Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

Clinical Risk Assessment and Management

POLICY NUMBER & CATEGORY	**C57**	**Clinical**
VERSION NO & DATE	**2**	**January 2019**
RATIFYING COMMITTEE	**Clinical Governance Committee**	
DATE RATIFIED	**January 2019**	
ANTICIPATED REVIEW DATE:	**January 2022**	
EXECUTIVE DIRECTOR	**XXXX, Director of Nursing**	
POLICY LEAD	**XXXX, Chair ICRG**	
POLICY AUTHOR (if different from above)	**XXXX, Consultant Clinical Psychologist, Clinical Risk Lead**	
FORMULATED VIA	Integrated Clinical Risk Group	

POLICY CONTEXT

This policy describes the following:

- the principles underlying clinical risk assessment in BSMHFT.
- the system for managing clinical risk assessment documentation within BSMHFT; and the training and post-training support that is provided to staff to support the practice of clinical risk assessment across all directorates.

POLICY REQUIREMENT (see Section 2)

- All service users referred to BSMHFT will, as part of their initial assessment and onward care will have a clinical risk assessment which is:
  - based on a structured clinical judgment,
  - developed in collaboration with family, friends and carers wherever possible, ○ updated regularly and when risk changes, ○ and is recorded in the appropriate place for the relevant service.
- All staff are required to be aware of this policy and their responsibilities within it.
- BSMHFT will support staff to develop the appropriate competencies in Clinical Risk Assessment and Management according to role.

CONTENTS

1 INTRODUCTION

1.1 **Rationale (Why)**

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

Structured clinical judgment is the approach recommended within Birmingham and Solihull Mental Health NHS Foundation Trust as the core technique for assessing and managing the risks posed by service users to themselves or to others. Structured clinical judgment is a method designed to promote best practice in risk assessment by the linking of judgment to an evidence-base, both of the risks to be managed (e.g., risk of violence) and good clinical practice. The basis for structured clinical judgements is a clinical assessment of historical and current circumstances which any MDT should be able to undertake.

The structured clinical judgment approach lends itself to multi-disciplinary team work, leading to the formulation of risk potential, and transparent risk management planning linked to the risk factors – and protective factors – identified in a single individual. Actuarial risk

assessment cannot be used in a satisfactory or transparent way to achieve this same outcome (Hart et al, 2007).

The purpose of this policy is to promote service user, staff and public safety by ensure a systematic approach to risk assessment and management at an individual practitioner, team and organisational level in order that the range of relevant clinical risks can be identified and then managed effectively and safely. The policy outlines the responsibilities of the Trust, teams and individuals in assessing and managing risk and recording risk information. Within this document 'clinical practitioners' are those staff where competency in clinical risk assessment, formulation and management is required to fit their role.

This policy describes the following:

- the principles underlying clinical risk assessment in BSMHFT.
- the system for managing clinical risk assessment documentation within BSMHFT; and
- the training and post-training support that is provided to staff to support the practice of clinical risk assessment across all directorates.

Risk assessment and management is an integral part of good clinical practice. As such it is integrated into a number of Trust policies (e.g. Safeguarding adults policy), operational procedures for teams, and in clinical guidelines. Most importantly the CPA policy advises of the service and individual staff members' responsibilities to service users. These set standards and requirements for Risk assessment and management in the context of the stage of the service user's pathway.

The need for clarity and transparency in the process of assessment of risk and sharing this information with other relevant clinicians, families and carers where appropriate, other teams and agencies has been highlighted in a number of critical incident reviews and independent inquiries. Consideration of risk is required at assessment and at key points of care (see Fig 1 for minimum Key Points of Care).

1.2 **Scope (Who, Where, When)**

Who

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

This policy applies to **all staff** in BSMHFT working with service users, their family members or carers or other service providers. All staff who have regular contact with service users, their families and carers must have an awareness of clinical risk issues, their important role in the care of service users and their responsibilities within the policy.

Where

All services need to conduct clinical risk assessments, formulate a management plan and ensure these are documented on a patient information system.

When

All service users referred to BSMHFT will, as part of their initial assessment will have a Trust clinical risk assessment completed by the assessing clinician. This is then updated by the lead clinician or care coordinator whenever clinically appropriate, at key points in the service user's care (see below) or at least annually prior to the service user's annual review of their care.

