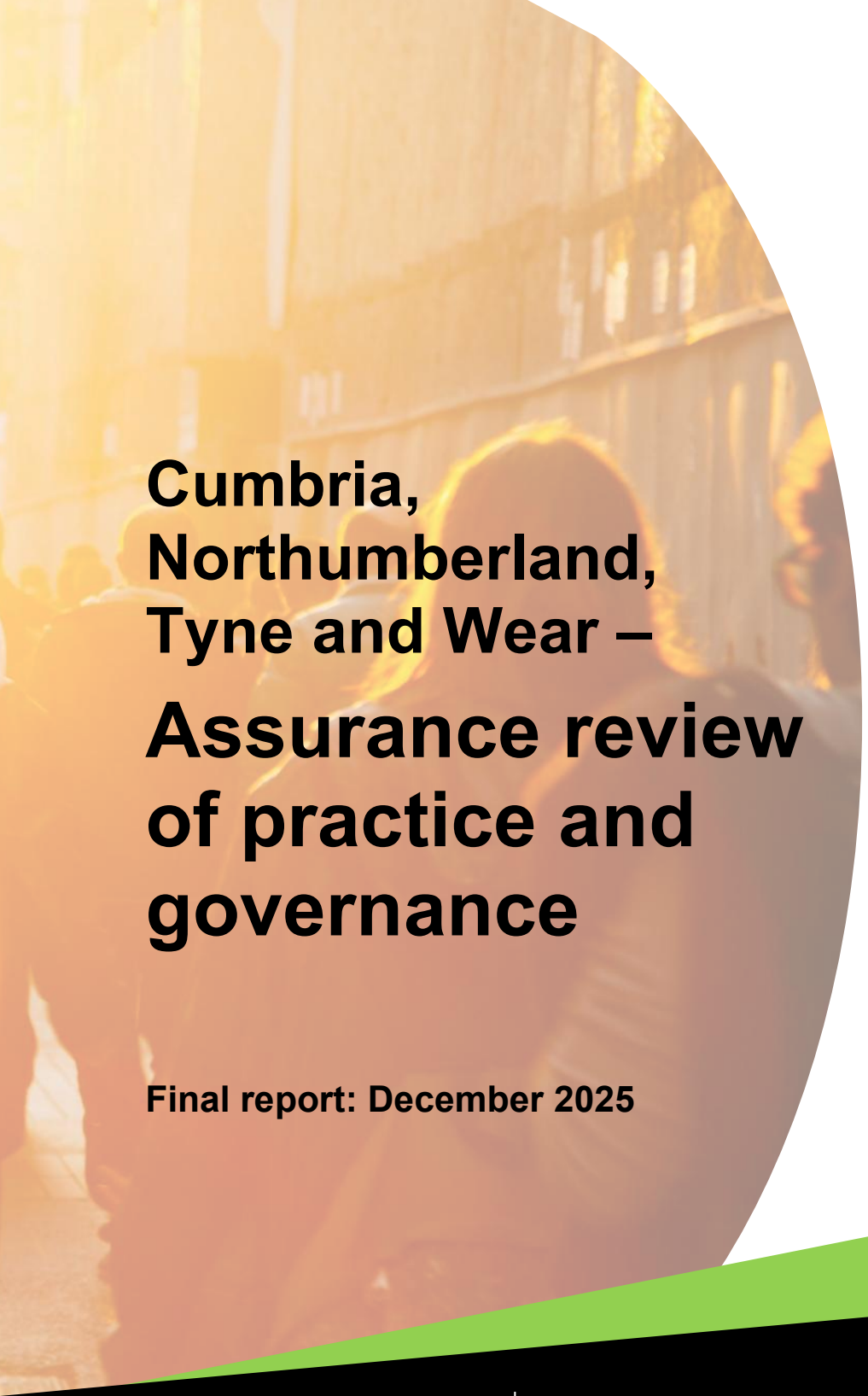

Cumbria, Northumberland, Tyne and Wear – Assurance review of practice and governance

Final report: December 2025

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Quality Assurance Review – Cumbria, Northumberland, Tyne and Wear – Phase Two

Please find attached our final report of 15th December 2025 in relation to a Quality Assurance Review for the recommendations resulting from several serious incident investigation and governance reports involving Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust and other local stakeholders. Our report has been written in line with the scope and approach as set out in our proposal of September 2024, and the method statement agreed in October 2024.

This report is a limited scope review and has been drafted for the purposes as set out in those terms of reference alone and is not to be relied upon for any other purpose.

Our report has not been written in line with any UK or other auditing standards; we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information.

Different versions of this report may exist in both hard copy and electronic formats and therefore only this final signed version of this report should be regarded as definitive.

James Fitton
Niche Health and Social Care Consulting

SUMMARY

This report presents the findings of an assurance review of practice, and of the governance of practice, within aspects of services provided by Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW). This review was aimed at examining the present-day situation - to assess whether, and to what extent, patient/client care is now being provided in ways compliant with current standards and expectations.

The review follows several patient safety investigation reports which addressed aspects of care, treatment, and governance across agencies in areas covered by CNTW. There were specific investigations relating to four cases.

The assurance review involved the following work:

- Audit on site of risk assessments for 30 cases falling within the relevant cohort.
- Direct interview of a sample of 21 practitioners, on a non-attributable basis, to discuss the ease of using the new system, the adequacy of the training that has been provided and any concerns or opportunities which they would wish to identify. These interviews were conducted 1-1 online.
- Review of the current patient safety incident and safeguarding reporting processes to assess compliance with national guidance and statutory obligations.
- Review of one specific patient safety incident, 14 after action reviews, and 15 safeguarding incidents.
- A high-level thematic review to assess whether patterns in reported patient safety incidents and safeguarding events remain reflective of themes identified in the index incidents.

We noted the following as the most significant examples of positive practice:

1. Almost all case records contained a completed risk assessment.
2. Within case records, risks and vulnerabilities were generally well recognised and described.
3. Important contextual factors for risks were mostly well recognised and described.
4. After action reviews contained detailed and clear chronologies.
5. Investigators' responses to families were thoughtful and compassionate.
6. Safeguarding forms provide a good and prompt record of incidents.
7. Overall governance processes were clear and well-designed.

The following were our five principal observations as to practice where improvements appear still to be required:

1. There still appears to be substantial uncertainty about the processes of risk formulation. Around 1/3 of case records lacked a detailed risk formulation; many interviewees thought this was an area of weakness in current practice.
2. Many safety plans are completed to a limited standard; this too was thought by interviewees to be an area where further training is required.
3. The involvement of service users and family members in the process remains underdeveloped. Documentation mostly does not clearly reflect the service user or family member's perspective.

4. The process for updating risk assessments is unclear, with a risk that it will become gradually less clear what the main current risks are for a particular service user.
5. After action reviews do not sufficiently lead to clear identification of gaps in practice or to improvement plans.

These five issues therefore form the basis of the recommendations arising from this review. Practitioners whom we interviewed were (almost all) supportive of the structure and intentions of the Trust's approach to risk assessment and safety planning, and (almost all) keen to see additional and regular training opportunities to improve practice.

We think such a training programme appears to be required and justified by these findings. This should ideally be a multi-modal programme, given varying learning preferences: direct face-to-face training; video and online materials; discussion and practice reflection; worked case examples. These need to include materials focussed on patient groups for whom practice is less certain, in particular children and young people, neurodivergent people, and people with memory problems.

Preparatory work for such a training programme should include establishing clearly the Trust's expected realistic practice standards and policies relating to: risk formulation; safety plans, involvement of service users and family members; updating assessments. We would expect this to be an iterative process, with changes being tested in training and in practice, and then further updated.

The practice in after action reviews needs to build on existing good practice which is already in place, but not applied sufficiently consistently.

We finally recommend that a further audit should take place in 18 months to 2 years' time, to ensure that good practice is continuing to develop and be embedded across the Trust.

Any assurance review is a point-in-time judgement. We know that CNTW are conscious of the need for continuing work, oversight, and vigilance to ensure improvements in practice are sustained, and indeed built upon further.

1 INTRODUCTION

1.1 Context

Several serious incident investigation reports addressed aspects of care, treatment, and governance across agencies in areas covered by the Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW). There were specific investigations relating to four cases.

