Practice Development: Implementing DH Principles of Best Practice (2010/11)

Southern Health NHS Foundation Trust: These evaluations are a summary of 297 responses across ACP & Community Pathway interviews and 26 community team workshops

Rank order	Item [category]	Mean score
1.	We adopt a flexible approach that captures *changing levels of risk* [Practice & process]	3.822
2.	Decisions reflect the appropriate *types and level of intervention* (inc. crisis responses) [Risk decision-making]	3.718
3.	*Harm minimisation & positive risk-taking* are underpinned by practical risk assessment [Value base]	3.715
4.	*Reasoned* positive risk-taking decisions are developed confidently, where appropriate [Risk decision-making]	3.598
5.	A *structured clinical judgement* approach is used for consistent and individualised decisions [Risk decision-making]	3.394
6.	A collaborative approach to working with risk includes *service users/carers* wherever possible [Value base]	3.358
7.	Risk management plans are developed in multidisciplinary & multi-agency *team-working* [Practice & process]	3.289
8.	Risk management is based on a recognition of *strengths* and principles of *recovery* [Value base]	3.285
9.	We have a clear *process* for identifying and analysing risks, formulating plans & responses [Practice & process]	3.155
10.	We access mental health *legislation, research & literature* in relation to risk [Knowledge & training]	2.939
11.	We have good systems for *communicating* risk information to the relevant people [Practice & process]	2.921
12.	We use recognised *risk tools* to guide and capture practice [Practice & process]	2.706
13.	Relevant *risk training* needs of individual's & teams are met in flexible ways [Knowledge & training]	2.660
14.	Good practice is locally underpinned by a supportive *organisational strategy* [Risk decision-making]	2.295

Themes emerging:

- The scores represent a relatively narrow range of 3.82 - 2.29 with an overall mean of 3.21 (out of 5) suggesting that services are broadly 'working with risk' reasonably well but able to benefit from on-going reflection and practice development
- Three highest relative scores are for *adopting a flexible approach in response to risk* (3.82 out of 5), *flexibility in risk decision-making* (3.72) and *practical risk assessment* (3.71)
- *Use of risk tools* (2.71 out of 5), *flexible response to risk training needs* (2.66) and a *supportive organisation strategy* (2.29) occupy the three relative lowest ratings

Distribution of Ratings [269 responses across the 26 community teams March-July 2011; the ACP & Community group interviews had already been summarised in 2 previous reports]

Value base	1. Risk management is based on a recognition of *strengths* and principles of *recovery*	DISAGREE AGREE 1 **[02]** 2 **[60]** 3 **[69]** 4 **[116]** 5 **[22]** **1% 22% 26% 43% 8%**
	2. *Harm minimisation & positive risk-taking* are underpinned by practical risk assessment	DISAGREE AGREE 1 **[00]** 2 **[18]** 3 **[60]** 4 **[146]** 5 **[45]** **0% 7% 22% 54% 17%**
	3. A collaborative approach to working with risk includes *service users/carers* wherever possible	DISAGREE AGREE 1 **[04]** 2 **[55]** 3 **[83]** 4 **[93]** 5 **[34]** **1% 20% 31% 35% 13%**
Risk decision-making	4. A *structured clinical judgement* approach is used (for consistent and individualised decisions)	DISAGREE AGREE 1 **[04]** 2 **[33]** 3 **[87]** 4 **[122]** 5 **[21]** **1% 12% 33% 46% 8%**
	5. *Reasoned* positive risk-taking decisions are developed confidently, where appropriate	DISAGREE AGREE 1 **[02]** 2 **[18]** 3 **[80]** 4 **[130]** 5 **[39]** **1% 7% 30% 48% 14%**
	6. Decisions reflect the appropriate *types and level of intervention* (inc. crisis responses)	DISAGREE AGREE 1 **[03]** 2 **[15]** 3 **[70]** 4 **[132]** 5 **[46]** **1% 6% 26% 50% 17%**
	7. Good practice is locally underpinned by a supportive *organisational strategy*	DISAGREE AGREE 1 **[57]** 2 **[100]** 3 **[70]** 4 **[36]** 5 **[05]** **22% 37% 26% 13% 2%**
Practice & process	8. We have a clear *process* for identifying and analysing risks, formulating plans & responses	DISAGREE AGREE 1 **[10]** 2 **[56]** 3 **[83]** 4 **[94]** 5 **[25]** **4% 21% 31% 35% 9%**
	9. We adopt a flexible approach that captures *changing levels of risk*	DISAGREE AGREE 1 **[01]** 2 **[15]** 3 **[61]** 4 **[126]** 5 **[63]** **1% 6% 23% 47% 23%**
	10. We use recognised *risk tools* to guide and capture practice	DISAGREE AGREE 1 **[34]** 2 **[81]** 3 **[81]** 4 **[52]** 5 **[18]** **13% 30% 30% 20% 7%**
	11. Risk management plans are developed in multidisciplinary & multi-agency *team-working*	DISAGREE AGREE 1 **[10]** 2 **[52]** 3 **[85]** 4 **[87]** 5 **[34]** **4% 19% 32% 32% 13%**
	12. We have good systems for *communicating* risk information to the relevant people	DISAGREE AGREE 1 **[25]** 2 **[81]** 3 **[77]** 4 **[70]** 5 **[15]** **9% 30% 29% 26% 6%**
Knowledge & training	13. We access mental health *legislation, research & literature* in relation to risk	DISAGREE AGREE 1 **[21]** 2 **[74]** 3 **[95]** 4 **[68]** 5 **[09]** **8% 28% 36% 25% 3%**
	14. Relevant *risk training* needs of individual's & teams are met in flexible ways	DISAGREE AGREE 1 **[25]** 2 **[93]** 3 **[96]** 4 **[42]** 5 **[11]** **9% 35% 36% 16% 4%**

