

13.3 Forensic Services – Low Secure and Specialist Community Forensic Team

When completing the FIMS Safety Assessment, Forensic services will use specialist assessments that replaces the 'risk to others' safety domain. FIMS will be reviewed during regular reviews and where clinically indicated by the MDT.

Specialist assessments that are used within Forensic Services include but are not limited to:

- HCR-20 Assessing Risk for Violence: Version 3 (Historical Clinical and Risk Management). Historical, clinical and risk management items are included in the content of this assessment tool. HCR – 20 Assessing Risk for Violence: Version 3 is reviewed and updated 6 monthly.
- The SAPROF (Structured Assessment of Protective Factors) is a structured risk assessment guideline specifically for the evaluation of protective factors for violence risk and serious problem behaviour.
- A combination of HCR-20v3, SAPROF, risk formulations, risk management and scenarios are combined to produce a comprehensive risk assessment.
- DUNDRUM 1 is a structured professional judgement tool used to triage appropriate levels of therapeutic security during access assessment.
- DUNDRUM 2 is a structures professional judgement tool used to triage urgency during access assessment.
- RSVP (Risk for Sexual Violence Protocol) is a structured guide for the assessment of those who have committed sexual offences.
- IPV (Intimate Partner Violence) is a risk assessment tool used to understand what an individual is attempting to accomplish by committing specifics acts of violence against a particular victim at a specified time.
- SARA (Spousal Assault Risk Assessment Guide) is a set of structured professional judgement guidelines for comprehensive assessment and management of risk for intimate partner violence.
- SRP (Stalking Risk Profile) is a structured professional judgement tool for assessing and managing risk in stalking cases.
- M-TTAF (Multi-trajectory Theory of Adult Fire setting) is an integration of current theory, typological, and research knowledge into a comprehensive etiological theory of fire setting along with its maintenance, and desistence.

13.4 NHS Talking Therapies and Young Minds Matter

While national guidance emphasises a move away from standard risk screens in many mental health services, the NHS Talking Therapies Service and Young Minds Matter (GHC) have made a conscious decision to retain the use of their risk screen. This decision reflects the specific needs and pressures within the services and helps keep patient safety at the heart of care.

The NHSTT and YMM (GHC) teams include a diverse range of practitioners, some of whom may not be registered clinicians, and they manage a high volume of referrals on a daily basis. These risk screen serves as a helpful and consistent prompt, guiding decision-making and supporting staff in identifying when additional action or escalation may be needed.

This process provides a clear framework for accountability and documentation, particularly when decisions need to be made quickly and under pressure. Importantly, it helps minimise the chance of missing significant red flags and supports NHSTT and YMM teams in delivering the safest, consistent and most appropriate care to all service users.

This approach is supported by and implemented in conjunction with the Clinical Standard Operating Procedure (SOP), NHS Talking Therapies Safety Assessment and Planning, which sets out additional guidance and standards for practice within NHSTT.

13.5 Mental Health Liaison Services

(Working Age, Older Adults, Alcohol, Community Hospitals, and CYP Services)

Service Context

Mental Health Liaison Services (MHLS) operate within Acute and Community Hospital settings. While MHLS contribute to assessments and safety planning, overall responsibility for patient care remains with the Acute Trust or Community Hospital, who follow their own governance processes.

Referrals are received via ward teams, community hospitals, or directly from EPR lists. All referrals are triaged or co-streamed (mental health services will triage alongside emergency staff) to determine the level of intervention—ranging from advice to full psychosocial assessment. Some patients may only be seen once or may be too physically unwell for comprehensive assessment. In such cases, MHLS provide safety advice to the hospital team, these are recorded as below.

Care Planning and Documentation

Due to the short-term and advisory nature of the service, MHLS do not complete formal care plans or Personal Safety Plans. Ongoing care is not typically followed up by MHLS, and as such, plans cannot be maintained or reviewed.

Instead, MHLS staff document:

- Safety considerations and clinical advice as part of assessments
- In **EPR** (progress notes), **Sunrise EPR**, and previously within fluid safety assessments
- Safety or care planning advice should be clearly titled as: “**Safety advice / care planning advice**”.

If other mental health teams (e.g., Recovery, Community, Eating Disorder services) are involved, they remain responsible for their patient’s care and safety planning. MHLS will contribute updates relevant to the hospital context and discharge.

Team Roles in Safety Management

All MHLS team members, excluding Lived Experience Practitioners, contribute to Safety Management assessments. Lived Experience input remains valuable in informing safety discussions. Each team focuses on relevant risks (e.g., alcohol-related risk, suicide risk), and any psychiatric involvement should be clearly reflected in the safety plan.

14. SAFEGUARDING CHILDREN AND VULNERABLE ADULTS

Gloucestershire Health and Care NHS Foundation Trust is committed to safeguarding and promoting the welfare of children and vulnerable adults. We operate a zero-tolerance approach to abuse and neglect, ensuring all individuals accessing our services are protected from harm.

