# Board of Directors - Public

| SUMMARY REPORT | Meeting Date: | 27 September 2023 |
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| | Agenda Item: | 18 |

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| **Report Title:** | **Use of Force Annual report** | |
| **Author(s):** | Lorena Cain, Nurse Consultant Restrictive Practices<br>Kelly McKernan, Head of Nursing, Acute and Community Directorate<br>Salli Midgley, Executive Director of Nursing, Professions and Quality | |
| **Accountable Director:** | Salli Midgley, Executive Director of Nursing, Professions and Quality | |
| **Other meetings this paper has been presented to or previously agreed at:** | **Committee/Tier 2 Group/Tier 3 Group** | Mental Health Legislation Committee |
| | **Date:** | 20.9.23 |
| **Key points/ recommendations from those meetings** | | |

**Summary of key points in report**


This is the 2nd annual report for the Use of Force in Sheffield Health and Social Care Trust and summarises our unrelenting commitment and focus to reducing the use of restrictions and use of force across our services.

SHSC has met the requirements for the Use of Force Act (2018) and worked in coproduction to achieve this.

Three wards have now ceased the use of seclusion; we know that the psychological impact of being in seclusion is significant and causes a further deterioration of mental health, this is why we have focused on reducing our seclusion room estate. We can also demonstrate that whilst reducing seclusion our use of other restrictions has not increased, in fact there is evidence to suggest moving into year three that our use of physical restraint has in fact reduced.

During the year we invited an external independent review to support our plans, Dr Brodie Paterson worked with the team on Burbage to deliver a suite of recommendations to further develop the ward team. These recommendations have been taken forward by the team and have seen positive improvements particularly with the use of Broset prediction tool in daily huddles.

Our focus on the inequalities particularly for black men in our inpatient wards has continued and our partnership with SACMHA (Sheffield African Caribbean Mental Health Association) has grown, their race equity officer has worked with ward teams to reduce the restrictions placed on black men and women as well as working to improve cultural competency and improve connections with communities.

In addition to this work, SHSC focussed on the ongoing work with the Pakistani Muslim Centre who were delivering the EPIC (Enhancing pathways into care) Project, during the latter part of year two we agreed to further invest in the programme and relaunch as a cultural advocacy programme, promoting the rights and cultural needs of all communities who are supported on our wards. This also improves access to external

agencies and reduces potential for closed cultures to develop, a key factor in the Edenfield expose in 2022/23.

Our partnership with the Restraint Reduction Network has produced resources on Psychological Restraint which were launched in early 2023. This work will be embedded in our RESPECT training and has been shared nationally, demonstrating our commitment to grow and learn within the sector. Central to this is our ongoing employment of a Human Rights Officer, the only role permanently employed in an NHS organisation. Our position in relation to surveillance remains that we do not use patient vision systems in our wards, nor do we utilise body worn cameras. Observations and engagements are undertaken by members of the multi-disciplinary team, predominantly nursing colleagues.

Training continues to be an area for improvement following the realignment of the training programme however assurance is noted in relation to the management of staffing to assure RESPECT trained staff on duty.

The report also confirms our consistent submission to the Mental Health Service Data Set, which is a key contractual requirement for NHSE and our data is available through the NHS Digital portal for external scrutiny and benchmarking.

**Recommendation for the Board/Committee to consider:**

| **Consider for Action** | | **Approval** | **X** | **Assurance** | **X** | **Information** | |
|---|---|---|---|---|---|---|---|

Board is asked to receive this annual report as assurance that we have met the legal duties with respect to the implementation and embedding of the Use of Force as outlined in the Act (2018).

Board is also asked to be assured through this review of the years progress that we have delivered on year 2 of our Least Restrictive Practice Strategy and have plans in place to deliver for our final year.