A risk assessment will be conducted at Key Points of Care (see Fig. 1) such as a transition within services (from one service or team to another); in response to clinical change in the service user's presentation and in responses to changes in circumstances that are relevant to their risk formulation. Risk assessment may also be prompted by the receipt of information from other sources such as: carers; other professionals; other agencies.

1.3 **Principles (Beliefs)**

Safety is at the centre of all good health care. Service users should expect that their safety and clinical risks presented by/appropriate to them will be assessed and reviewed as often as deemed necessary in order that the risks identified can be managed effectively, safely and progressively over time.

Service users expect staff in BSMHFT to demonstrate competence in the assessment and management of clinical risk. Competence in this area will be promoted by (i) Trust training courses and resources that are freely available and appropriate for the needs of clinical staff in the different directorates, and (ii) an easily accessible network of qualified support and advice with which care plans incorporating risk management guidance can be checked and improved.

BSMHFT takes the view that risk should be managed in the least restrictive way possible and should take into account and balance the benefits a person may receive from taking a risk with the possible negative consequences. A good therapeutic relationship must include both sympathetic support and objective assessment of risk and an understanding of the benefits of positive risk taking. This is particularly important in mental health but it is also more sensitive and challenging. Patient autonomy has to be considered alongside public safety.

Family members and carers will often have much more contact with the service user than clinicians. They can provide useful information about risk and often provide a significant amount of support to the service user. In order to produce the most thorough risk assessment, and the most effective management plan, families and carers should be identified at the earliest opportunity in the care of a service user and their involvement in the identification of risk and subsequent assessment of the effectiveness of the risk management plan should be promoted by staff.

Risk is an unavoidable component of the life of any individual and it is neither possible – nor desirable – to remove all risk from the experience of service users. However, members of the public have a right to be protected from any significant harm that may be posed by a service user of BSMHFT, where those rights are legitimately subject to (a) the limitations of available information and (b) the capacity of Trust staff to anticipate often complex clinical risk.

BSMHFT works within a recovery model where service user's strengths and aspirations lie at the heart of reducing risk. Staff should focus their expertise on identifying major risks such as the risk of harm to self and others while recognising that helping service users meet their needs and aspirations (e.g. housing, finances, relationships, psychological recovery and

employment) in order to build a meaningful life may be the most effective way to reduce these risks.

All clinical risk assessments will be sensitive to the age, race, religion, culture, gender, sexual orientation, disability, and communication needs of service users.

Service users and carers will receive all the support eg information, encouragement, they wish and require in order to contribute to risk assessments and risk management planning, as well as to make careful and acceptable judgments about the potential benefits as well as the potential hazards of any situation they encounter or with which they are attempting to manage.

Adults who lack capacity in law will be protected from significant harm.

2 POLICY (What)

All Trust staff are responsible for the recognition, communication and management of risk with the Trust to where possible safeguard service users, carers, staff and the wider public.

2.1 To this end:

- All service users accessing an assessment and future care within BSMHFT will have a formal assessment of risk.
- All risk assessments will be recorded in the appropriate place on RiO according to the service conducting the risk assessment and as agreed by the Integrated Clinical Risk Committee as detailed in the Procedures section of this policy below.
- The process of risk assessment is continuous and risk will be reviewed as a minimum at Key Points of Care (see list below) and in addition prior to leave from an inpatient unit. If risk circumstances have changed this will be recorded in the main electronic patient record. Documentation of risk assessment must occur as a minimum at the key points of care.

Fig 1: Key Points of Care for Risk Assessment and Documentationn

Clinical Indicators

- ✓ When mental state or risk management appears to be deteriorating and the concerns of staff about the safety of the service user increase.
- ✓ When mental state or risk is resolving and the current risk assessment appears management plan is no longer appropriate
- ✓ When there is a change in the Service User's circumstances pertinent to risk formulation such as loss of job, break down of a relationship, changes in the ability of carers to provide care.
- ✓ When concerns are expressed by family, friends or carers; external partners; or the general public about the safety of the service user. Service Transition Indicators
- ✓ On referral or re-referral into BSMHFT services within 7 days of the first appointment attended
- ✓ Prior to transitioning or transferring to any other team by the referring clinician or team and again within 7 days by the receiving team
- ✓ At initial contact by urgent care services within 24 hours
- ✓ On admission to an inpatient unit by the named nurse or inpatient Responsible Clinician within 24 hours of admission and within 7 days following admission and at each CPA review thereafter
- ✓ When prescribing leave for a sectioned patient,
- ✓ Prior to leave and prior to discharge for all service users in an inpatient unit
- ✓ When considering step down from CPA to Care Support
- ✓ At the annual review
- ✓ Discharge from the trust