Key Principles:

- Empowerment: Supporting individuals to make informed decisions.
- Prevention: Identifying and mitigating risks before harm occurs.
- Protection: Supporting those in greatest need.
- Partnership: Collaborating with local authorities and agencies.
- Accountability: Maintaining transparency and clear lines of responsibility.

Responsibilities: All staff must adhere to safeguarding policies, report concerns, and complete mandatory training. Designated Safeguarding Leads provide support and ensure compliance.

15. PRINCIPLES OF WORKING WITHIN DIVERSITY

Assumptions around age, gender, sexual orientation, religion, marital status, race, culture or ethnicity may affect judgement around risk and determine a subsequent risk management plan. It is important that those developing plans within the principles described consider all of these factors. It is a process of personal reflection coupled with consideration of available research relating to stereotypes.

16. CRIMINAL JUSTICE AND SAFEGUARDING CONSIDERATIONS

When completing a safety assessment, staff must carefully consider any relevant criminal justice involvement, including (but not limited to) Multi-Agency Public Protection Arrangements (MAPPA), Multi-Agency Risk Assessment Conferences (MARAC), bail conditions, and restraining orders.

If any of these are selected within the assessment, staff should ensure the following is considered:

- **Legal restrictions or conditions** imposed through bail, restraining orders, or other court measures. Clearly document any no-contact orders, exclusion zones, curfews, or other requirements.
- **Safeguarding implications:** Consider whether any criminal justice conditions are linked to safeguarding concerns. This may include risks to children, adults at risk of abuse or neglect, or victims of domestic abuse. Where safeguarding is indicated, staff must follow Trust safeguarding procedures and make appropriate referrals.
- **Information sharing:** Be clear about what information should or should not be shared with affected individuals (e.g. victims, family members, carers), particularly where this could compromise legal processes or safeguarding arrangements.
- **Confidentiality and legal duties:** Ensure that all information is handled in line with data protection and information governance requirements. Where information sharing is necessary for safeguarding, this must be lawful, proportionate, and well documented.

If you are unsure about how to manage or document criminal justice or safeguarding-related information, please seek advice from the **Specialist Community Forensic Team (SCFT)** by contacting: scftreferrals-advice@ghc.nhs.uk

GHC Advice line for Safeguarding (adults and children) 0300 421 6969

17. DEFINITIONS

Term	Full Description
Safety Assessment	A safety assessment is a structured process used to evaluate potential concerns and vulnerabilities to ensure the safety and well-being of individuals. This process was previously referred to as a risk assessment but has been redefined to emphasise person-centred and therapeutic language. The term "safety" highlights the proactive and supportive approach to care, focusing on promoting security and addressing concerns collaboratively.
Dynamic Safety Assessment	A dynamic safety assessment is an ongoing process that adapts to changes in a person's circumstances and needs.
FIRM	This approach provides a structured, collaborative way to assess safety by identifying factors that predispose, precipitate, perpetuate, and protect against safety concerns. It moves beyond checklists, ensuring personalised and dynamic safety planning.
Proportionate Level of Assessment	A proportionate level of assessment ensures the depth and detail of safety planning align with the individual's current circumstances and needs. This approach balances thoroughness with efficiency, avoiding unnecessary complexity while maintaining focus on safety and well-being.
Positive risk-taking / Therapeutic Safety Management	Positive risk-taking involves making informed decisions that balance potential benefits with potential risks, encouraging growth, learning, and development while ensuring safety and well-being through a proactive approach to safety management that supports service users in making informed choices about their care while balancing safety and recovery.
FIMS	An approach that emphasises understanding safety concerns, promoting well-being, strengths, and protective factors, and encouraging proactive and person-centred safety planning.
Safety Management Care Plan	A plan based on the findings and formulation of a safety assessment, including clear, actionable strategies to promote safety and prevent harm.
Debriefing Practices	Conducting sessions after a clinical incident to ensure the emotional and psychological well-being of the service user, following trauma-informed care principles.

18. PROCESS FOR MONITORING COMPLIANCE

Are the systems or processes in this document monitored in line with national, regional, trust or local requirements?	YES
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Monitoring Requirements and Methodology	Frequency	Further Actions
Targeted training will be provided during the policy rollout phase (September 2025 – October 2025), in conjunction with routine safety assessment training (currently known as Risk Training in Clinical Practice).	Attendance at targeted training will be monitored from the first week of delivery to track which teams have attended or are booked to attend, ensuring good representation from all teams to which the policy applies.	Review training content to ensure alignment with policy updates and best practice. Identify additional training needs based on staff feedback and incident reviews.