**Board are asked to approve the report for publication on the website aligned to the Use of Force requirements.**

| **Please identify which strategic priorities will be impacted by this report:** | | | | |
|---|---|---|---|---|
| Recover services and improve efficiency | *Yes* | ***X*** | *No* | |
| Continuous quality improvement | *Yes* | ***X*** | *No* | |
| Transformation – Changing things that will make a difference | *Yes* | ***X*** | *No* | |
| Partnerships – working together to make a bigger impact | *Yes* | ***X*** | *No* | |

| **Is this report relevant to compliance with any key standards ?** | | | | | **State specific standard** |
|---|---|---|---|---|---|
| **Care Quality Commission Fundamental Standards** | *Yes* | ***X*** | *No* | | |
| **Data Security and Protection Toolkit** | *Yes* | ***X*** | *No* | | |
| **Any other specific standard?** | | ***X*** | | | ***Use of Force (2018)***<br>***NHSE standard Contract***<br>***Health and Social Care Act*** |

| **Have these areas been considered ? YES/NO** | | | | | If Yes, what are the implications or the impact?<br>If no, please explain why |
|---|---|---|---|---|---|
| Service User and Carer Safety, Engagement and Experience | *Yes* | ***X*** | *No* | | ***Involvement and learning with people who use services, their families, carers and significant others is implicit in the use of restrictive practices*** |
| Financial (revenue &capital) | *Yes* | ***x*** | *No* | | ***Claims and litigation potential can be linked to inappropriate use of force and the trauma caused.*** |

| | | | | | |
|---|---|---|---|---|---|
| Organisational Development /Workforce | *Yes* | ***X*** | *No* | | ***Training and development for clinical colleagues is critical to support the least restrictive approach to working with people in distress*** |
| Equality, Diversity & Inclusion | *Yes* | ***X*** | *No* | | ***Work is underway to understand the impact across the EDI agenda of the various investigations/enquiries and concerns. This will be represented in future EDI dashboards.*** |
| Legal | *Yes* | ***X*** | *No* | | ***As noted above, inappropriate use of force can be challenged under the Act and also under Human Rights legislation (Article 3)*** |
| Environmental sustainability | *Yes* | | *No* | ***X*** | ***There is limited impact on environmental sustainability related to Use of Force and the reporting in this paper*** |

Sheffield Health and Social Care
NHS Foundation Trust

# Least Restrictive Practice/Use of Force Annual Report

## April 2022 – March 2023

## Safe and Positive Care – connecting with people to make a difference/working together to support safe and positive care and reduce restrictive practice

Authors: Kelly McKernan, Head of Nursing, Lorena Cain, Nurse Consultant for Restrictive Practice; Salli Midgley, Director of Nursing, Professions and Quality and Responsible Person for Use of Force; Henry Harrison Strategy and Quality Performance Manager, Quality Directorate.

# Contents

## Executive Summary from the Responsible Person for the Use of Force

Welcome to our second annual report. 2022 – 2023 has been another busy year for Sheffield Health and Social Care Trust, our focus has been unrelenting on delivering reductions in the use of restrictions and use of force within our services and improving the outcomes and impacts of our care across racialised communities.

We are incredibly proud of our clinical teams and their achievements this year, Dovedale 2 has continued to work without a seclusion room which was removed in 2021/22 and during 22/23 Burbage ward and G1 ward also removed their seclusion rooms from use. We know that the psychological impact of being in seclusion is significant and causes a further deterioration of mental health, this is why we have focused on reducing our seclusion room estate from 6 rooms to 3.

During the year we invited an external independent review to support our plans, Dr Brodie Paterson worked with the team on Burbage to deliver a suite of recommendations to further develop the ward team. I am delighted that the team have been taking these recommendations forward and have seen positive improvements particularly with the use of Broset prediction tool in their daily huddles.

Our focus on the inequalities particularly for black men in our inpatient wards has continued and our partnership with SACMHA (Sheffield African Caribbean Mental Health Association) has grown, their race equity officer has worked with ward teams to reduce the restrictions placed on black men and women as well as working to improve cultural competency and improve connections with communities.

In addition to this work, SHSC focussed on the ongoing work with the Pakistani Muslim Centre who were delivering the EPIC (Enhancing pathways into care) Project, during the latter part of year two we agreed to further invest in the programme and relaunch as a cultural advocacy programme, promoting the rights and cultural needs of all communities who are supported on our wards. This also improves access to external agencies and reduces potential for closed cultures to develop, a key factor in the Edenfield expose in 2022/23.