Our analysis identified a total of 75 resultant multi-part recommendations arising (with some duplication noted). These recommendations were addressed to a wide range of key stakeholders, and combinations of stakeholder agencies.

It was agreed with NHS England that the approach to undertaking an assurance review in these cases needed to pay proper regard to the scale and complexity of these overlapping recommendations. It was agreed that the aim must be to ensure that an appropriate balance is struck between ensuring proper assurance and avoiding unproductive and burdensome review work.

1.2 Phase One work

A first phase of scoping work reported in August 2024. This scoping work encompassed:

- a series of single-organisation review meetings, for up to half a day for those with the most recommendations. These considered any action plans which had been prepared, and discussed:
    - The extent to which actions were already being addressed by other independent assurance processes
    - The extent to which actions were already being overseen by internal or system-wide assurance processes.
    - The extent to which organisations would consider some form of independent validation of the impact of their actions useful.
    - The form that such validation might take; this could be statistical analysis, case note review, qualitative interviews or other forms of assurance.
- preparation and circulation of a draft report, summarising the material above, and proposing potential assurance review actions.
- preparation of a final phase one report, including organisations' responses to the potential assurance review actions, and outlines of two resultant projects. These projects related only to CNTW.

1.3 Purpose and structure of report

This report is intended to provide an independent perspective on changes in both practice and governance which have taken place within relevant services since the events which led to the patient safety reports. It does not re-review any aspect of the care and treatment provided in those original cases. Nor can this report provide complete assurance that no safety incidents will ever recur – such a level of assurance cannot of course ever be offered.

What this report does provide is an analysis of both current practice, and the governance of current practice which, taken together, offer a detailed perspective on the risk of safety incidents within these services. Essentially, it aims to answer the question as to how people presenting with similar needs and concerns to those in the originating cases are now being cared for and treated within current services.

After this introduction, the report is structured as follows:

- Section 2 provides a detailed description of the method used
- Section 3 explains the findings of our audit of current practice
- Section 4 contains a thematic analysis of our programme of practitioner interviews, focussed on risk management practice
- Section 5 explains the findings of our audit of the governance of safety incidents
- Section 6 draws together the main findings, and sets out recommendations arising

2 METHOD

This section sets out the method used in this review

Project one: Real-world evaluation of impact of new electronic risk assessment tool

Purpose

To assess the efficacy of the new risk assessment tool that has been implemented at CNTW. Although centred on the quality of risk assessments that are being undertaken, this should also capture involvement of the service user and their families in risk assessment and care planning processes.

2.1. Scope

The first step was identification of the relevant cohort. This was agreed to be

- Service users who have reported involvement in domestic abuse with or without the overlay of addictions (drugs and/or alcohol)
- Service users who have had safeguarding concerns raised in relation to domestic abuse and/or addictions and/or housing issues
- Service users who have been in receipt of services for a prolonged period of time

The second step was to identify and agree the standards being sought, and the evidence which would be considered either “acceptable” or “good” in each case. These drew on NICE good practice guidance, but with particular regard to evidence of:

- Biopsychosocial assessments and risk formulations
- Involvement of the multidisciplinary team and relevant agencies in the formulation and subsequent risk assessment
- Documentation and ease of access to historic risks
- Identification and appropriate escalation of safeguarding concerns
- Risks to adherence to treatment plans
- Medication management, risks to compliance and review
- Substance misuse
- Domestic abuse
- Involvement of the service user and family members in the development of risk assessments (including risks to carers/family members where required) and personalised safety plans
- Alerts to other team members/agencies

2.2. Assurance approaches

We used two approaches to provide assurance:

- Audit of risk assessments for a defined number of cases falling within the relevant cohort

- Direct interview of a sample of practitioners, on a non-attributable basis, to discuss the ease of using the new system, the adequacy of the training that has been provided and any concerns or opportunities which they would wish to identify. These interviews were conducted 1-1 online.

We had also intended to conduct direct interviews of a sample of service users and relevant family members, again on a non-attributable basis, seeking to understand their experiences of the revised system of work and whether they have experienced services which complied with practice expectations. It did not prove possible to arrange any such interviews; no names or contact details were made available to Niche by the Trust. We understand that services were approached for this purpose, but no service user or family member details were forthcoming.

2.3 Documentary audit of risk assessments

The Trust were asked to identify a sample of cases which met the relevant cohort criteria, as set out above. We audited 30 cases; aiming for this sample to be based on care and treatment provided in the past 6 months at most.

The audit was conducted on site with relevant Trust staff involvement, both to simplify the process of access (as no copying of records was required) and to permit minor access queries to be resolved quickly and simply. We are very grateful for the support and hospitality provided to our team member.

2.4 Interview of a sample of practitioners

Interviews were carried out after, and were therefore informed by the documentary audit. The topic guide is attached as Appendix 5.

We carried out a total of 21 practitioner interviews, selected from staff with experience of using the new risk assessment tool.

The findings were thematically analysed, using NVivo, and discussed between all members of the Niche team.

Project two: sample review of handling of patient safety incidents and safeguarding events

Purpose: To assess whether patient safety incidents and safeguarding events are now being handled in accordance with local policies and expected good practice; and to assess whether learning is being captured and acted upon; and whether patterns in reported serious incidents and safeguarding concerns remain reflective of themes identified in the index incidents.

2.6 Sample

Relevant patient safety incidents and safeguarding events were defined as meeting the following principles:

- Sufficiently similar to the index cases to test changes in practice
- Sufficiently recent to ensure practice is current

It was therefore agreed that patient safety incidents and safeguarding events should be selected from the following categories:

- They should involve service users in receipt of mental health services in 2024
- The incident/safeguarding concern should have been raised in 2024
- They should involve aspects of care that have been highlighted through the index investigation reports such as domestic abuse, substance misuse, concerns regarding risk assessment (including risks to carers/family members where required) and care planning, concerns regarding adherence to treatment plans, service user and family involvement, medication compliance and alerts to other team members/agencies

Our original intention has been to review up to 15 patient safety incidents. However, only one patient safety incident investigation met the above criteria, so the review was expanded to consider After Action Reviews (AARs). This resulted in a sample of 30 cases:

- One PSII
- 14 AARs
- 15 safeguarding events

We set out below a summary of the cases by category:

PSII/AARs

Identifier	Summary information
653769 (PSII)	Female service user seriously assaulted mother.
699110	Female service user suicide at home. History of drug and alcohol misuse, overdoses and disengagement with services.
698887	Male service user suicide at home. Under CTT for low mood and intrusive negative thoughts, receiving Cognitive Analytical Therapy.

698148	Female service user suicide at home. Intermittent contact with CTT, Crisis team and PLT. Documented diagnosis of somatoform disorder.
696702	Male service user suicide at home. Inpatient admission followed by community follow-up. Psychosis, drug induced mania and delirium all queried.
696205	Male service user suicide at home. CTT & NRP, police involved. Changing diagnoses of schizophrenia, Emotional Unstable Personality Disorder (EUPD) and Post Traumatic Stress Disorder (PTSD).
693883	Female service user attempted suicide at home. Later died in hospital; open to CTT for anxiety, depression comorbid with post menopausal syndrome.
693153	Male service user, attempted suicide in the community. Later died in hospital. Lengthy mental health history. Under CTT, treatment medication based.
687194	Female service user suicide at home. Under EIP, working diagnosis of first episode psychosis; presentation later revisited as in keeping with personality structure. Calls to police and crisis reporting paranoia and poor sleep.
685662	Female service user suicide at home. History of contact with services, most recently under EIP. Experiencing ongoing tactile hallucinations.
685367	Female service user death at home (cause unknown). Referred to crisis by GP for delusional thinking and paranoid ideation.
681440	Male service user suicide at home. Under Talking Therapies for suicidal thoughts and ideation.
680114	Female service user attempted suicide at home, later died in hospital. Previously referred to EIP for concerns about psychosis and impact on children (one under services). Period of contact with crisis services.
678184	Male service user suicide in the community. History of depression and low mood. Under CTT, often did not attend appointments
674535	Female service user suicide in the community. Brief voluntary admission. Crisis and PLT contacts, including latter on day of incident.

Safeguarding events

Identifier	Summary information
636884	Male reporting wife has assaulted him; step daughter likely to have heard dispute.