Competency should be assessed not only through mandated training and team local competency framework, but also as part of ongoing supervision.	As part of routine clinical supervision (supervision frequency is within 40 days).	Use reflective practice discussions and direct observation to assess application of the policy. Provide additional support or refresher training where needed. Routine line management supervision and separate clinical supervision are both essential in supporting staff, developing practice, and ensuring the policy is implemented safely and effectively.
Safety Assessment Compliance and Feedback Process	Bi-annually	<p>Indicators of compliance with the new policy include:</p> <ul style="list-style-type: none"> • A key performance indicator to monitor whether a safety assessment has been completed for each referral and reviewed annually thereafter. • Lived experience of the safety assessment process — specifically, whether it felt personalised and compassionate. A patient survey will be developed to gather this feedback. <p>Provide feedback to teams and use the findings to inform training and continuous improvement plans.</p>
Serious untoward incident investigation processes	As incidents occur	Review how safety assessments were conducted in relation to the incident. Identify learning points and implement changes where necessary to improve practice.

19. INCIDENT AND NEAR MISS REPORTING AND REGULATION 20 DUTY OF CANDOUR REQUIREMENTS

To support monitoring and learning from harm, staff should utilise the Trust’s Incident Reporting System, DATIX. For further guidance, staff and managers should reference the [Incident Reporting Policy](#). For moderate and severe harm, or deaths, related to patient safety incidents, Regulation 20 Duty of Candour must be considered and guidance for staff can be found in the [Duty of Candour Policy](#) and Intranet resources. Professional Duty of Candour and the overarching principle of ‘being open’ should apply to all incidents.

20. TRAINING

- **Mandatory Training:** Risk Assessment is already designated as essential to role for 1,250 members of staff at GHC. The content of this training will be updated as part of the implementation planning. The existing three-year training schedule will remain in place; however, staff will have the option to attend the updated training up to six months in advance of their due date.
- **Supplementary Learning:** An e-learning package will be developed to complement the updated training. This will be supported by question-and-answer sessions and/or workshops during the initial rollout.
- **Specialist Training:** Additional specialist training may be required to meet the specific learning needs of staff working in specialist services.

21. REFERENCES

National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) guidelines: Emphasises the importance of personalised safety assessments focusing on individual needs and supporting immediate and long-term psychological and physical safety.

NHS England. (n.d.). Staying safe from suicide. [online] Available at: <https://www.england.nhs.uk/long-read/staying-safe-from-suicide/> [Accessed 2 Jun. 2025].

NICE guidelines on self-harm: assessment, management, and preventing recurrence: Recommends that safety assessment tools and scales should not be used to predict future suicide or repetition of self-harm but should instead focus on the person's needs.

Assessment of suicide risk in mental health practice: shifting from prediction to therapeutic assessment, formulation, and risk management: Advocates for a therapeutic approach to safety assessment, emphasising understanding the individual's unique circumstances and collaborative safety planning.

Best Practice in Managing Risk (2007): Provides foundational principles for safety management in mental health services.

National Patient Safety Agency (2004): Offers guidelines for improving patient safety across healthcare settings.

NHS Patient Safety Strategy: Emphasises the importance of involving carers and families in decision-making to support holistic safety planning.

BJPsych Advances: Discusses the concept of therapeutic risk-taking, highlighting that enabling service users to take managed risks can be a justifiable and beneficial choice when appropriately assessed and supported.

Centre for Mental Health (2018) – Briefing on effective mental health care practices and proportionate approaches in lower-need populations: Supports a streamlined or "light touch" approach to safety assessment in services addressing populations with predominantly lower levels of need.

Department of Health and Social Care (2019) – Right Touch Regulation in Health and Care: Provides guidance on proportionality in professional judgment and assessment.

Healthcare Quality Improvement Partnership (HQIP) (2017): Recommends the broader use of safety formulations in clinical practice.