Item Ranking & Comments: The *validity of the evaluation tool* is partly reflected in the *consistency of the relative rankings of the items* across 28 different ACP/Community groups and teams. The following identifies these rankings (each rating is out of 14). The narrative comments are a very broad summary of complex information from 297 responses, with a **response/recommendation** for each item.

1.	Risk management is based on a recognition of *strengths* and principles of *recovery*	12th, 11th, 5th, 2nd, 6th, 6th, 5th, 3rd, 12th, 7th, 6th, 8th, 3rd, 12th, 11th, 3rd, 9th, 4th, 5th, 9th, 14th, 8th, 5th, 5th, 2nd, 6th, 9th, 2nd [**overall 8th**] • **10** out of 28 ratings are within two places of the overall rating • This item highlights more than just identifying people's strengths, in practice it should be about using a strengths approach to inform and construct risk management responses • Not currently systematically prompted so focus on this varies across different staff members • Some staff identified more with *recovery* than my focus on *strengths*, which linked in part with the variable local uptake of the WRAP initiative • ***Highlighted with a checklist in the Good Practice Guidelines to prompt greater consistency of implementing this principle across all staff in the Trust***
2.	*Harm minimisation & positive risk-taking* are underpinned by practical risk assessment	5th, 5th, 1st, 4th, 1st, 1st, 1st, 1st, 3rd, 1st, 3rd, 2nd, 6th, 3rd, 2nd, 2nd, 3rd, 1st, 4th, 3rd, 4th, 5th, 1st, 4th, 2nd, 2nd, 4th, 6th [**overall 3rd**] • **26** out of 28 ratings are within two places of the overall rating • Most staff confident about doing risk assessment in practice, as opposed to form-filling • All staff recognise the realistic focus is on *minimisation* not elimination of risk • Most staff are able to highlight the importance of being able to access detailed qualitative information, but also recognising the barriers to access in practice • ***Supported through recognition of main components in the Good Practice Guidelines***
3.	A collaborative approach to working with risk includes *service users/carers*	10th, 8th, 5th, 5th, 10th, 6th, 8th, 2nd, 6th, 13th, 7th, 8th, 2nd, 9th, 5th, 10th, 6th, 7th, 6th, 1st, 12th, 10th, 8th, 9th, 11th, 5th, 1st, 1st [**overall 6th**] • **13** out of 28 ratings are within two places of the overall rating