650969	Triage assessment due to family raising concerns; child heard screaming in background. Emergency response.
652032	Service user in custody on suspicion of murdering partner. Police request for information.
655424	Allegation made during EIP appointment that service user has assaulted his partner's sister.
659449	Allegation that adult child has assaulted mother. SG referral.
667717	ABH. Bail condition that service user does not contact victim/partner; both attended outpatient appointment. Police updated.
670165	*Information sharing with the police*
674814	DA incident; male service user behaviour escalating. Three children: SG referral, MARAC and DASH checklist.
677803	Mother looking after adult son who is violent towards her. Police involved. Son arrested for separate offence.
678723	Mother reporting adult son has assaulted her. Police involved. Safety advice given.
688768	Contact from carer asking if husband's behaviour would be considered abusive.
691976	Service user in custody for assaulting father. No indication for use of MHA or MH services.
699114	Parents contacted Trust to report adult son has assault father. Not arrested, NFA.
701388	Service user accused of assaulting sister; history of false allegations on both sides. NFA.
705259	Allegation of DV between ex partners living together. Young baby involved; under social services.

2.7 Terms of reference

We agreed the following terms of reference for the governance audit:

- Carry out a review of the current patient safety incident and safeguarding reporting processes to assess compliance with national guidance and statutory obligations.
- Undertake a high-level thematic review to assess whether patterns in reported patient safety incidents and safeguarding events remain reflective of themes identified in the index incidents.
- For each of the sample, review and assess evidence of compliance with relevant local policies.
- For each of the sample, review and assess the appropriateness of case escalation and closure.

- Via the review, identify areas of good practice, opportunities for learning and areas where further improvements to services and processes may be required.
- Produce a document, suitable for sharing with other providers, on the learning from the review

2.8 Case review framework

For the case reviews, the standards against which the patient safety incidents and safeguarding events were assessed were aligned to local policies and national best practice guidance. The full framework is attached as Appendix 3.

Three standards of evidence were proposed: standard met, standard partially met, and standard not met.

2.9 Identification of cases

Following approvals, the Trust were asked to identify cases which meet the project criteria. This produced a grid of cases for review.

Cases were not re-investigated

The document review was supplemented by a small number of interviews with key stakeholders.

3 FINDINGS – PRACTICE AUDIT

This section presents in detail the findings of the casenote audit. Question wording has been trimmed for presentation – full wording is available at Appendix 1.

Have the risk factors been described? Sample size 30

Audit question	Good	Acceptable	No	N/A
Predisposing	19	9	2	0
Changeable (modifiable/dynamic)	15	13	2	0
Future risk factors	15	12	3	0
Mitigating (protective)	18	9	3	0
Has alcohol/substance use been considered as a factor likely to increase risk to self and others?	13	12	4	1
Have mental state factors been considered in the risk posed?	17	10	3	0
Has the risk of domestic violence been considered?	16	7	5	2
Has harm to named individuals/groups of individuals been discussed?	15	7	5	3
Have safeguarding concerns been considered? e.g. radicalisation, risk to children or adults, self-neglect	16	9	3	2
Recognition of key risk and protective factors for vulnerability	18	10	2	0

Risks were generally well recognised and described. Twenty-nine of the thirty records we reviewed contained a risk assessment. The best examples clearly distinguished between types of risk. In most cases, risks were captured in the correct area of the risk assessment document. Where we rated records as acceptable, this was because, although risks had not been identified in this section of the risk assessment, they had been identified and recorded elsewhere in the document, such as in the formulation. Risks to individuals and groups were generally well documented with evidence of referrals to appropriate agencies in the clinic records. The best examples were clearly and concisely written, which would assist others to quickly understand the risk factors.

Risk and vulnerability were well recognised and documented in 28 of the 30 records we reviewed.

There was one record of the 30 sampled with no risk assessment documentation. This was raised at the time of the audit and the Trust alerted the responsible team.

Contextual factors – sample size 30

Audit question	Good	Acceptable	No	N/A
Has the clinician asked about the social and family support, home life, caring responsibilities, education situations and peer group? Please list which factors identified.	17	12	1	0
Has the clinician asked about the use of social media and its relationship to identified risk factors or mental health? Please list which factors identified.	2	1	27	0
Has the clinician explored whether the patient has depression, cognitive impairment, physical ill health, frailty? Please list which factors were identified.	14	12	4	0

There are three elements to complete in the risk assessment which consider contextual factors. The first prompt is for information about home life and social support. Twenty nine of the thirty records included this information. Factors frequently identified were family, friends, housing arrangements, and pets.

In contrast, the second prompt which related to the use of social media was rarely completed with only three records out of thirty including this information.

The final prompt in this section was completed in twenty-six of thirty records. Examples of physical factors identified included chronic physical health conditions and mobility issues. As with risk factors, there were a number of records where the information was captured elsewhere in the risk assessment or clinical record and not in this section.

Risk formulation – sample size 30

Audit question	Good	Acceptable	No	N/A
Is there a comprehensive risk formulation which integrates the above risk factors?	7	13	10	0

Twenty of the thirty records included a formulation of risk. Ten records were assessed as having no formulation of risk with reasons for this including:

- the section was blank
- contained a history rather than a formulation
- contained contact notes.

The seven records which were judged as including good evidence were concisely written, and brought together both identified factors and how they could interact in the future. The risk formulation also detailed what might be helpful to manage risks and promote safety. The best examples were clearly and concisely written. There were several reasons why ten were assessed as having no formulation, including:

- section left blank
- the section included a history or a record resembling a mini mental state examination or, a recent consultation
- did not join up how factors interacted and mitigated

This could indicate that those completing were not sure what should be included in a risk formulation, and more training may be required.

Risk management plan– sample size 30

Audit question	Good	Acceptable	No	N/A
Does the risk management plan aim to address the identified risks?	5	10	15	0
Does the risk management plan consider a specialist forensic referral or advice from other agencies e.g. safeguarding, police?	5	11	6	8
Is there evidence of discussion about reducing access to means, including medications, illicit substances and weapons?	5	12	8	5
Has the clinician considered potential toxicity of all prescribed and non-prescribed medications?	3	8	19	0
Has the patient been offered a psychological intervention after self-harm?	5	3	4	18

Sixteen risk assessments included evidence that a specialist referral was considered, or advice sought from other agencies. In seven records, there was no evidence that a referral had been considered. In eleven of the sixteen records, the evidence was captured in other areas of the risk documentation or care records. This may indicate that there is a need for a prompt for those completing to consider specialist referrals, and include them in the risk management plan. This would help the document to be a comprehensive source of information for professionals and reduce the need to check through other documents.

Reducing access to means of harm was seen in seventeen of the records. In five records where there were no concerns about accessing means, this was assessed as not applicable. In eight records, where there were indications such as substance misuse, or previous use of weapons, there was no evidence that this had been considered in the risk assessment.

In eight of the twelve cases, where the person had self-harmed, they had been offered a psychological intervention; four people had not.

In eleven of the thirty records there was evidence that the risk of potential toxicity of prescribed and non-prescribed medication had been considered. There was no evidence in nineteen records. We did not review whether the professional background of the person who completed the risk assessment affected whether this was completed, but this should be considered and explored to see whether confidence is an issue and whether it is connected to professional background.

Safety plan– sample size 30

Audit question	Yes	No	N/A
Have all 6 components of the safety plan been discussed: triggers/warning signs, personal coping strategies, connecting with friends family who can help, social prescribing options/community peer networks, professional emergency supports, reducing access to means	16	10	4
Is there a clear distinction between a risk management plan (clinically guided and evidence based) and a safety plan (patient centred)?	18	8	4
Is there evidence that the safety plan has been copied and pasted from other document?	5	21	4
Have other relevant risk assessment tools been completed e. g.falls, HCR (if applicable) Please list which tools used	5	1	24
If there is a change in presentation/risk event has there been a review of the risk assessment and safety plan?	22	4	4
Does the safety plan match all the risk factors identified?	16	11	4

Of the twenty-six records with a safety plan, sixteen had a safety plan which included all six components. Where there was a safety plan, 18 of the 26 were distinct from the risk management plan, and written in a patient-centred way. There were five safety plans which were copied and pasted from another document: in some cases this included a prepopulated list of questions for the professional to answer. The use of a prepopulated list may have assisted professionals in producing a standardised response, but it meant that the safety plan was not written in a personalised way. It also meant that there was a chance that not all risks were covered, if the person had a risk that was not on the prepopulated list.