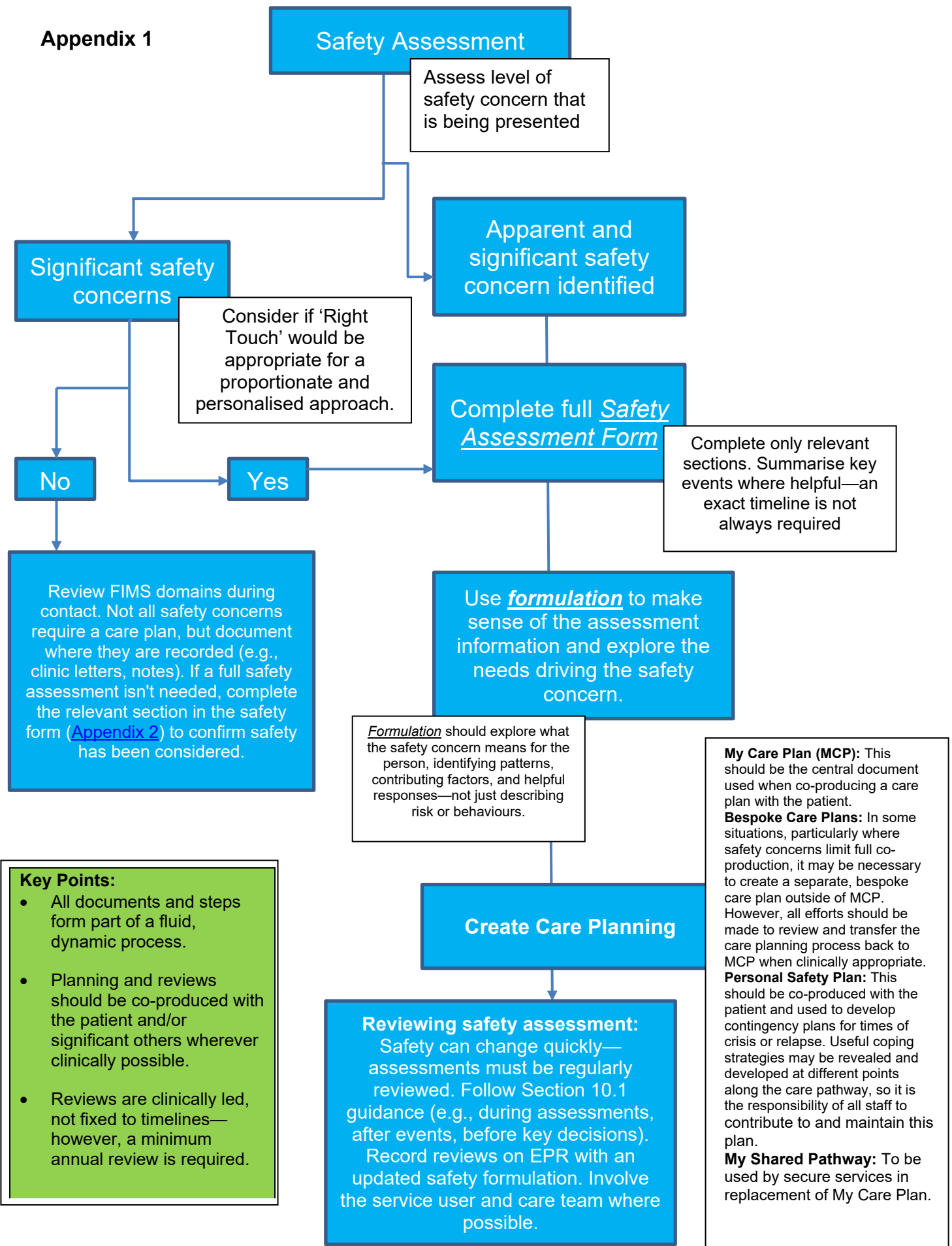
NHS Resolutions (2018): Reviews safety management in clinical practice and recommends the use of safety formulations.

NICE NG225: Provides guidelines on therapeutic risk-taking, ensuring that service users are supported in making informed choices about their safety while staff uphold legal and ethical standards.

South West Yorkshire NHS Trust - Risk Assessment Policy: Provides a comprehensive method for the effective and focused management of the principal risks to achieving the Trust's strategic objectives in line with the values of the Trust.

Avon and Wiltshire Mental Health Partnership - Safety Assessment Policy: Emphasises proactive safety measures, including hazard assessment, pre-job safety briefings, and the use of visual/audible traffic control.

Appendix 1



Key Points:

- All documents and steps form part of a fluid, dynamic process.
- Planning and reviews should be co-produced with the patient and/or significant others wherever clinically possible.
- Reviews are clinically led, not fixed to timelines—however, a minimum annual review is required.

My Care Plan (MCP): This should be the central document used when co-producing a care plan with the patient.

Bespoke Care Plans: In some situations, particularly where safety concerns limit full co-production, it may be necessary to create a separate, bespoke care plan outside of MCP. However, all efforts should be made to review and transfer the care planning process back to MCP when clinically appropriate.

Personal Safety Plan: This should be co-produced with the patient and used to develop contingency plans for times of crisis or relapse. Useful coping strategies may be revealed and developed at different points along the care pathway, so it is the responsibility of all staff to contribute to and maintain this plan.

My Shared Pathway: To be used by secure services in replacement of My Care Plan.

Appendix 2

Quick Guide for Clinicians: Using the Formulation Informed Management of Safety (FIMS) Assessment for Safety in Mental Health

Purpose of the FIMS assessment

The **FIMS** framework offers a structured approach to understanding and responding to safety concerns in mental health care. It supports a holistic, person-centred understanding of safety, while enabling effective and collaborative planning to promote wellbeing and reduce the likelihood of harm.

Key Components of the FIMS Assessment

Broad Categories to Assess for Safety:

- **Concerns regarding suicide:** Act with suicidal intent, suicidal ideation
- **Harm to self:** Self-injury, self-injury
- **Harm from others**
- **Harm to others**
- **Accidental injury or unintentional harm**
- **Other Behaviours that impact personal or others' safety**

Key Elements of Safety Formulation:

What are the safety concerns, and who or what do they affect?

How likely are these concerns to become incidents?

What factors might trigger or maintain the safety issues?

When and where might these issues arise?

What protective factors or strengths does the individual have?

Developing the Safety Management Plan:

Tailored strategies to reduce potential harm and promote safety.