Our partnership with the Restraint Reduction Network has produced resources on Psychological Restraint which were launched in early 2023. This work will be embedded in our RESPECT training and has been shared nationally, demonstrating our commitment to grow and learn within the sector. Central to this is our ongoing employment of a Human Rights Officer, the only role permanently employed in an NHS organisation. Our position in relation to surveillance remains that we do not use patient vision systems in our wards, nor do we utilise body worn cameras. Observations and engagements are undertaken by members of the multi-disciplinary team, predominantly nursing colleagues.

I am delighted to confirm that we continue to meet the requirements of the Use of Force Act and regularly monitor these alongside patient experience.

**Salli Midgley, Director of Nursing, Quality and Professions. 2023.**

## 1.0 Introduction and Background – The Use of Force

Our first annual report covered June 2021 – June 2022. To align future reports with annual reporting, this report will repeat some of that period, April 2022 – June 2022 so that the full reporting period is covered, and this will remain consistent for all future reports.

The report sets out the key objectives identified and achieved for Year Two (April 2022 – March 2023), along with the aims of the Trust in line with statutory requirements and our commitments as detailed in the Clinical and Social Care Strategy to be a least restrictive, safe and positive, human rights respecting and trauma informed organisation.

*We made a commitment to ensure our care is the least restrictive, the most positive and takes account of human rights, choice and engagement, and collaboration. We inspire to reduce our restrictive practices to the least amount, and where we do use them ensure they are safe and positive, are done in collaboration with service users and their families/carers and are supported by best practice, a clinical model and sit within the framework of trauma informed care and human rights* (LRP Strategy June 2021)

Production of the strategy included links to the Clinical and Social Care Strategy, the People Strategy, the Quality Objectives (SHSC) and the CQC recommendations from the Out of Sight report (October 2020). The Use of Force Act (2018) and subsequent statutory guidance (Dec 2021) has driven forward this necessary and exciting workplan.

We aim to achieve these responsibilities through:

- Providing effective, robust policies and procedures that reflect best practice.
- Delivery of training that meets the needs of staff and fulfils the requirements of the national and statutory guidance.
- Providing expert advice and support to all staff.
- Providing ongoing data and assurance of compliance to the Trust Quality Assurance Committee.
- Ensuring we are compliant with the Use of Force Act requirements and the CQC Out of Sight report recommendations.
- Use of reflective practice, supportive challenge and support to help our staff identify and use alternatives to Use of Force and prevent it occurring at all.
- Developing accessible information for service users and those that support them.

We are reporting against the following service lines in this annual report

- Acute and PICU wards (Michael Carlisle and Longley Centre)
- Rehabilitation wards (Forest Close)
- Low Secure wards (Forest Lodge)
- Older People Mental Health Wards (Michael Carlise and Grenoside)

Care homes are excluded from Use of Force legislation. Information on Care homes is reported into Least Restrictive Practice Oversight Group on any use of physical restraint. Seclusion, segregation and rapid tranquillisation are not utilised in the care homes.

### 1.1 The team

The Least Restrictive practice strategy and Use of Force plan is directly supported by the Director of Nursing/Responsible Person for Use of Force, the Head of Nursing for Acute Inpatients and Older Adult Services, the Nurse Consultant for Restrictive Practice and the RESPECT team who provide training and support to clinical teams aligned to the requirements in the Use of Force Act. The RESPECT team comprises 1 Professional Lead, 1 Assistant Professional Lead, 4 RESPECT Trainer Practitioners and 1 Expert by Experience.