In twenty-four records there was no indication that another risk assessment tool was warranted and this issue was therefore assessed as not applicable.

Five risk assessments noted that other relevant risk assessments had been completed. Examples included:

- the alcohol use disorders identification test (AUDIT) (in three cases)
- FACE which predated the Trust risk assessment (in one case)
- a malnutrition risk assessment tool (in one case).

For the record with no risk assessment it was not possible to determine if another risk assessment should have been completed and this was therefore recorded as no.

Risk assessments and safety plans were updated in 22 cases where required because of a change in risk, or a change in team.

Involvement of the service user and family members/carers in the development of risk assessments and care planning – sample size 30

Audit question	Yes	No	N/A
Is there evidence that the service user has/ been offered a copy of the safety plan?	3	23	4
Is there evidence of family/carer involvement in developing the risk assessment and safety plan? If no, please note why	9	14	7
Is there evidence that the service user has been involved in updating of risk assessment/ safety plan	7	17	6
Is there evidence that the family/carer has been involved in updating of risk assessment/ safety plan	5	18	7

The only way to evidence that a copy of the safety plan had been shared with the service user, was if the practitioner recorded it. In well completed ones, written from the service user's perspective with personalised actions, it was clear that there had been service user involvement. However, this did not demonstrate that they had received a copy of the plan. In four cases there was no safety plan, and these were assessed as N/A for all these questions.

For the question 'Is there evidence of family/carer involvement in developing the risk assessment and safety plan? If no, please note why' two further records were assessed as n/a as there were no family/carers involved in their care. The reasons why family/carers were not involved were not recorded.

There was a box to tick to indicate if the carer/family had been involved in the development of the plan. We saw that practitioners updated risk assessments differently. Some created a new risk assessment, which meant that it was possible to track where changes had been made. This also meant there was an audit trail of when actions were ticked to show family/carers had been involved in the updating of the risk assessment/safety plan with family/carer. Other staff amended the existing risk assessment, which meant it was not clear what changes had been made. The audit trail of actions for ticking boxes would not be available either. We reviewed the Trust risk assessment policy and there was no guidance on this matter, which reduces the chance of a standardised, shared approach to completing the document.

In two records we saw that there was a significant change in risk which had been identified during a medical review. On both occasions, doctors identified the risk and documented actions to respond in clinical care notes. However, the risk assessment, management and safety plan had not been updated. It would be helpful to consider the barriers to this. The practice we saw suggested that the updating of the risk assessment, management plan and safety plan was considered the responsibility of the care coordinator. If a person was to be admitted, and the care coordinator had not updated the risk identified by a medical practitioner, there would be a risk that that the most up to date information was not readily available. This practice could reduce the benefits of using the biopsychosocial assessment, as the communication of current risk would be reliant on the receiving staff reading continuation notes.

We did not see examples of very lengthy documents with long histories, but this may be due to the relatively recent introduction of the risk assessment tool; there is the potential for this to happen, if practitioners continue to add to the current risk assessment when updating.

4. THEMATIC ANALYSIS OF INTERVIEWS

This section presents a thematic analysis of our interviews with staff directly involved in use and review of the risk assessment documentation. Its aim is to present their views in a structured and organised way; discussion of its implications follows in section 6 below.

4.1 Design of document

For conducting an assessment

The large majority of our interviewees preferred the new documentation to the predecessor FACE-based documents. Most interviewees recognised – and preferred – that they are no longer being asked to score or rate risks, but simply to describe them. Most also thought standards of risk assessment had been improving.

"The previous approach was too 'tick-boxy' – this is more holistic and personalised. It identifies immediate dangers."

"Nothing has been lost in moving away from FACE."

"I support its principles – a multi-factorial narrative, collected into a plan."

Positive features were identified as:

- it's made everyone think more about risk, and how they document it. This has generated useful discussion.
- it gives a fuller, more subjective view of risk - *"more meat on the bone."*
- a single structure across the Trust is the right approach, rather than permitting services to develop or adapt their own.
- the more formulation-based narrative model: *"The documentation is more reflective of the conversation which happened."*
- the prompts in the safety plan – they give a good *"headstart"* as to what practitioners should be including.
- "*more personalised"* approach to considering risk which has *"removed the subjectivity of scales"*

It was suggested there is now an opportunity for the Trust to set up a new research-based initiative to see how this assessment can be transformed into *"a guided narrative and risk registration tool."*

A minority of interviewees disagreed with this overall preference. Some liked the prompts in the old system, although they also noted that the prompts weren't always the right ones. Most interviewees thought the new approach is more time-consuming; not all thought the time is justified by the benefits. Some argued for the retention of some form of numbered scales (potentially alongside narrative), suggesting (for example) that they encourage both staff and service users to reflect on risks which are increasing or reducing, and what can be done about them. It was also suggested that FACE permitted a clearer identification of multiple risks.

Some supporters of the new approach also sought to improve aspects of its design and implementation. Although some said the form is well-designed, and flows well, others suggested changes:

- Prompts would be useful to support staff to understand the difference between the risk management plan and the safety plan
- Character limitation can be a problem – there isn't always space to put what's needed.
- On the other hand, some thought the structure should do more to encourage people to be clear and concise. *"At the moment, too much material appears together in an unstructured way."*
- It is still too easy to fill the template with jargon, and cut-and-pasted material.
- Prompts would be useful as to which biopsychosocial elements go where.
- One person suggested a *"more intelligent"* structure – *"if you describe a risk, a box appears asking how it might be mitigated."*
- It was also suggested that validated psychometric instruments could somehow be embedded in the structure of the assessment – either as instruments, or as prompts for more narrative discussion.
- The section for emergency support and contacts should be automatically copied across to the safety plan, so it's available in both the BPS and the safety plan.

Some interviewees discussed the approach's suitability for different client groups. Children, neurodivergent people, and people who were being assessed for memory problems were particularly suggested to need a different, more tailored approach. People at risk of suicide and self-harm were most often suggested as the group for whom the approach is most useful. Views however differed as to what (if anything) should be done about this; a majority valued the consistency of documentation across the Trust, but others wanted more flexibility.

This need for flexibility of understanding was also often stressed in relation to individual cases. For example:

- For some individuals, self-isolation can be a protective action, not a risk
- In complex relationships, actions to reduce risks for a child could increase risks for their parent

For updating an assessment

The large majority of interviewees had some concerns about how well the approach supports updating of risks, and actions in response. This partly relates to the loss of historical FACE-based risk assessments; however, it also relates to the ongoing accumulation of new narrative material.

Many interviewees weren't clear how they are supposed to keep the risk assessment up to date if new risks become apparent.

"It's not easy to see the chronological order of entries as the risk assessment is updated. It can be very difficult to work out who has added or amended what and when."

"People tend to deal with what's 'hot' for the client – historic risks may be missed. So, for example, whether they have any history of fire-setting, or of carrying a weapon."

"It doesn't feel like a 'dynamic tool'. The formulation isn't always current, and it's not always easy to tell what the current formulation is."

The central issue here seemed to be uncertainty as to when an assessment should be completely redone, and when it should be simply updated. If risks change, it isn't very time-consuming to add new material, but sometimes with the consequence over time (if this is done repeatedly) of reducing clarity for readers. Areas of risk can get lost in a long narrative assessment.

"Checking previous versions and updates can be really difficult. If much changes, a new form should always be done."

4.2 Training

The programme of training which had been provided to support implementation had been largely well-received, and reduced staff anxiety about the change. Many interviewees noted that it had been a difficult transition from the previous system – it was *"a bit of an adjustment."*

"The initial training was very accessible – it helped [xx] to overcome initial scepticism."

"The case study examples were particularly useful."

"Initially staff were apprehensive about the new system, but training helped to alleviate this."

"One of the videos in particular was really useful."

The champions programme was more mixed in its impact. Some interviewees spoke very positively about them, but many were unaware of their existence. One interviewee thought it would be helpful for champions to meet face-to-face to facilitate sharing practice and creating networks.