Where there are concerns about changes in the risk presentation of the service user these must be communicated with other members of the MDT and other key professionals working with the Service User.

A risk management plan will be recorded alongside the documented risk assessment and also in any care plan agreed with the service user.

Where a risk is identified which would come under the following categories:

- Allergy/Atypical reaction to substances
- Infections i.e. MRSA, TB, C.Diff, D&V, Chicken Pox/Shingles
- MARAC referral/protection plan
- CHILD referral/protection plan
- ADULT referral/protection plan
- Do Not Attempt CPR an electronic care records Alert will be created as described in The BSMHFT Clinical Guideline: The RiO Alerts.

3 PROCEDURE

This section of the policy document covers the key areas:

- General format of clinical risk assessment and risk management planning in BSMHFT.

- Support and training for best practice in clinical risk assessment and management.

3.1 General format of clinical risk assessments and risk management plans

Clinical risk assessment and management are integral to the Care Programming Approach. The general format described below is intended to support and enhance current practice when assessing and managing clinical risks within the CPA process.

The emphasis of the risk assessment and management process is to support and enable service users to recognise their role in developing strategies to maximise recovery and their safety and that of others. Focussing on engagement and developing a therapeutic relationship which promotes trust is possibly the most powerful tool in enabling mutual risk assessment and effective risk reduction. The positive promotion of the service user's family, carers and friends can often result in a more informed risk assessment and a more realistic approach to risk management.

Assessment of the key areas of risk will aim to answer the following questions:

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

A clinical risk assessment will be recorded in the appropriate place for the service concerned and make reference to the following six elements:

1. Known history or current concern of a key risk behaviour

2. A clear statement about the nature of the harmful outcome to be prevented (e.g., harm to others, harm to self, suicide).

3. A brief summary of the risk history and related precipitating and protective factors that are relevant to the harmful outcome to be prevented (e.g., mental illness, personality disorder, substance abuse, social support). The record is to be used and updated when the service user's care is reviewed.

4. A risk formulation, in which the practitioner working with the client and/or colleagues in a multidisciplinary team provides an account or explanation for the risks presented by the service user. This account will explain how and why the most relevant risk and protective factors interact with one another to create increased risk. The formulation may

reference the following: Presenting problems (symptoms, emotional, behavioural, target risk behaviours). Predisposing factors (historical/static risk factors.) Precipitating factors (acute dynamic factors of risk), Perpetuating factors (stable dynamic factors of risk), Protective factors (strengths and recovery goals).

5. A risk management plan which will be linked directly to the risk and protective factors used in the risk formulation. The plan will provide suggestions of treatment strategies designed to repair or restore psychological (and/or physical) functioning. It will provide suggestions for supervision strategies, designed to contain, organise or structure the service user's day-to-day life thus reducing the potential for harmful outcomes to be triggered. The plan will also make some suggestions for how risk can be monitored during the period between reviews, by identifying early warning signs of a relapse to violence or self-harm or suicide and suggestion what might be done to prevent them from resulting in a harmful outcome. The plan should clarify if further assessments are required and how these will be undertaken.

6. It is expected that the risk management plan will help to reduce the most important risk factors or to support the most important protective factors, reducing the potential for harmful outcomes to happen. Reviews should examine the effectiveness of risk management strategies and recommend either: their continuation because risk is being effectively managed; or their improvement in order to manage risk more effectively or confidently. A risk management plan should recommend what those conducting future reviews need to look out for as evidence of improved or insufficient risk management.