Incorporate strengths, coping skills, and available resources.

Collaborate with the individual and their support network.

Define actions, responsibilities, and plans for handling crises.

How to Use FIMS on EPR

Accessing the FIMS Template:

Log into the EPR system.

Open the individual's record and navigate to the "Safety Assessment" section.

Select the "Formulation Informed Management of Safety (FIMS)" assessment form.

Completing the FIMS Assessment:

1. Populate the relevant sections for safety categories, triggers, and protective factors.
2. Use dropdown menus and expand fields to provide detailed descriptions where needed.

3. Include relevant historical information, recent observations, and input from other professionals or family (where appropriate).

Formulating Safety Concerns in EPR:

Use narrative sections to create a comprehensive safety formulation, including:

- Specific safety issues and those affected.
- Likelihood and severity.
- Known triggers, patterns, and influencing factors.
- Protective factors, coping strategies, and strengths.
- Ensure the language and structure align with the FIMS framework.

Regular Reviews and Updates:

Review and update the FIMS assessment regularly to reflect any changes in circumstances or safety needs.

Use the "Amend" or "Review" options to keep the assessment accurate and up to date, ensuring accessibility for all relevant professionals.

Best Practices for Clinicians

- **Collaborate with the Individual:** Involve the person and their support network to ensure safety plans are person-centred and meaningful.
- **Use Multi-Source Information:** Gather insights from the individual, their carers, and historical records to inform a comprehensive safety assessment.
- **Dynamic Monitoring:** Recognise that safety concerns may change; review and update the FIMS assessment regularly.
- **Share Information Appropriately:** Ensure safety information is shared with relevant teams and agencies, adhering to consent and confidentiality policies.

When to Use FIMS

- At **initial assessments** or first contact with the individual.
- During **reviews** of care plans or **significant changes in circumstances** (e.g., discharge, admission, or transfer).
- Following any **incident** involving the individual.
- When there is a **noticeable change** in the individual's presentation or safety needs.

Remember: The **FIMS** assessment is a **dynamic, collaborative** tool that enables clinicians to address safety proactively and holistically in mental health care.

Appendix 3

Care Planning

Steps for Safety Planning and Documentation

1. Use *My Care Plan (MCP)* as the Primary Care Planning Tool

- MCP should be the central document for co-producing care plans with the patient.
- It supports a personalised, collaborative approach to safety and wellbeing.
- Use this space to clearly document safety-related interventions and strategies, including how the individual's strengths, needs, and coping approaches will be supported.
- Outline roles, responsibilities, and crisis responses where safety concerns are identified.

2. Create a *Bespoke Care Plan* if Co-production is Not Clinically Possible

- In situations where safety concerns prevent full co-production, a separate bespoke care plan may be needed outside of MCP.
- Clearly document specific safety-related actions, responsibilities, and crisis plans within this document.
- These bespoke plans should be reviewed regularly, with the aim of returning to MCP as soon as clinically appropriate.

3. Complete a *Personal Safety Plan* as Part of Contingency Planning

- Co-produce this plan with the patient to guide care during crisis or relapse.
- Include effective coping strategies, which may be revealed at different points along the care pathway.
- All staff are responsible for contributing to and maintaining the relevance of this plan over time.

4. Collaborate with the Wider Support Network

- Engage the patient meaningfully throughout the planning process.
- Involve carers or family (with consent) and the wider multidisciplinary team.
- Ensure all plans are realistic, safe, person-centred, and achievable.

5. My Shared Care Pathway

- **My Shared Care Pathway** is a collaborative, patient-centred approach **used in secure mental health services**. Recovery-focused goals set together by the patient and multidisciplinary team
- Risk and safety considered alongside patient preferences
- Transparent and fair process to aid progression and eventual reintegration into the community.

Appendix 4

Positive Safety Management

Empowerment and Non-Paternalistic Approach: Positive safety management focuses on empowering both staff and service users to make informed choices, rather than taking a paternalistic approach. This aligns with the principles of therapeutic risk-taking, which is recognised within the NHS as a valuable approach in supporting recovery and autonomy. According to NICE guidelines, therapeutic risk-taking should follow a comprehensive assessment, involve shared decision-making, and focus on leveraging the individual's strengths and coping strategies to achieve positive outcomes (NICE NG225).

Collaboration with Service Users and Carers: Engaging service users and carers in identifying effective strategies is essential. A collaborative approach ensures care plans are personalised and incorporate the valuable insights of those involved. The NHS Patient Safety Strategy emphasises the importance of involving carers and families in decision-making to support holistic safety planning (NHS Patient Safety Strategy).

Balancing Benefits and Harms: Weighing the potential benefits and harms of different actions is central to positive safety management. The concept of therapeutic risk-taking, as discussed in BJPsych Advances, highlights that enabling service users to take managed risks can be a justifiable and beneficial choice when appropriately assessed and supported (BJPsych Advances).