A minority of interviewees were less complimentary. Some noted that the system was introduced before quite a lot of training materials were available. Some interviewees told us that they had left the training unsure of what information to put where in the form. Comments included:

"*Put lots in which was not applicable."*

"*Sometimes it feels very empty."*

"*Hard to know what to put where."*

"The crib sheet helps xx complete it, but still not sure it's right,"

"Adapted practice to fit the tool, it doesn't feel we're doing it as well as could be."

Most interviewees thought further training was still required (although a minority thought this no longer necessary). Some interviewees felt that the focus of the training was not relevant for the people they support. While it was acknowledged that the tool should fit any service, the training focus was felt to be more suitable for the secondary care setting, rather than primary care.

Teams had developed different ways to support staff after training. Examples included:

- local guidance such as 'crib sheets'
- local training to support practice
- mock exemplar assessments for colleagues to refer to.

Topics people hoped to see addressed in further training were:

- Improving consistency in completion. Staff and services may interpret risk differently, and currently complete assessments to widely varying standards.
- More emphasis on risk formulation and personal safety planning.
- Better capturing of the service user perspective, especially in safety plans.
- Confidence-building in delivering the approach. What do you put in a blank field?
- Increase staff understanding of the difference between a risk management plan and a safety plan.
- Making the language more accessible for service users.
- Updating of assessment when risk reduces (as this seems to be done less than when risk increases.)
- Increasing completion of the form by all members of the MDT.
- Improving understanding of which documents are shared with service users.
- Supporting staff to explain the reason why it is a risk for the person rather than simply writing lists of risk factors.

Better safety planning was a theme we heard many times. Some interviewees were quite concerned about aspects of current practice:

"Some colleagues don't understand the concept of safety planning. They refer to clients' coping strategies as "safety plans", even maladaptive coping strategies. Safety plans should always be understood as an intervention."

It was also noted that some colleagues were not clear on the difference between a risk formulation, a risk management plan and personal safety plan. There were concerns that:

- the risk formulation section was left blank or
- the risk management plan was copied into the safety plan or
- the safety plan was a generic copy and paste of emergency numbers

Interviewees also had comments on how future training would best be delivered.

- A focus on the conversation as much as on the documentation. What do you ask? What do you ask given particular responses?

- Have useful and relevant worked examples – how to make the approach most useful, especially to the service user.
- At least yearly refresher training might be needed.
- Some preference for face-to-face training, rather than a reliance on online modules.
- A request to incorporate team events, Q&A sessions, and audit. *"Videos are useful, but not sufficient."*
- Greater diversity of practitioners delivering the training, especially for client groups where the assessment's fit may be less easy.
- Training tailored and delivered to teams working with specific client groups
- Ensure that the rationale for the approach was included.

4.3 Impact on practice

As an assessor

We asked interviewees how use of the new approach is affecting their practice. Most could not readily think of examples of consequential changes. Several observed that the approach goes with the grain of the way they'd want to practise anyway

"*It's a record of decisions and judgements, rather than encouraging new ideas."*

"It's a record of thoughts, not a prompt to thought."

"You end up writing the same thing in multiple ways, with the potential for a copy and paste approach."

"There can be a fear of missing things."

One interviewee did note that the approach is quite helpful for guiding a conversation for someone with suicidality / self-harm. Another commented that it had generated more conversation with service users and families. One person noted that it was easier to see the risks which "*makes it easier to feed back in virtual clinics."*

Some interviewees reflected on why this limited impact on practice might be. Examples we heard included:

- A difficult fit with a particular client group or pathway
- The structure of the documentation encourages repetition
- Difficulty in completing the documentation when there are minimal risks
- *"There's a sense of safety in asking a set of pre-set questions. A formulation-based model can feel more uncertain."*
- The structure works best if it fits with the practitioner's preferred approaches, and their existing expertise. *"It's a good thing if you know what you're doing."*

As a reader

Interviewees were very largely positive about the experience of reading assessments prepared by colleagues. People reported finding them helpful as to things to be mindful

of. With referrals of unfamiliar patients, we heard it can be useful to review the risks which colleagues have identified.

There is, however, a clear link here to the updating issue identified at 1b above. The system is still relatively new, so usually there's not too much to read. But sometimes *"it's a bit of a heartsink if you're facing a wall of text."* This could become a bigger concern in due course, as the volume of material grows.

As an MDT member

We asked interviewees if the new approach had led to any changes in the ways of working of the various multi-disciplinary teams. The almost universal response was that it had made no difference to MDT working. One interviewee noted that there was a "*better spread of professional comment"* when discussing the assessment in the MDT. They also felt that it helped the MDT to "*think more broadly and it promotes professional practice*." Several people noted that it was easier to see the risks in the new assessment.

People reflected that this lack of change was not necessarily a problem, in that the approach has not made MDT processes somehow harder or less effective. But they also could not describe any positive changes for MDTs which had been facilitated by the new assessment approach.

Relevant observations, in each case from one interviewee, included:

- uncertainty if the approach and structure directly ensure that an assessment is fully rounded across members of the MDT.
- WRAP plans prepared by the mental health and wellbeing practitioner don't feed into the risk assessment
- support workers should be permitted to contribute to the assessment if they have something valid to contribute. At the moment that doesn't happen.
- all members of the MDT, including doctors, were expected to review and update the assessment.
- [xx team] try to think about the role of other agencies in the risk management plan.
- it can be challenging for all members of the MDT to think outside of their own experience when completing the assessment.

4.4 Impact on outcomes

We asked interviewees if, in their judgement, the new approach had improved safety and outcomes for patients. Even people who were otherwise positive about the approach struggled to identify confidently benefits of this nature. One interviewee thought that it may be easier to see the impact in the secondary care setting. Several reflected that it would be good to monitor the approach's effectiveness at an individual patient level: how risks have been addressed, and what risks remain.

Otherwise, responses essentially followed interviewees' general perspectives on the approach. The more positive noted, for example:

- the structure is proving helpful in managing safety and outcomes
- it supports conversations about things the client themselves can do
- improving outcomes should be seen as a realistic goal of the process

On the other hand, people who were especially concerned about the accumulation of narrative were concerned that the approach risks making things less safe, and that this will escalate as the detail increases over time.

We also heard differing opinions as to the level of ambition which should be set here. Some thought that improving outcomes or safety is driven almost entirely by direct interactions with patients, and not from documentation, however well designed. However, others hadn't yet *"given up"* on the idea of a fully impactful risk assessment tool, even if this can't yet meet that standard.

4.5 Involvement of service users and families

Overall, the introduction of this new approach appears to have made little difference to the way that services are involving service users and families. The large majority of interviewees described no differences at all: the risk assessment isn't used as part of family or service user engagement process; the documentation isn't reviewed with the service user or family member; service users aren't given a copy of their safety plan. Practitioners described speaking with service users and family members as part of the information-gathering process, in the same way as they had always done.

In a small number of teams, it had already been usual practice to share safety plans, before the introduction of the new assessment. We did hear one example of a team which has devised a separate paper-based process (using exactly the same template) to ensure that safety plans can be shared as intended. In another example, the team asked the service user what they wanted the safety plan to look like and created it in Word with illustrations as requested by the service user. Some teams used leaflets with a handwritten section which they would complete with the service users. These were, however, the exception. Other interviewees noted that they do not go through the risk assessment directly with families – they do, however, have the structure of the assessment in their head as they are working, and then write it up afterwards.

Many interviewees, however, wanted to improve involvement processes, and noted that there remains the potential to do things differently. For example:

- The current format does not lend itself to being gone through directly with a patient. Several interviewees mentioned that they'd really welcome this being more user-friendly, in its wording and structure.
- This would mean in particular a format in which the patient's view came across more directly and more clearly – rather than simply (or mainly) the professional's view.
- It would help if information pulled through more easily into letters, such as discharge letters and when being printed off for service users.

Comparisons were drawn with DIALOG+, where there's a very clear presumption that it is done with the patient. This would imply a fully collaborative risk assessment.

5. FINDINGS – GOVERNANCE AUDIT

5.1. Handling of patient safety incidents and safeguarding events

AARs

The Trust provided 14 AARs and one PSII for review. We had originally intended to review 15 PSIIs, but only one PSII was available for the period of review.