3.1.1 Families, Friends and Carers

All those living with or routinely supporting the service user should be identified at an early stage. They should be informed of how they will be involved in the management of risk, and information about risk factors or any risk behaviour should be shared between family and friends and the clinicians. A discussion should then take place about how, in a collaborative way, these risks can be managed. Family and friends should be clear about when and how they should express any concerns. Carers assessments will be offered to all those involved in the life of the service user (including young carers).

It is important to recognise that family relationships are likely to change rapidly and may reflect sources of risk and stress as well as resource for Service Users. Careful consideration must be given when thinking about a service user's relationships as protective and identify how and when this may change. There are specific tools that may help to identify certain risks e.g. domestic violence and DASH . Service users may also present risks to those living with them or providing care for them. These are intrinsic considerations of a holistic risk assessment.

In order to ensure that information is shared in a way that maximises the effectiveness of risk management, the clinician may need to have a proactive discussion with the service user about confidentiality issues. This discussion should respectfully encourage the service user to appreciate the value of the involvement of family and friends in managing risk and being clear about how information will be shared.

3.1.2 Multi-disciplinary working

Risk assessment should be regarded as ideally a multidisciplinary undertaking – the views of many (e.g. a care team) are more desirable than the views of one. However, one member of the clinical team may take responsibility for collating and communicating the findings of the

assessments made. If clinical practitioners feel that they are unable to formulate management plan that will adequately protect the safety of the service user or others they must consult a senior clinician, or others in the multi-disciplinary team.

When staff assess a person for the first time, they are responsible for ensuring that they access all available sources of information to formulate the risk assessment. Wherever possible, information should be sought about longitudinal changes in risk behaviour. Such information sources could include:

- Relatives and carers
- Advocates
- Previous contacts with other mental health, physical health and learning disability
- services (whether internally within the Trust or externally to the Trust)
- Primary Care Records
- Other health professionals involved
- Other health or social services involved.
- Criminal Justice Service agencies, including Police and Probation.

The information sources used must be recorded in the electronic patient record.

3.2 Recording Risk Assessments

There are a small number of approved clinical risk assessments in use across BSMHFT. The table below shows which assessment tool is approved within each service. Should a service wish to adopt the routine use of a different tool they must seek approval from Clinical Governance Committee via the Integrated Clinical Risk Management Committee. This does not preclude clinicians using a tool they have been trained in if clinically appropriate. However this should be in addition to the prescribed list of tools for the service.

Table 1 Approved Service Arrangements for Risk Assessment and Recording Location

Service	**Approved risk assessments**	**Where documented**
Single Point Of Access	SPOA do not undertake a **comprehensive** assessment of risk however they make a judgement about risk based on their telephone triage and information contained in the referral and any contact they make with professionals, service users and/or carers.	This judgement, and the sources and evidence upon which it is based, is documented in the progress note.
Birmingham Healthy Minds	IAPTUS risk assessment and management plan	The assessment tab of IAPTUS
Secure Care	Level 2 Risk Formulation HCR 20 SAPROF SVR 20 START	RIO Risk Tab

HMP Birmingham	Level 1 risk screening tool or Level 2 Risk Formulation according to Clinical presentation	RiO Risk Tab
Older adult and Adult CMHTs, Early intervention	Level 1 risk screening tool	RiO Risk Tab

Teams and Assertive Outreach		
Adult and Older Adult inpatient wards	Level 1 risk screening tool	RiO Risk Tab
Home treatment teams and RAID	Level 1 risk screening tool	RiO Risk Tab
Solar (CAMHS)	Level 1 risk screening tool SAVRY (Violence)(12-18) EARL <11years Erasor (Sexual Violence) <18years	RiO Risk Tab
Street Triage	Level 1 risk screening tool	RiO Risk Tab
Place of safety	Level 1 risk screening tool	RiO Risk Tab
SIAS		

The cooperation of a service user in a clinical risk assessment should be sought. Their collaboration in the identification of most relevant risk and protective factors, the risk formulation and the risk management plan is essential. The reason for any non-cooperation should be sought and recorded. Risk assessments may proceed without the cooperation of the service user where risks to self or others require urgent management. The service user should be informed of this.

In conducting a risk assessment, wherever possible multiple sources of information should be utilised and these sources should be recorded in the record of the risk assessment. Themes from serious incident reviews have identified that a) involving carers could offer significant opportunities to assess risk more accurately and responsively and offer further opportunities for risk management and b) clinicians may be prone to underestimate the increased risk signified by very historical events or incidents.