Clear Communication and Shared Decision-Making: Transparency about potential benefits and challenges, along with involving all parties in decision-making, is crucial. NICE guidelines stress the importance of open dialogue in safety planning, ensuring patients and carers understand the rationale behind risk decisions and are fully involved in discussions (NICE NG225).

Supporting Positive Potentials and Minimising Harm: Care plans should support service users in achieving their goals while managing risks. The NHS Patient Safety Strategy promotes a balance between safety and independence, reinforcing the need for structured safety plans that encourage personal growth while preventing harm (NHS Patient Safety Strategy).

Informed Consent and Capacity: Service users and carers must be fully informed about decisions and care plans, with adherence to policies on consent and capacity. NICE guidelines on therapeutic risk-taking ensure that service users are supported in making informed choices about their safety while staff uphold legal and ethical standards (NICE NG225).

Utilising Resources and Support: Making full use of available resources and support systems helps to balance desired outcomes with potential challenges, ensuring a holistic and effective approach to care. Staff should refer to NHS guidance and evidence-based frameworks to ensure best practice in managing therapeutic risks (BJPsych Advances).

Appendix 5

NHS Talking Therapies Safety Concern INFORMATION – Safety Screening MHICT GLOS. This is for use of MHICT Services ONLY

Safety Screening & Planning – GHC

v1.4

Stage: (auto inserted from IAPTus)

Date Completed:

Initial Screening or Safety Review

Reason for Safety Review:

Risk to Self

Does your patient have any thoughts of harming themselves?	Yes/No Evidence/Not assessed
Has your patient ever self-harmed in the past?	Yes/No Evidence/Not assessed
Is there a history of self-harm in your patient's family?	Yes/No Evidence/Not assessed
Does your patient have the means, access and intent to harm themselves today?	Yes/No Evidence/Not assessed
Is there anything that would stop your patient from action on thoughts of self-harm?	Yes/No Evidence/Not assessed
Record further information here:	
Does your patient have any thoughts of suicide?	Yes/No Evidence/Not assessed
Has your patient considered acting on these thoughts?	Yes/No Evidence/Not assessed
Has your patient attempted suicide in the past?	Yes/No Evidence/Not assessed
Is there a history of suicide in your patient's family?	Yes/No Evidence/Not assessed
Does your patient have the means, access and intent to attempt suicide today?	Yes/No Evidence/Not assessed
Is there anything that would stop your patient from action on thoughts of suicide?	Yes/No Evidence/Not assessed
Record further information here:	
Is there any evidence of self-neglect?	Yes/No Evidence/Not assessed
Is the patient at risk of deterioration today due to self-neglect?	Yes/No Evidence/Not assessed
Record further information here:	

Is there someone or something that could currently help to keep your patient safe?	Yes/No Evidence/Not assessed
Record further information here:	
What support does your patient currently have around them?	

Risk from Others

Is your patient currently at risk/do they feel threatened by others around them? (E.g. violence, abuse, exploitation)	Yes/No Evidence/Not assessed
Does your patient need to access safety from risk/threat today?	Yes/No Evidence/Not assessed
Record further information here:	

Risk to Others

Does your patient currently pose a risk to others or perceive others to be at risk from them? (E.g. physical violence, threats of violence, verbally violent, sexually inappropriate, neglect of others, driving. Do they pose a safeguarding risk to others?)	Yes/No Evidence/Not assessed
Do you or your patient need to act today to reduce this risk?	Yes/No Evidence/Not assessed
Record further information here:	

Other Risk Behaviours

Does your patient present with other risk behaviours? (E.g. substance/alcohol use, hoarding tablets, dangerous driving)	Yes/No Evidence/Not assessed
Does your patient consider this a risk?	Yes/No Evidence/Not assessed
Record further information here:	

Safety Plan

Does your patient present with current risk? <i>If yes complete a safety plan</i>	Yes/No Evidence/Not assessed
Has there been a deterioration in wellbeing for your patient? <i>If yes consider completing a safety plan</i>	Yes/No Evidence/Not assessed
Has historic risk been identified for your patient? <i>If yes consider completing a safety plan</i>	Yes/No Evidence/Not assessed
Is a safety plan required for your patient?	Yes/No/Requires supervision

discussion

If you answer is “No” state your reason why not:

Even if you decide no safety plan is required, discuss this decision in your next supervision session.

When is the next planned review of your patient’s safety?

- Within 24 hours
- Within next 7 days
- Weekly in line with Treatment
- Patient is on Waitlist and will not be reviewed until they reach the top of the list
- Patient is Hosted and will be reviewed on (date):

Using the above information build a safety plan with your patient. You may want to consider the following safety tips:

- Take self out if situation
- Talk to someone
- Calm self down by ...
- Discuss problem with when calm
- Speak to GP if concerned
- Use Samaritans if needed call 116 123
- Use Out of hours GP if needed via NHS 111
- Crisis Team 0800 1690398
- Contact the Connect and Offload (CanDo) service (Telephone: 0808 801 0606, Text: 07537 410 022, Email: cando@rethink.org available 2-9pm)
- Calm Harm phone app
- Stay Alive phone app
- Go to A&E
- In an emergency call 999

If you and/or your patient identify immediate risks then document this in the “*Safety in the next 24 hours*” section. If not, you can document safety planning in the “*Safety after 24 hours and beyond*” section

Safety in the next 24 hours: *(Document all the safety actions you have agreed with your patient)*

To help me in the next 24 hours I can....