Identifier	Standard met	Partially met	Not met	Could not be answered
653769[1]	20	4		2
674535	15	5	6	
678184	22	2	2	
680114	19	4	3	
681440	19	3	1	3
685367	18	4	1	3
685662	14	4	8	
687194	16	8	2	
698887	15	2	2	7
693153	21	3	2	
693883	20	3	3	
696205	16	2	8	
696702	13	2	11	
698148	20	4	2	
699110	13	8	5	

Please refer to Appendix 4 for a full breakdown of scores.

The Trust AARs were of an acceptable standard. Most framework standards were met in relation to credibility and thoroughness. The reports were well written, with few errors, or areas of incongruence.

Of note, the AARs (and PSII) contained detailed chronologies of the service user's care and treatment. These were comprehensive, and we did not identify gaps in this respect. We would hope service users and/or their families would find the level of detail informative.

Similarly, we found the investigators' responses to family questions were thoughtful and generally provided a good level of detail. Responses struck a compassionate tone across the reports.

[1] PSII

It is our view that the AARs were largely completed in line with Trust policy and guidance. However, we found the AARs were lacking in terms of their system review, analysis and learning: 'impact'. Most reports did not use the comprehensive chronologies to facilitate robust analysis of why there were gaps in practice and in turn, the actions needed to address these. We were left with a sense that many of the reports could have explored the patient journey in more detail and said substantially more (e.g. 680114, 685367, 687194, 696702 and 699110).

We did identify instances of helpful commentary and analysis alongside the AAR chronology (693883), but this was typically not borne out in the learning and improvement plan. It is our view that at least three reports (685367, 696205 and 698148) could have been of a good standard had the analysis and learning been strengthened.

The improvement plans were largely somewhat passive in their response to issues identified. For example, suggesting staff hold reflective discussions (698148 and 693883), and in one instance, staff being 'encouraged' to attend training (693883). Improvement plans did not always address each of the points raised in the AAR. For example, case 698148 identified that the service user's mother did not receive callbacks – there is no action in the improvement plan in response to this. Similarly, five points are identified in AAR 699110; the improvement plan sets out two broad actions in response to these (e.g. develop a documented strategy) which would arguably capture all five points if effectively implemented, but offers little by way of assurance (i.e. policy/process wasn't followed in the first instance – is the Trust assured a strategy would be?). The improvement plans were limited as a mechanism of meaningful change or assurance.

Identifier	Standard met	Partially met	Not met	Could not be answered/did not apply
636884	14	4	1	5
650969	12	2	1	10
652032				24
655424	7	7	1	9
659449	12		3	9
667717	9		1	14
670165	10	1	1	12
674814	17		1	6
677803	11		1	12
678723	6	3	2	13
688768	9		1	14
691976	11		1	10
699114	8	1	1	14
701388	9		2	13
705259	12			12

Five reports did not have improvement plans; we agreed with this in relation to one case (698887) but consider the other four should have had improvement plans. For example, AAR

696205 - which we found to be a thorough and thoughtful report - identified four areas where there were gaps in practice (e.g. care plan not developed) and underpinning system issues, yet there was no improvement plan in response to these issues.

As result of the above, we would advise the Trust to assure itself that its QA processes ensure AARs are subject to robust review. We note all reports had been signed off at director level, but we consider several reports contained unaddressed issues, which should have been identified as part of the sign off process. Similarly, we note almost none of the cases were identified as requiring escalation, which we would challenge given the gravity of some of the cases, particularly AAR 680114.

In summary, the AARs were well written, underpinned by detailed chronologies and struck a compassionate tone. However, analysis was limited and in most cases we identified unexplored lines of enquiry. Leading from this, learning and improvement planning should be strengthened. However, we do not consider this would be a challenge for the Trust: as noted, many of the reports did contain thoughtful commentary, typically in the tabular timeline 'work system issue' column, it is this that needs to be harnessed effectively.

It is of note Trust policy says all staff invited to an AAR must attend. In almost all the cases we reviewed, we found gaps in attendance (in one case, seven out of 27 staff invited attended). We assume that some absences were due to shift patterns and scheduling conflicts. Despite these absences, it is our view that most services and teams involved were represented at the AARs.

Safeguarding events

The safeguarding sample was composed of web incident forms. These were descriptive in nature, setting out the purpose of the contact, details of the service user and affected parties, and any next steps. In some cases we were provided with supporting information e.g. entries in RiO, but the information was generally limited. Only two of the 15 cases warranted safeguarding referrals (659449 and 674814). It was not possible to apply our framework in its entirety to any of the cases; there was insufficient information. It is important to emphasise that this is different from a standard not being met, which we did not identify as a significant issue in these cases.

As a record-keeping mechanism, the webforms were completed to a good standard. They were clearly written and we have no concerns in respect of the level of detail documented. Incidents were documented promptly and next steps were clearly outlined. However, the webforms provide limited insight into the Trust's handling of incidents that lead to safeguarding referrals. Of the two safeguarding referrals we reviewed, 674814 was completed to a reasonable standard but 659449 lacked information. Taking into account the small sample size, we cannot make any broader comments about the Trust's handling and management of safeguarding incidents.

5.2. Themes

We were asked to consider whether patterns reported in patient safety incidents and safeguarding were reflective of the themes identified in the index events. Aspects of care highlighted included domestic abuse, substance misuse, concerns regarding risk assessment and care planning, concerns regarding adherence to treatment plans, service user and family involvement, compliance and alerts to other team members/ agencies.

Acknowledging the limitations of the sample size, we identified the following themes in seven or more of the 15 cases: substance/alcohol misuse, risk assessment, care planning, multi-team and/or agency, and compliance with medication and/or engagement with services. Family involvement and delays/lack of escalation were identified to a lesser extent in four cases for each theme. Domestic violence was not a feature in any case.

We were unable to undertake a thematic review of the safeguarding incidents due to the limited information documented, a reflection of the nature of the alert (e.g. information sharing), as opposed to poor record keeping.

5.3. Incident reporting processes

The Trust has a clear incident and safeguarding formal reporting structure. It was able to describe reporting processes, from the point of triage through to Board, via key meetings: the Patient Safety Learning from Improvement Panel (PSLIP), Trustwide Safety Group (TSG), Operational Management Groups Care Groups (e.g. community), individual clinical business unit (CBU) Safety Group meetings, and the Quality and Performance Committee (Q&P), which reports into the Board.

We were provided with the terms of reference for the PSLIP, TSG and Q&P which set out the purpose of each meeting, membership, authority, deliverables, and any subgroups reporting into the meeting. The terms of reference had all been subject to recent review, in keeping with the life cycle of each document.

Incidents

The Trust demonstrated the application of its governance structure using PSII 653769. We were given the completed PSII sign off proforma for the case, submitted to the Q&P Committee in January 2025. This detailed the timeline of the incident review process, improvement actions and corporate sign off. We were given the January 2025 Q&P committee minutes at which the PSII was presented for sign off.

The Trust also provided evidence of incident monitoring at Care Group level, the April 2025 minutes for which detailed monitoring of:

- Overdue ELRs and AAR
- Open incident action plan updates
- Incident action plan for approval

Safeguarding

As above, the Trust provided details of its oversight of incident 691976. This included:

- IR webform completed 30 September 2024
- Early Learning Review completed 8 October 2024, Director sign off, 14 October 2024
- TSG recording, 8 October 2024, incident reported and requests from the meeting documented (e.g. cases involving psychosis to be brought back to the TSG within six weeks for update)

- TSG minutes, 24 October 2024, noting the incident had been escalated to AAR (no additional comments).
- AAR with Director sign off, 16 December 2024 (to note, the date of the incident is incorrect).
- Team meeting minutes from January 2025 detailing the AAR improvement plan being discussed (the action was to remind staff to complete IR1s, therefore the action was complete)
- Email trail of Locality sign off of improvement plan (completed in early April 2025)
- Minutes of the April 2025 Community Care Group meeting, which include sign off of the completed improvement plan

The Trust shared its most recent Quality and Safety report (submitted to the Q&P committee) to illustrate higher level incident and safeguarding reporting into the Board.

6. REVIEW OF FINDINGS AND RECOMMENDATIONS

This assurance review was intended to consider the extent to which risk assessment practices, and associated governance structures, now ensure a safe system of care.