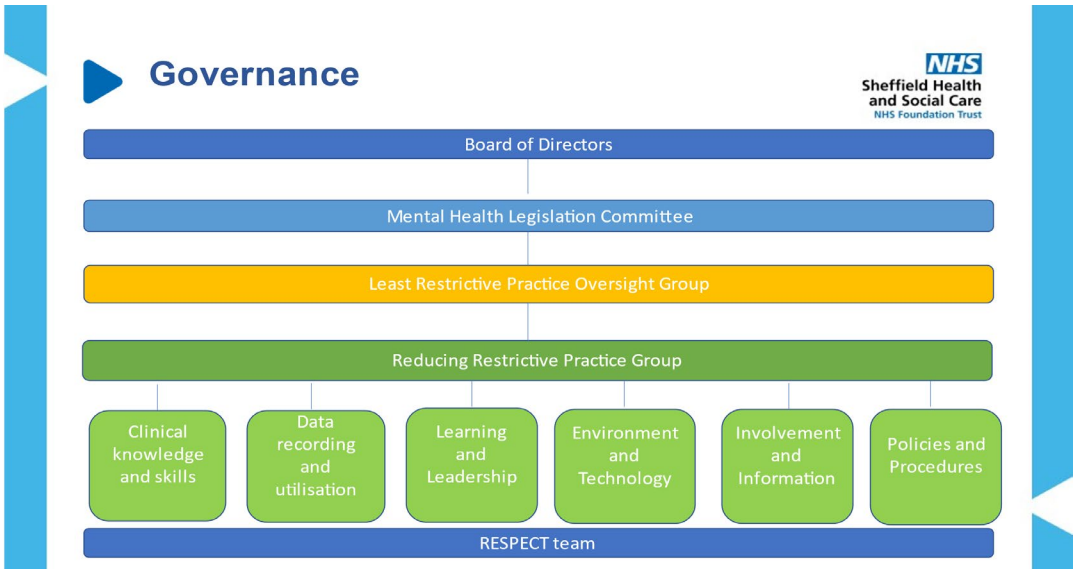
Delivering the strategy has also been supported by our Business and Performance Manager, who has assisted in developing the dashboards to monitor use of restrictions and the Project Management Office (PMO) in developing the workplan tracker, deadlines and action owners. In Year Two the Quality Improvement team also supported.

The work of SHSC is to ensure support at team level for implementing the strategy, reducing restrictive practice, delivering the required training, supporting quality and performance via use of data, audits and reviews and planning improvements supported by the improvement plan, with the overall aim to ensure we meet the statutory and legal requirements of the Use of Force Act.

The broader implementation engages all our staff working into clinical teams and beyond as well as many people with lived experience in supporting our coproduction work.

### 1.2 Governance and reporting

#### 1.2.1 Internal Governance and Assurance




The Nurse Consultant for Restrictive Practice attends the Directorate Integrated Performance and Quality Reviews (IPQR) to support the conversation and any subsequent action related to the Restrictive Practice/Use of Force data and workplan.

A monthly operational group of ward staff, service users and anyone interested in the Restrictive Practice agenda to operationalise and implement the strategy workplan and use data to inform further improvement actions.

The Least Restrictive Practice Oversight Group (LRPOG) oversees and assures the improvement plan supported by PMO. Reports are produced quarterly for the LRPOG and are submitted to Mental Health Legislation Committee for further assurance and approval.

*LRPOG meeting dates and quarterly report submissions*
May 2022 – Quarter Four
August 2022 – Quarter One
November 2022 – Quarter Two
February 2023 – Quarter Three
May 2024 – Quarter Four

In addition to this a number of other meetings have been established to ensure that the conversations take place at a team level and cascade up. Wards are provided with monthly data in regards to their use of restrictive practice at their monthly ward governance meeting, which is attended by members of the ward MDT and leadership, members of the acute leadership team and directorate leadership team also attend on a ad-hoc basis. This meeting allows for very specific ward/patient focussed discussions.

### 1.3 Co-production – How we have worked with Service users, carers, partners and staff

Co-production has been at the heart of the strategy, working alongside service users, staff, teams and partners to truly represent the needs and strengths of all the groups and individuals, diversity and characteristics.

During Year two experts by experience have worked alongside us as we have developed and delivered sessions of awareness raising, training and local projects.