Family members and other carers should be encouraged to participate in the service user's assessment and care in a collaborative manner and within the bounds of consent and confidentiality. Clinicians should remember that consent is not required to receive information from those concerned about the service user.

Issues of concern regarding Medications Concordance should be considered in the risk assessment process and documented. This should be considered when drawing up a formulation of risk as it may relate to precipitating or perpetuating factors and should be referred to within the management plan.

Provision should be made for service users who have limited cognitive ability or limited language or communication skills. For example, the risk assessor may work more closely with fellow practitioners and family members or carers to gather information and develop the formulation. If the service user's first language is not English or if the service user has hearing problems, an interpreter should be used to ensure communication is possible.

Attempts should also be made to engage service users who are acutely mentally ill. However, if risk of harm to the self or others is regarded as imminent and unacceptably

high or potentially unmanageable, the risk assessment should proceed urgently. The absence – and indeed, the presence – of cooperation should be recorded in all communications made following the assessment (e.g., a report). Efforts should be made to engage the reluctant service user in a collaborative risk assessment as soon as possible in their care, rather than waiting for a further trigger or occasion of elevated risk.

This policy applies to clinical risk assessments carried out on all service users regardless of ethnic or cultural background, gender orientation or sexual preference.

3.3 Support and training for best practice in in clinical risk assessment and management.

In BSMHFT all registered clinicians who have direct patient contact or supervise those with direct patient contact are required to undertake fundamental training in Clinical Risk Assessment and Management on joining the trust and every 3 years thereafter.

In addition staff with direct patient contact are required the complete the Level 1 Suicide Prevention E-learning, which incorporates information about deliberate self-harm.

Secure services make available local training in the following assessments to their staff who are required to use them in their role as appropriate: START, HCR 20, SVR 20 and SAPROF.

Responsive support and bespoke training is also offered by request or following audit/incident findings from the CPA Clinical Risk Trainer.

4 RESPONSIBILITIES

Post(s)	Responsibilities	Ref
All Staff	Be aware of clinical risk and the impact upon the care and safety of service users and others To proactively seek to engage family, friends and carers, including considering risks to them. Ensure that risk information is recorded, communicated and escalated through appropriate clinical and operational processes Ensure actions are taken in a timely way to mitigate the risks identified Ensure any failures to comply or systemic failures or omissions are escalated via operational procedures Report any risk behaviours or near miss information through the Eclipse system.	
Registered Clinicians	As above and Record all risk related information; assessments and risk management activities in line with the policy. Access agreed training and supervision to ensure their competence in Clinical Risk Assessment and Management. All clinical practitioners are required to attend fundamental Clinical Risk Assessment and Management training once every three years. Ensure that they have read the current Risk Assessment and Management Plan and Care Plan for those service users for whom they provide care.	
Team managers	To ensure that there are opportunities for staff to discuss service users with complex or difficult to manage risk in a multidisciplinary setting	
Associate Directors and Clinical Directors	To ensure that staff members are made aware of this strategy, are sufficiently trained in risk assessment and management and that this strategy is implemented in their services.	
Clinical Managers	Ensure that all practitioners utilising clinical risk assessment tools use (a) only tools described in this policy and (b) the structured professional judgment approach. Further, service managers will ensure that all practitioners are trained and familiar with the tools they use.	
Medical Director	The Medical Director is responsible for the development of this strategy and for ensuring the effective management of clinical risk within BSMHFT. The Medical Director is the Chair of the Integrated Clinical Risk Committee. The Medical Director is also responsible for ensuring effective risk management practice within the medical work force.	

Chief Executive	The Chief Executive is responsible for ensuring effective clinical risk management within BSMHFT	

5 DEVELOPMENT AND CONSULTATION PROCESS

Consultation summary		
Date policy issued for consultation		30/6/17
Number of versions produced for consultation		V1
Committees or meetings where this policy was formally discussed		
Risk Rapid Improvement Event		1/2/17
Integrated Clinical Risk Group		29/6/17
Where else presented	**Summary of feedback**	**Actions / Response**
Families and Carers Pathway Group	Comments regarding positive collaboration with Families and Carers	Mostly incorporated to policy.