We noted the following as the most significant examples of positive practice:

1. Almost all case records contained a completed risk assessment.
2. Within case records, risks and vulnerabilities were generally well recognised and described.
3. Important contextual factors for risks were mostly well recognised and described.
4. After action reviews contained detailed and clear chronologies.
5. Investigators' responses to families were thoughtful and compassionate.
6. Safeguarding forms provide a good and prompt record of incidents.
7. Overall governance processes were clear and well-designed.

The following were our five principal observations as to practice where improvements appear still to be required:

1. There still appears to be substantial uncertainty about the processes of risk formulation. Around 1/3 of case records lacked a detailed risk formulation; many interviewees thought this was an area of weakness in current practice.
2. Many safety plans are completed to a limited standard; this too was thought by interviewees to be an area where further training is required.
3. The involvement of service users and family members in the process remains underdeveloped. Documentation mostly does not clearly reflect the service user or family member's perspective.
4. The process for updating risk assessments is unclear, with a risk that it will become gradually less clear what the main current risks are for a particular service user.
5. After action reviews do not sufficiently lead to clear identification of gaps in practice or to improvement plans.

These five issues therefore form the basis of the recommendations arising from this review. These are described in narrative form below, rather than as numbered recommendations, given their interconnected nature. This is essentially therefore a single recommendation with supporting clarifications as to its composition.

Practitioners whom we interviewed were (almost all) supportive of the structure and intentions of the Trust's approach to risk assessment and safety planning, and (almost all) keen to see additional and regular training opportunities to improve practice.

We think such a training programme appears to be required and justified by these findings. This should ideally be a multi-modal programme, given varying learning preferences: direct face-to-face training; video and online materials; discussion and practice reflection; worked case examples. These need to include materials focussed on patient groups for whom practice is less certain, in particular children and young people, neurodivergent people, and people with memory problems.

Preparatory work for such a training programme should include establishing clearly the Trust's expected realistic practice standards and policies relating to: risk formulation; safety plans, involvement of service users and family members; updating assessments. We would expect this

to be an iterative process, with changes being tested in training and in practice, and then further updated.

The practice in after action reviews needs to build on existing good practice which is already in place, but not applied sufficiently consistently.

We finally recommend that a further audit should take place in 18 months to 2 years' time, to ensure that good practice is continuing to develop and be embedded across the Trust.

Appendix One – practice audit framework

	Good evidence: in line with best practice guidance	Acceptable evidence	Notes
Have the risk factors been described?			
Predisposing	A clinical risk assessment requires a comprehensive understanding of previous risks, including the patient's exposure to adverse childhood events and other experiences of trauma. It also informs judgement about what sorts of risk to consider.	Some predisposing risks are captured and others are recorded elsewhere in the document.	
Changeable (modifiable/dynamic)	Current identifiable biological, psychological or social risk factors and include signs and symptoms on mental state examination that relate to risks, such as depressive or psychotic symptoms, suicidal or aggressive thoughts and cognitive decline.	Some biological, psychological or social risk factors are included: refers to some of the symptoms found on mental state examination. Others are captured elsewhere in document.	
Future risk factors?	Anticipates events which can impact risk such as significant dates, e.g. anniversary of a death, or events which can increase risk factors	Includes some but not all- which are elsewhere in the document.	
Mitigating (protective)	Identifies both patient-related and treatment-related factors that are relevant, information about the patient's previously utilised positive coping strategies, supportive family and friendships, employment, social prescribing opportunities and treatment engagement and response.	Includes some of the factors and others are recorded elsewhere in document.	
Has alcohol/substance use been considered as a factor likely to increase risk to self and others?	Identifies current and historical use of alcohol/substances and any risk related events which apply for self and others	Includes some of the factors and others are recorded elsewhere in document.	
Have mental state factors been considered in the risk posed?	Current signs and symptoms have been	Current signs and symptoms have been	

	assessed and considered in the risk assessment.	assessed and recorded elsewhere in document.	
Has the risk of domestic violence been considered?	There is information relating to domestic violence indicating perpetrator/victim and includes details of appropriate referrals/actions.	There is documentary evidence in the record that the risk of domestic violence has been considered.	
Has harm to named individuals/groups of individuals been discussed?	Details of those at risk has been recorded and considered in the risk assessment.	Details of those at risk has been recorded and considered elsewhere in document.	
Have safeguarding concerns been considered? e.g. radicalisation, risk to children or adults, self-neglect	The risk assessment includes details of any safeguarding concerns and actions taken such as referrals.	The risk assessment includes details of any safeguarding concerns and actions taken such as referrals are recorded in the care records.	
Recognition of key risk and protective factors for vulnerability	The risk assessment include specific factors that relate to the likelihood of an individual being victimised, taken advantage of, or exploited by others along with any factors which mitigate the risk.	The care records include specific factors that relate to the likelihood of an individual being victimised, taken advantage of, or exploited by others along with any factors which mitigate the risk.	
Contextual factors			
Has the clinician asked about the social and family support, home life, caring responsibilities, education situations and peer group? Please list which factors identified.	The risk assessment includes details of social factors.	Some social factors were recorded here: others captured elsewhere in risk document or care records	
Has the clinician asked about the use of social media and its relationship to identified risk factors or mental health? Please list which factors identified.	The risk assessment includes details of use of social media which has impacted risk or mental health.	Impact of social media use considered captured elsewhere in risk document or care records	
Has the clinician explored whether the patient has depression, cognitive impairment, physical ill health, frailty? Please list which factors were identified.	The risk assessment includes details of biological and psychological factors.	Some of the factors were recorded/captured elsewhere in risk document.	
Risk formulation and safety plan			
Is there a comprehensive risk formulation which integrates the above risk factors?	The risk formulation considers how all the various factors (predisposing static, modifiable dynamic, future and strengths and protective factors) could interact in future and what	In the clinical record, there is a narrative risk formulation, with detail of triggers, relapse indicators and early warning signs, how they could interact and what might be helpful to	

	might be helpful to manage risks and promote safety.	manage risks and promote safety.	
Does the risk management plan aim to address the identified risks?	All identified risks are included in the risk management plan with mitigations in place.	There is evidence that all risks are mitigated in other sections of the document such as formulation of risk/safety plan.	
Does the risk management plan consider a specialist forensic referral or advice from other agencies e.g. safeguarding, police?	The risk management plan includes details of specialist/ interagency referrals where appropriate.	The clinical record includes details of appropriate specialist/interagency referrals.	
Is there evidence of discussion about reducing access to means, including medications, illicit substances and weapons?	The risk management plan includes details of specific items of risk and how this is managed.	The clinical record includes details of how access to means has been reduced.	
Has the clinician considered potential toxicity of all prescribed and non-prescribed medications?	Following self-harm incident the medication used is identified, and how it was sourced and risks mitigated. If the person has substance misuse the risks relating to overdose and rescue medication captured.	The clinical record includes information about the medication used in self harm: the clinical record includes the risks relating to overdose and rescue medication if the person has substance misuse.	
Has the patient been offered a psychological intervention after self-harm?	The risk assessment details psychological intervention offered following self-harm.	The clinical record includes details of the psychological intervention offered following self harm.	
For the following items, the criteria was present or not.			
Have all 6 components of the safety plan been discussed: triggers/warning signs, personal coping strategies, connecting with friends family who can help, social prescribing options/community peer networks, professional emergency supports, reducing access to means	The safety plan is personalised and includes all 6 components, and written from the service user perspective.		
Is there a clear distinction between a risk management plan (clinically guided and evidence based) and a safety plan (patient centred)?	There is a personalised safety plan E.g. I will go to my aunt's house if I'm feeling unsafe: which is different in tone/perspective from the risk management plan.		