	wherever possible	• Staff reflections lacked clarity of focus with an occasional narrow focus on sharing forms as the means by which collaboration occurs • More attention needs to be given to eliciting the service user's understanding and experience of risk, not just their view on staff members assessments • Where available, carers support staff were highlighted as a valuable resource; however, is this at the cost of all staff taking greater responsibility for working with carers? • ***An area that needs further practice development attention generally***
4.	A *structured clinical judgement* approach is used (for consistent and individualised decisions)	6th, 5th, 9th, 8th, 4th, 9th, 5th, 4th, 9th, 7th, 5th, 7th, 4th, 4th, 1st, 6th, 7th, 6th, 8th, 3rd, 4th, 5th, 3rd, 6th, 5th, 2nd, 4th, 11th [**overall 5th**] • **<u>20</u>** out of 28 ratings are within two places of the overall rating • The different components of the *approach* to risk assessment were not usually articulated clearly by staff, with inconsistent knowledge of the narrow evidence base • Consistent understanding of use/misuse of historical information and context; with most staff giving maximum weighting to this component of the overall risk assessment • ***Components are outlined, and include specific recognition of structure and role of intuition, in Good Practice Guidelines***
5.	*Reasoned* positive risk-taking decisions are developed confidently, where appropriate	4th, 4th, 2nd, 5th, 4th, 4th, 2nd, 8th, 3rd, 4th, 1st, 1st, 8th, 6th, 6th, 6th, 2nd, 4th, 3rd, 6th, 3rd, 3rd, 5th, 3rd, 7th, 6th, 1st, 5th [**overall 4th**] • **<u>22</u>** out of 28 ratings are within two places of the overall rating • The concept is generally understood (with some of the usual confusion in use of language), but it is not supported by any identifiable systematic approaches to it • Good examples of *positive risk-taking* in practice were identified across all teams, but the language used to describe what people were doing in their practice lacked consistency

		• More emphasis is needed by everyone to briefly document the information that was available on which the decision was based, and the clear reasons for the decision • ***Supported through detailed <u>definition</u> and what is needed to support it (inc. checklist) in Good Practice Guidelines***
6.	Decisions reflect the appropriate *types and level of intervention* (inc. crisis responses)	1st, 2nd, 4th, 3rd, 8th, 3rd, 3rd, 5th, 2nd, 5th, 3rd, 5th, 8th, 2nd, 2nd, 4th, 5th, 3rd, 2nd, 3rd, 1st, 4th, 2nd, 1st, 2nd, 1st, 3rd, 2nd [**overall 2nd**] • **<u>22</u>** out of 28 ratings are within two places of the overall rating • Good recognition of need to respond flexibly to dynamic changes in risk, but not easily documented each time • Greater confidence was generally attributed to decisions made within teams as opposed to those made across or between teams • More emphasis is needed by everyone to briefly document the information that was available on which the decision was based, and the clear reasons for the decision • ***Supported by recognition of the <u>types of decisions and influences on risk decision-making</u> in Good Practice Guidelines***
7.	Good practice is locally underpinned by a supportive *organisational strategy*	14th, 13th, 14th, 11th, 14th, 14th, 14th, 14th, 14th, 14th, 14th, 14th, 14th, 14th, 14th, 14th, 13th, 14th, 13th, 14th, 10th, 12th, 13th, 12th, 14th, 10th, 10th, 13th [**overall 14th**] • **<u>24</u>** out of 28 ratings are within two places of the overall rating • Generally seen as risk averse with inconsistent understanding and support for the realities of what staff are working with • CIR's are more often experienced as a critical approach to what was not done, rather than a balanced reflection of the evidence • A number of staff expressed the view that the Trust are too quick to instigate a CIR in instances where it was not needed • A number of views were expressed that the amount of time put into CIR's was not reflected in the quality of feedback coming to staff

		• ***Priority for practice development reflection by within the Practice Based Evidence initiative with management representatives***
8.	I/we have a clear *process* for identifying and analysing risks, formulating plans & responses	3rd, 9th, 8th, 8th, 9th, 6th, 5th, 11th, 7th, 7th, 8th, 6th, 4th, 7th, 8th, 6th, 4th, 8th, 9th, 6th, 12th, 8th, 9th, 6th, 5th, 9th, 10th, 14th [**overall 9th**] • **16** out of 28 ratings are within two places of the overall rating • Staff frequently identified a *process* within their team, but not a clear one • Lack of consistency about the *process* and adaptation of *formulation* in practice; with an over-reliance on Psychology staff to facilitate detailed reflection • Weekly MDT meetings were seen as the main place for this to happen, but it was also believed to be hampered by time constraints &/or dominant personalities in some instances • ***Highlighting an emphasis on making sense of complex risk information in Good Practice Guidelines***
9.	I/we adopt a flexible approach that captures *changing levels of risk*	2nd, 1st, 5th, 1st, 3rd, 1st, 3rd, 6th, 1st, 2nd, 2nd, 2nd, 1st, 1st, 2nd, 1st, 1st, 2nd, 1st, 2nd, 2nd, 1st, 7th, 1st, 1st, 2nd, 10th, 9th [**overall 1st**] • **23** out of 28 ratings are within two places of the overall rating • Most teams express confidence in their priority for responding to identified risks and changing risks (e.g. crisis responses) • Most staff are able to identify degrees of flexibility amongst their team colleagues to offer support and advice • Some staff identified a relative slowness to adapt to the more nuanced changes in an individual's risk profile • ***Supported by recognition of the types of decisions and influences on risk decision-making in Good Practice Guidelines***
10.	I/we use recognised *risk tools* to guide and capture practice	8th, 14th, 11th, 14th, 11th, 13th, 11th, 6th, 7th, 11th, 12th, 10th, 11th, 7th, 11th, 12th, 10th, 12th, 12th, 11th, 9th, 13th, 14th, 13th, 12th, 11th, 4th, 6th [**overall 12th**] • **21** out of 28 ratings are within two places of the overall rating • The emphasis placed on introducing and implementing RiO means very few staff can think beyond RiO, and many are