6 REFERENCE DOCUMENTS

7 BIBLIOGRAPHY

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The CPA approach and Care Standards Handbook. (CPAA, 2014)

Violence: The short term management of disturbed/violet behaviour in inpatient psychiatric settings and emergency departments. Clinical Guidance 25. (2005) London: National Institute for Clinical Excellence.

Preventing suicide in England: Third progress report on the cross-government outcomes strategy to save lives. (2017) Department of Health

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Rethinking Risk to Others in Mental Health Services: Final Report of a Scoping Group. Royal College of Psychiatrists (2008)

Self-harm in over 8s: long-term management. Clinical guideline (2011) NICE **www.nice.org.uk/guidance/cg133**

Self-harm, suicide and risk: helping people who self-harm. College Report CR158 June 2010, Royal College of Psychiatrists

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Making Mental Health Care Safer: Annual Report and 20-year Review. (2016). University of Manchester.

8 GLOSSARY

9 AUDIT AND ASSURANCE

Element to be monitored	Lead	Tool	Freq	Reporting Arrangements	Acting on Recommendations and Lead(S)	Change in Practice and Lessons to be shared
Level 1 risk assessment completion	CPA Co-ordinator	KPI report	Live	Via service performance reports	ADs and CDs	Service Performance and Clinical Governance Committees

10 APPENDICIES

Appendix 1 – Equality Impact Assessment

Equality Analysis Screening Form

A word version of this document can be found on the HR support pages on Connect
http://connect/corporate/humanresources/managementsupport/Pages/default.aspx

Title of Proposal	**Policy for Clinical Risk Assessment and Management**		
Person Completing this proposal	**XXXXX**	**Role or title**	**Consultant Clinical Psychologist**
Division	**Specialities**	**Service Area**	**Dementia and Frailty**
Date Started	**30/11/08**	**Date completed**	**8/1/19**
Main purpose and aims of the proposal and how it fits in with the wider strategic aims and objectives of the organisation.			
To review the Clinical Risk Assessment and Management Policy. This sets out the expectations that service users can have of our staff in relation to assessment of risks that they may face to their physical and mental health or well-being. The policy describes the approach to clinical risk assessment supported by the trust and the support available for staff to acquire risk assessment competency.			
Who will benefit from the proposal?			
Service Users, Friends, Family, and Staff			
Impacts on different Personal Protected Characteristics – *Helpful Questions:*			
Does this proposal promote equality of opportunity? *Eliminate discrimination?* *Eliminate harassment?* *Eliminate victimisation?*	*Promote good community relations?* *Promote positive attitudes towards disabled people?* *Consider more favourable treatment of disabled people? y* *Promote involvement and consultation?* *Protect and promote human rights?*		

Please click in the relevant impact box or leave blank if you feel there is no particular impact.

Personal Protected Characteristic	**No/Minimum Impact**	**Negative Impact**	**Positive Impact**	**Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.**
Age	**X**			
Including children and people over 65 Is it easy for someone of any age to find out about your service or access your proposal? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability			**X**	**Ensuring all SU can access an appropriate and collaborative risk assessment.**
Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				
Gender	**X**			
This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your proposal?				
Marriage or Civil Partnerships	**X**			
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity	**X**			
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?				
Race or Ethnicity	**X**			

Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief	**X**			

Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation	**X**			
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				
Transgender or Gender Reassignment	**X**			
This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your proposal or service?				
Human Rights			**X**	**The policy describes a collaborative approach to Risk Assessment that is supportive of autonomy wherever possible**
Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				
If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)				

		No		
	High Impact	**Medium Impact**	**Low Impact**	**No Impact**

What do you consider the level of negative impact to be?				
If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required. If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding.				
If the proposal does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**				
Action Planning:				
How could you minimise or remove any negative impact identified even if this is of low significance?				
N/A				
How will any impact or planned actions be monitored and reviewed?				
N/A				
How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.				
Via good practice dissemination and CRAM training				
Please save and keep one copy and then send a copy with a copy of the proposal to the Senior Equality and Diversity Lead at hr.support@bsmhft.nhs.uk. The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis.				