I can speak to...

What can I do to reduce the risk of me acting on thoughts of (self-harm/ suicide/ risk to others):

(disposing of medication, self-harm equipment, setting up a box of hope)

If things feel worse I could...

Safety after 24 hours and beyond:

What are your patient's main needs? – What are their goals & needs? What is their main concern?

Suicide & Self Injury – what will help your patient to keep safe?

Things that can help me manage thoughts of suicide, self-harm or a worsening of my mental health (please complete for all)

What warning signs or triggers are there that make me feel more out of control?

What have I done in the past that has helped?

What ways of coping do I have?

What would I say to a close friend who was feeling this way?

Are there things I can remind myself of that give me hope or are reasons to keep going:

Who can I call:

- 1.
- 2.
- 3.

Violence & Aggression - what will help your patient to stay safe? Or to keep others safe?

Things that can help reduce my risk from others (please remove this section if not relevant):

I can contact the following people to discuss my concerns:

Warning signs that risk from X is escalating are:

If arguments escalate I can (consider whether there is a safe place in the home to be – eg/ bathroom with locked door):

If I am under threat I can call 999

Things that can help reduce my risk to others (please remove this section if not relevant)

What warning signs or triggers are there that make me feel more out of control?

How do I know I am starting to feel angry?

When I feel this way I can:

(consider removing self from situation, breathing exercises or safe-adrenalin releasing techniques such as exercise)

It may also help me to talk to X about how I am feeling:

<p>Other Risks - what will help your patient to keep safe?</p> <p>Self-neglect:</p> <p>Alcohol/substance use:</p> <p>Safeguarding:</p> <p>Falls:</p> <p>Physical Health:</p> <p>Environment:</p> <p>Financial:</p>

Safety Check

Is there anything from the above discussion that you consider needs action taken today to support your patient's safety?	Yes/No
Record further information here:	
Do you need to seek supervision today to discuss your patient's safety?	Yes/No
Do you need to make an onward referral to support your patient's safety?	Yes/No

- Crisis
- Recovery
- Advocacy
- Local Authority Safeguarding Team
- MAPPA
- MARAC
- Police
- PREVENT
- Social Care
- Housing
- Drug & Alcohol
- Food Bank
- GP
- Another Organisation:

Do you consider your patient suitable for treatment with NHS Talking Therapies?

Yes/No/Requires supervision discussion

If you don't consider your patient suitable, provide your rationale:

Discuss this Safety Screening in your next planned supervision unless you need to discuss it sooner

Appendix 6

Formulation, Informed, Management of Safety (FIMS) Assessment EPR – Template

Safety Assessment Form

Safety Assessment Date:

Current Mental Health Act (MHA) status:

Options: Informal / Detained under the Mental Health Act (MHA) / Community Treatment Order (CTO) / Not applicable

Section 1 – Safety Assessment

1. Current or Historical Concerns around Suicide

Act with suicidal intent		Suicidal ideation	
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- a) Current suicide safety concerns?** Have there been any concerns at all in the last 2 weeks?

- b) Historical suicide safety concerns?** Where there is a history of multiple or repeated incidents, summarising these thoughtfully can support a more meaningful formulation and help ensure that record keeping remains focused and relevant to the individual's current needs.

E.g. from 2010 - 2015 there were multiple incidents of self-harm using sharp objects which started at school and were concealed from family, teachers and friends. From 2015 - 2020 there were over 30 admissions to GRH A&E following overdose of over the counter medications, usually paracetamol.

2. Concerns around Harm to Self

Self-injury or harm		Self-neglect	
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- a) Current self-injury safety concerns?** Have there been any concerns (even if not immediately high) in the last 2 weeks?

b) Historical self-injury safety concerns? Where there is a history of multiple or repeated incidents, summarising these thoughtfully can support a more meaningful formulation and help ensure that record keeping remains focused and relevant to the individual's current needs.

e.g X has a long-standing history of self-injury, primarily through superficial cutting to the forearms, typically in response to intense emotional distress, perceived rejection, or a sense of losing control. Frequency has increased in the past month following relationship difficulties. Injuries are usually managed independently and have not required medical attention recently. X reports the behaviour functions as a short-term coping mechanism rather than an attempt to end their life.