We have continued to work on building connections and work with Sheffield Voices, Disability Sheffield, Advocacy, Sheffield Flourish, SACMHA and the Pakistani Muslim Centre throughout Year two and we are now delivering regular advocacy support to our inpatient teams for those from an ethnic diverse background, have provided easy read leaflets on the Use of Force, SafeWards and Search as well as other pieces of work in response to our findings and the feedback we receive.

We continue to seek contributions into our training packages mainly that of the RESPECT training and rapid tranquilisation training. People with lived experience have shared their stories of these areas of restrictive practice informing care planning, staff approach and considerations on how we might improve.

There is an already established network of collaboration with the Restraint Reduction Network and Navigo who support our developments and implementation plan. We have established a working relationship with both statutory and non-statutory advocacy to ensure that it is integrated into our working practices and peoples' rights are considered and upheld. Supportive of this is the quarterly advocacy meet where sharing and learning takes

place, and the service user voice is heard via the advocates. Year 3 will continue to see the contract service from Pakistani Muslim centre and SACMHA delivered, and evaluations of feedback shared.

*"Attending the restrictive practice round table was very insightful. first pleasant surprise was just how much work is being put into taking the least restrictive route, and how mindful everyone is that men from minoritized ethnic communities are overrepresented" (peer worker SACMHA)*

The service user voice is at the heart of the training package related to psychological restraint developed during Year 2 into Year 3 and this will be rolled out later in 2023.

## 2.0 Legislation

### 2.1 Requirements and delivery of The Use of Force Act (2018)

The Use of Force Act started as a campaign to bring about Senis Law.
Seni's Law is named after Olaseni Lewis, a black man from Croydon in London who died aged 23 whilst being restrained by 11 police officers while in a mental health hospital.

The Trust holds a statutory responsibility under the Use of Force Act (2018) and accompanying statutory guidance on The Mental Health Units Use of Force (December 2021)

The aim of the Mental Health Units (Use of Force) Act 2018 and the statutory guidance is to clearly set out the measures which are needed to both reduce the use of force and ensure accountability and transparency about the use of force in our mental health units. This must be in all parts of the organisation, from Executive Boards to staff directly involved in patient care and treatment.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Use of force

What do we mean by use of force?

Use of force is the term used to describe techniques staff use that include some sort of force, such as restraint, seclusion and rapid tranquilisation.

We have a leaflet available that explains what the use of force is and your rights if any force is used by a member of staff. We also have a policy which outlines our approach in more detail.

This information will help you to understand what might happen to you while you are on the ward what your rights are and what help and support is available to you.

Get in touch

If you have any questions about the use of force on our ward please speak to the Ward Manager, Consultant or members of the nursing team. You can also ask to speak to the Nurse Consultant for Restrictive Practice.

**Implementation, delivery and assurance of the Use of Force Requirements**

Meeting our statutory requirements as set out by the Use of Force Act was a priority for Year One and these were all completed or in progress. The exception being our Older Adult dementia ward (G1) related to the Use of Force and personal care. During Year two this was addressed by team-based sessions and the development of a local procedure for reporting and recording restraint. This has been identified as a national area of concern and we have supported other organisations by sharing our work. The development of a SOP commenced in Year two and subsequently has been approved. The work required is considering how we may effectively and efficiently use the current incident reporting system (Ulysses), to meet the requirements of the Act. Work has also commenced with the lead for