		currently of the view that it is less useful than what they have recently had to give up using • RiO is widely recognised as the tool that must be used to capture the documenting of risk information, but it was less widely understood that other recognised tools can be used to prompt and shape the process of information gathering and analysis • A consistent reflection from staff is that RiO has narrowed the focus onto poor tick-box approaches… the problem is reinforced by the messages about audit • ***Highlighting the priority for <u>using the narrative free-text summary</u> as a means to structure and capture good practice, with <u>tick-boxes as a secondary task</u>… needs to be discussed and thought through with Trust management in relation to audit priorities***
11.	Risk management plans are developed in multidisciplinary & multi-agency *team-working*	11th, 3rd, 2nd, 13th, 1st, 9th, 9th, 10th, 9th, 5th, 8th, 2nd, 6th, 10th, 7th, 5th, 8th, 8th, 6th, 11th, 4th, 1st, 3rd, 8th, 7th, 8th, 4th, 11th [**overall 7th**] • **<u>14</u>** out of 28 ratings are within two places of the overall rating • Staff generally more positive about MDT working than multi-agency working • MDT meetings are widely used, but inconsistent quality is reported • Some staff expressed that time constraints meant that only the complex risky cases benefitted from proper MDT review; individual care coordinators are left to work alone in the majority of cases • ***Attention drawn to some relationships within Good Practice Guidelines, but remains an area that requires constant attention within and between teams***
12.	I/we have good systems for *communicating* risk information to the relevant people	7th, 9th, 11th, 12th, 11th, 4th, 13th, 8th, 9th, 2nd, 10th, 13th, 12th, 4th, 9th, 11th, 14th, 11th, 10th, 8th, 8th, 5th, 9th, 10th, 9th, 14th, 14th, 2nd [**overall 11th**] • **<u>16</u>** out of 28 ratings are within two places of the overall rating • Focus of attention is more on RiO (driven by fear of audit) but only Trust services are on RiO • Many staff reported that RiO offered accessibility for those able to use it, but

		the quality of overall communication has become more complex due to many relevant people not having access to RiO • Some staff were identifying the inappropriate use of RiO for conducting inter-personal or inter-team conflicts through the tone of some recording • 'Just look on RiO' should not be a substitute for good verbal communication of details • ***Identified as an area for continuing attention within <u>components</u> in Good Practice Guidelines***
13.	I/we access mental health *legislation, research & literature* in relation to risk	8th, 7th, 13th, 5th, 6th, 12th, 9th, 11th, 3rd, 10th, 10th, 12th, 10th, 11th, 10th, 9th, 10th, 10th, 13th, 9th, 4th, 11th, 11th, 11th, 9th, 11th, 4th, 9th [**overall 10th**] • **<u>20</u>** out of 28 ratings are within two places of the overall rating • Generally focused on use of AMHP's knowledge within teams, little attention to literature and research • Interest was often described as extinguished by time constraints and work priorities • ***Emphasis should remain more on legislation used in everyday practice, but teams could think about who within their ranks could act as the wider resource***
14.	Relevant *risk training* needs of individual's & teams are met in flexible ways	13th, 12th, 9th, 8th, 13th, 11th, 12th, 13th, 12th, 11th, 12th, 11th, 12th, 13th, 11th, 13th, 12th, 13th, 11th, 11th, 10th, 13th, 12th, 14th, 13th, 11th, 13th, 6th [**overall 13th**] • **<u>24</u>** out of 28 ratings are within two places of the overall rating • Too focused on a one-size-fits-all Trust training which is too general for specific needs of each team • The *Practice Based Evidence* approach of this initiative was widely reported to be supportive and relevant, but too rarely experienced • ***Practice Based Evidence initiative priority to propose a <u>revised risk training strategy</u> for a more flexible approach at Trust level alongside an individual/team responsibility for personal learning***