3. Concerns Around Harm From Others

Child Protection Plan (CPP) indicator		Domestic Abuse	
Caused by medication / services / treatment		Emotional / psychological abuse include bullying	
Financial abuse		Neglect	
Physical Harm		Unlawful restrictions (e.g. locks on doors, physical restraint, etc.)	
Sexual abuse / exploitation		Vulnerability	

a) Current violence, aggression and safety concerns to others? Have there been any concerns (even if not immediately high) in the last 2 weeks?

b) Historical violence, aggression and safety concerns to others? Where there is a history of multiple or repeated incidents, summarising these thoughtfully can support a more meaningful formulation and help ensure that record keeping remains focused and relevant to the individual's current needs.

4. Concerns Around Harm To Others

Exploitation of others (e.g. financial, emotional)		Fire Setting	
Hostage Taking		MAPPA	
To Children		Probation Service Involvement	
To Vulnerable adults		Sexual assault (including touching/exposure)	
Access to weapons		Stalking	
Violence/aggression/abuse to family		Violence/aggression/abuse to general public	
Violence/aggression/abuse to other clients		Violence/aggression/abuse to staff	

a) Current exploitation, vulnerability or safeguarding safety concerns? Have there been any concerns (even if not immediately high) in the last 2 weeks?

b) Historical exploitation, vulnerability or safeguarding concerns? Where there is a history of multiple or repeated incidents, summarising these thoughtfully can support a more meaningful formulation and help ensure that record keeping remains focused and relevant to the individual's current needs.

5. Current or Historical Concerns around Accidents

Accidental harm outside the home (e.g. wandering)		Driving/road safety	
Falls		Fire	
Unsafe use of medication			

a) Current safety concerns of falling, physical health and/or environmental risk?
 Have there been any concerns (even if not immediately high) in the last 2 weeks?

b) Historical safety concerns in regards to falls, physical health and/or environmental safety concerns? Where there is a history of multiple or repeated incidents, summarising these thoughtfully can support a more meaningful formulation and help ensure that record keeping remains focused and relevant to the individual's current needs.

6. Current or Historical Concerns around Other Behaviour

Absconding/Escape		Correspondence	
Damage to property		Incidents involving the police	
Phone Calls		Social Media	
Theft		Visitors	
Substance Misuse / Alcohol		MARAC	

a) Current substance misuse concerns? Have there been any concerns (even if not immediately high) in the last 2 weeks?

b) Historical substance misuse? Where there is a history of multiple or repeated incidents, summarising these thoughtfully can support a more meaningful formulation and help ensure that record keeping remains focused and relevant to the individual's current needs.

Section 2 – Carer’s or Other’s Views

VIEWS OF SERVICE USER, CARER OR OTHERS IN FORMULATION & SAFETY MANAGEMENT PLAN

a) Has service user been involved in the safety assessment?

Yes

No If you have selected no please provide a rationale as to why in box below.

Does the service user agree with the safety assessment and what are their views?

b) Does the service user consent to the

carer / others being involved in the safety assessment?

Yes No

a) Carer's and others views

Section 3
-

Formulation

Safety ASSESSMENT FORMULATION

Two option of formulation: **Low Secure Safety ASSESSMENT FORMULATION:** for use by Montpellier unit only and one option for all other services

Predisposing Factors (What has happened in my past): Explain why the service user had safety concerns in the past. Summarise important elements of the personal history and their impact on safety concerns: (age, relationships, children, employment status, broad statement about mental disorder, admissions, stress, drugs, etc.).

Precipitating Factors (Triggers): What are the early warning signs and signature indicators of safety concerns? What factors may increase safety concerns in the future?

Perpetuating Factors (What makes things worse): The factors in the person's life that contribute to ongoing safety concerns over time
Protective Factors (What helps): The main factors that may help reduce or limit safety concerns.
Summary (formulation – How this helps you stay safe?)

Based on the assessment and formulation above, please ensure the following actions are completed:

- Develop care plans in collaboration with the service user.
- Title care plans derived from the safety assessment as "Safety Assessment – [related clinical area]" (e.g., harm to self, absconding, falls).

Section 4 – Right Touch Approach

**** Right Touch Approach and Safety Consideration Statement****

Part 1: Safety Consideration and FIMS Framework Review

In line with the Right Touch Approach and recognising that a full safety assessment is not always required, it is important to evidence that safety concerns have been considered. Service users are seen at different stages of treatment and along different care pathways (e.g., triage, stable and reviewed yearly).

Please confirm that during your contact with the service user, you have reviewed the domains and factors within the FIMS Framework.

Yes

Part 2: Documentation of Safety Considerations

GHC acknowledges that not all safety considerations will need to be recorded within a full safety assessment. Please indicate where safety considerations have been recorded (e.g., medical clinic letter, progress notes, or other relevant records).

Appendix 7
Low Secure Safety Assessment Formulation
(Forensic Services — Low Secure and Specialist Community Forensic Team Use Only)

Section 3A – Formulation

Low Secure Safety ASSESSMENT FORMULATION

Drivers (Motivators)
Destabilisers (factors that impaired, disturbed, or disrupted the process of decision making)
Disinhibitors (factors that decreased the perceived likelihood of costs of negative consequences of violence)
Protective Factors
Summary (formulation)