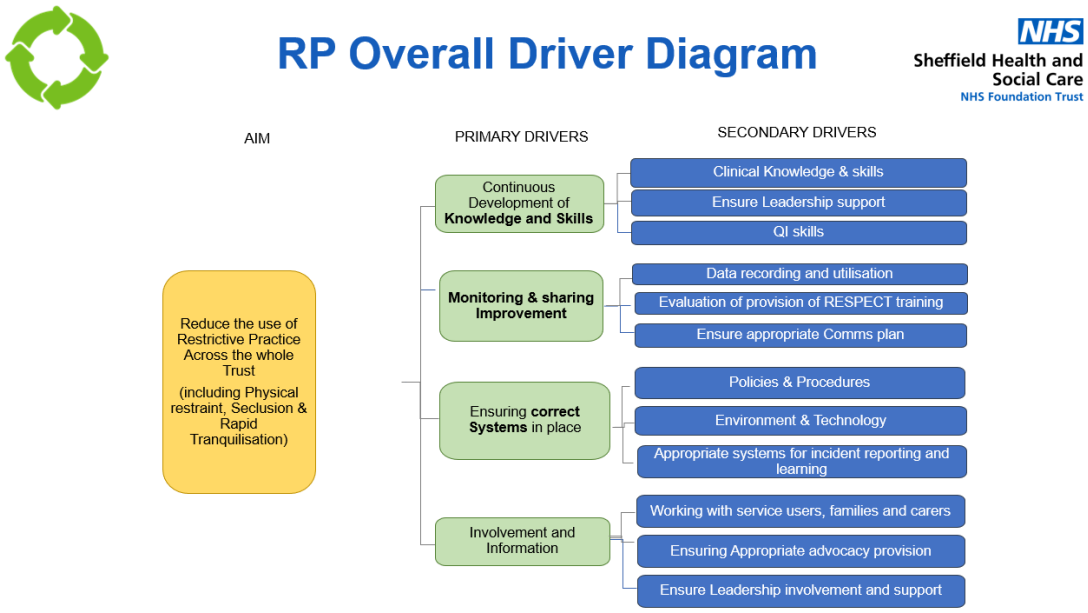
the new Electronic Patient Record (Rio) which is anticipated to be implemented during October/November 2023.

| Use of Force Requirements | |
|---|---|
| 1. Service providers operating a mental health unit to appoint a 'responsible person' who will be accountable for ensuring the requirements in the Act are carried out | Achieved in Year one<br>Remains compliant in Year two |
| 2. The responsible person for each mental health unit must publish a policy regarding the use of force by staff who work in that unit. The written policy will set out the steps that the unit is taking to reduce (and minimise) the use of force by staff who work in the unit. | Achieved in Year one<br>Remains compliant in Year two<br>Review date is April 2024 |
| 3. The responsible person for each mental health unit must publish information for patients about their rights in relation to the use of force by staff who work in that unit. | In progress in Year one<br>Full implementation achieved in Year 2<br>Booklet and poster produced led by service users and staff and delivered to ward teams.<br>Recording documentation developed and integrated into EPR.<br>Used within training.<br>Further work underway related to translations and digital versions |
| 4. The responsible person for each mental health unit must ensure staff receive appropriate training in the use of force | Achieved in Year one<br>Remains compliant in Year two following review of RESPECT training programme and additional sessions provided.<br>Further training has been developed and delivered related to care planning, human rights, SafeWards and Use of Force. |
| 5. The responsible person for each mental health unit must keep records of any use of force on a patient by staff who work in that unit, which includes demographic data across protected equality characteristics | Achieved in Year one with identified issues related to ethnicity.<br>Progressed in Year two with more comprehensive data sets, data reports with breakdown of protected characteristics and an improvement plan to address unknown ethnicity recording.<br>Continued compliance with submission to Mental Health Dataset V5 |
| 6. If a patient dies or suffers serious injury in a mental health unit, the responsible person must have regard to any relevant guidance relating to investigations of deaths or serious injuries | Policy and procedure in place in Year one<br>Compliance continues in Year two with evidence of further investigations and learning.<br>Actions have identified changes to policy or development of training or support packages |
| 7. If a police officer is going into a mental health unit on duty to assist staff who work in that unit, the police officer must always wear and operate a body camera when reasonably practicable. | All use of police is incident reported and shared as necessary with our police liaison. |

## 2.2 Our Strategy and Quality Objective

Our three-year strategy can be found here: Least Restrictive Practice Strategy

We have worked with our colleagues in Quality Improvement to support us in implementing and achieving our aim of reducing the use of restrictive practice across the whole Trust. From this we have developed a driver diagram, illustrated below, to inform our process and approach. This drives our workplan.