Is there evidence that the safety plan has been copied and pasted from other document?	The safety plan is personal to the service user, and has been developed with them, and not copied from other documents or a check list.		
Have other relevant risk assessment tools been completed e.g.falls, HCR (if applicable) Please list which tools used	Where there are other risks identified such as falls an appropriate risk tool has been completed.		
If there is a change in presentation/risk event has there been a review of the risk assessment and safety plan?	The risk assessment and safety plan has been updated in response to change in presentation/risk.		
Does the safety plan match all the risk factors identified?	The safety plan includes responses to all identified risk factors.		
Involvement of the service user and family members/carers in the development of risk assessments and care planning			
Is there evidence that the service user has/ been offered a copy of the safety plan?	There is a record in the risk assessment/care records that shows a copy has been offered.		
Is there evidence of family/carer involvement in developing the risk assessment and safety plan? If no, please note why	The risk assessment shows evidence of carer involvement including direct quotes, and additional completion of box indicating involvement.		
Is there evidence that the service user has been involved in updating of risk assessment/ safety plan	When updated, the risk assessment shows evidence of service user involvement.		
Is there evidence that the family/carer has been involved in updating of risk assessment/ safety plan	When updated, the risk assessment shows evidence of discussion with family/carer.		

Appendix Two – policy and guidance

Trust guidance

The Trust provided us with policy and guidance covering

- Incident policy and guidance
- Domestic abuse- previously MARAC
- MAPPA policy and guidance
- Safeguarding adults
- Safeguarding children

A full list of documents is available on request.

National guidance

Regulation 20, Duty of Candour, CQC

Serious Incident Framework, NHS England 2015

NHS Patient Safety Strategy: Safer Culture, Safer Systems, Safer Patients, NHS England & NHS Improvement, 2019

Engaging and involving patients, families and staff following a patient safety incident, NHS England, 2022

Working together to safeguard children, a guide to multi-agency working to help, protect and promote the welfare of children, HM Government, 2023

Working together to safeguard children, Statutory framework: legislation relevant to safeguarding and promoting the welfare of children, HM Government, 2023

Safeguarding children, young people and adults at risk in the NHS, 2024

Patient Safety Incident Response Framework, NHS England, 2024

Appendix Three – governance audit frameworks

AAR/PSII framework

Rating	Description	Number
	Standards met	
	Standards partially met	
	Standards not met	

Standard		Niche commentary and rating	
Theme 1: Credibility			
1.1	The AAR cover sheet is complete, detailing the incident and RIO numbers, departments/services involved, and completion date		
1.2	KLOEs identified by the ELR are documented in the report e.g. under 'potential contributory systems and process issues requiring further review by AAR'.		
1.3	The AAR was led by the Lead Clinician or Investigation officer		
1.4	The AAR was completed within 40 working days of being allocated, or there is clear evidence of the reasons for delay and process for approving this with commissioners.		
1.5	The report has a description of the investigation, it is accessible to readers and written in plain English, without typographical errors.		
1.6	Staff have been supported following the incident.		
1.7	A selection of clinical and operational staff were engaged in the AAR process		
1.8	Associate director sign off/approval is documented.		
Theme 2: Thoroughness			
2.1	Each section of the report has been completed		
2.2	Bereaved/affected patients, families and carers were offered the opportunity to have input into the review; their experience/concerns/questions have been reflected and addressed.		
2.3	It is clear how the Duty of Candour regulations and/or Being Open have been met for this incident or reasons why they haven't are included (e.g. consent).		
2.4	Background/context of the service user's care and description of the incident is included.		
2.5	There is a detailed chronology of care.		
2.6	Findings are identified and underpinning analysis detailed e.g. benchmarking of practice/ what should have happened.		
2.7	The report adopts a systems-based approach to understanding what has happened i.e. broader system issues are described.		

Standard		Niche commentary and rating	
2.8	The report reflects areas of learning and where improvement action is required.		
2.9	Areas of good practice are described.		
2.10	There are no obvious areas of incongruence.		
2.11	PSLIP escalation decision is documented.		
Theme 3: Impact			
3.1	The report examined the problems (what happened), sets out what should have happened, and the fundamental issues (the why).		
3.2	The report identifies contributory system and process issues requiring further review.		
3.3	Learning and improvement plan/s clearly relate to the findings and/or system/process issues identified.		
3.4	The learning supports measurable, and outcome focused actions/improvement plans.		
3.5	The improvement plan/s reflects and responds to each of the findings, with action owners and realistic timeframes identified.		
3.6	The actions will address the concerns identified.		
3.7	The report has been shared with the affected service user(s)/ families; answers to questions are clearly set out.		

Safeguarding framework

Standard		Niche commentary and rating	
Theme 1: Credibility			
1.1	My personal safeguarding form completed (if appropriate)		
1.2	Web based incident form completed and submitted to Safeguarding & Public Protection (SAPP) team SPoC		
1.3	Attachments and progress notes completed by reporting staff member as required		
1.4	SAPP triage incident form: RiO progress notes, safeguard system and reporting staff member updated (or contact made if further information needed)		
1.5	Referral form completed within 24hrs of concerns being identified		
1.6	Safeguarding referral copied to patient records		
1.7	Referral to SPoC/Local Authority logged		
Theme 2: Thoroughness			
2.1	Details of the individuals involved and who is at risk documented e.g. completion of GTKY when a carer is involved.		
2.2	First names and surnames have been spelt correctly and consistently		
2.3	Dates and times of incident/s detailed		

Standard		Niche commentary and rating	
2.4	Details of the injuries or alleged harm recorded		
2.5	Suggested actions to address concerns documented		
2.6	The web incident form and referral are written clearly, without typos or grammatical errors.		
	Children only		
2.7	Parental responsibility documented		
2.8	Consent from those with parental responsibility documented (unless this would place the child at risk; decision to not seek consent recorded)		
2.9	Child's voice and lived experience reflected and any actions detailed		
2.10	Child's voice and lived experience reflected and any actions detailed e.g. Keeping Children Safe assessment completed		
2.11	Evidence that capacity for those aged under 18yrs has been considered (e.g. Gillick Competency)		
2.12	Support currently available to the family documented		
Theme 3: Impact			
3.1	Safeguarding referral submitted within 24hours of concerns being raised		
3.2	Local Authority outcome logged within five days (if service user open to Trust)		
3.3	Other agencies contacted as appropriate		
3.4	Any immediate actions recorded e.g. adult SG meeting		
3.5	Status of SG process at time of review and impact for future learning e.g. any concerns remaining, difficulties sharing information etc?		

Appendix Four – full audit scores

AARs/PSII

	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.8	2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8	2.9	2.10	2.11	3.1	3.2	3.3	3.4	3.5	3.6	3.7
653769		N/A		N/A																						
674535																										
678184																										
680114																										
681440									*	*																*
685367									*	*																*
685662																										
687194																										
698887														**	**	**						**	**	**	**	
693153																										
693883																										
696205																										
696702																										
698148																										
699110																										

*Family details not provided

** no concerns identified – agree

Safeguarding incidents

	1.1	1.2	1.3	1.4	1.5	1.6	1.7	2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8	2.9	2.10	2.11	2.12	3.1	3.2	3.3	3.4	3.5
636884																								
650969																								
652032	*Information share with police*																							
655424																								
659449																								
667717																								
671065																								
674814																								
677803																								
678723																								
688768																								
691976																								
699114																								
701388																								
05259																								

Appendix Five – Interview topic guides

Practitioners – topic guide

a. Whether the audit findings represent a fair summary of practice
b. Whether the new risk assessment approach has been implemented as intended. What barriers and facilitators have been identified to the process of implementation?
c. Have there been any practical concerns in use? How are these dealt with?
d. How are practitioners making use of the risk assessment data? How does this support decision-making?
e. In their experience, how does the new approach to risk assessment affect safety and outcomes?
f. How are the risk assessment and safety plans working together?
g. How does the approach support engagement with patients and families?
h. How does the approach affect multidisciplinary working?
i. Have there been any unintended consequences of the use of the risk assessment approach (either positive or negative)?
j. How can the implementation of the approach be improved in future?
k. How can identified benefits of the approach be sustained in future?

Service users and relevant family members – topic guide

a. What has been your experience of the risk assessment process?
b. How were you involved in the process?
c. Do you have a copy of your safety plan? (If so) What are your views of it?
d. How was it explained to you what the risk assessment process was, and how it would work?
e. How well did you understand these explanations? Was there anything you'd like to have understood better?
f. What effect has the risk assessment approach had for you?
g. Has use of the risk assessment approach helped or changed your care and treatment? In what ways?
h. Has the approach changed your relationship with staff? In what ways?
i. How can the risk assessment approach be improved in future?

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