### 2.2.1 Year Two delivery and assurance

There are 6 workstreams aligned to deliver the strategy:

- Clinical Knowledge and Skills
- Data Recording and Utilisation
- Learning and Leadership
- Environment and Technology
- Involvement and Information
- Policies and Procedures

(Full details of the workstreams are provided in Appendix 2)
This gives structure and focus to the improvements required for each year. This has been enabled by linking the strategy to other strategic work across the Trust such as the People Strategy, the Health and Safety Strategy and the Clinical and Social Care Strategy as the overall driver. Delivery has been by the support of people to lead on workstreams and task and finish groups that support co-production and outcomes.

A review process took place during December 2022 bringing together people with lived experience and staff across internal and external services to review Year one and look

forward to Year two and three. This process enabled sharing and learning, closure of achieved actions and refresh of the long-term action plan. This was concluded at the end of Year two and approved.

Bringing together SHSC's 3 year Quality Objectives to form part of the strategy workplan has enabled shared information and reporting and supports assurance via the required governance groups.

**Quality objective one priorities for 2022/2023 were:**

• Achieve a consistent reduction in the use of seclusion and physical restraint across our inpatient services, this may be demonstrated by the number of incidents and include a reduction in the length of the use of seclusion or restraint
• Roll-out of the revised Respect training programme, which will include the introduction of a second day update covering activity, carers, care planning and race inequalities (activity was changed to search training)
• Embedding SafeWards (a model with 10 interventions designed to improve the safety of patients in inpatient settings) and demonstrating the impact of this through evaluation and measurement
• Work as an early adopter with NHS England to develop our patient and carer race equity framework with a focus on the use of restrictions across patients from ethnically diverse backgrounds
• Co-produce and co-deliver human rights training, in collaboration with Sheffield African Caribbean Mental Health Association (SACMHA) and Sheffield Flourish.

**How have we done?**

- We have achieved an overall reduction in seclusion and physical restraint. It is not 'consistent' in regards that the number of incidents does fluctuate month on month, however the overall trajectory is a downward trend. This is supported by us having removed seclusion facilities from 2 wards during Year Two, with a further (temporary) removal in Year Three. We report that this is not across all ethnicity groups.

- The RESPECT training was revised and the roll-out of different components has taken place throughout the year. A further new revised package will be delivered in Year three

- SafeWards is still being established across the wards, with a regular SafeWards forum to support this and a peer evaluation planned for Year Three.

- We are working with NHS England to be an early adopter of Patient Carer Race Equity Framework (PCREF) and we continue to strengthen our partnerships with FLOURISH and SACHMA to improve inclusivity and co-production. As part of this we developed a contract with both SACMHA and Pakistani Muslim centre and appointed to a Race equity community lead.

The 4 areas we committed to focusing on all have established initiatives or QI projects and this work will continue into Year Three.

**For Year Two the Least Restrictive Practice strategy focussed on:**

1. Restrictive Practice reporting for personal care
2. Post Incident reviews
3. Physical health monitoring following restrictive practice
4. Care-planning and involvement of service users and their families

**Overall, our key successes across the strategy and quality objectives:**

- Development of RESPECT training to include Race equity, care-planning, search with Expert by Experience involvement. Consistent and sustained positive feedback and indication of benefits from evaluation.
- Partnership working with Flourish, SACMHA, Sheffield voices, Advocacy and Disability Sheffield
- Sustained RP oversight and operational groups
- Additional resource into RESPECT team and identified leadership.
- System of review and support to teams and individuals via the daily incident huddle
- Information for service users and those that support them – safety pod, Use of force, safe wards, search all developed with service users.
- Introduction of Human Rights officer and training and development plan
- Introduction of Race Equity worker and PCREF
- Introduction of Engagement and Experience officers
- De-escalation space improvements
- Sensory assessment and action plan to address recommendations.
- Post incident support and review project
- Continued safe wards project and monthly forum.
- Audits and quality improvement projects
- Development of standard operating procedures to support practice and policy implementation and local training sessions to support this.
- Local training and support
- Removal of seclusion from an acute ward and dementia ward with no increase in restrictive practice
- Commissioning and receipt of resources with the Restraint Reduction Network to highlight the impact of psychological restraint

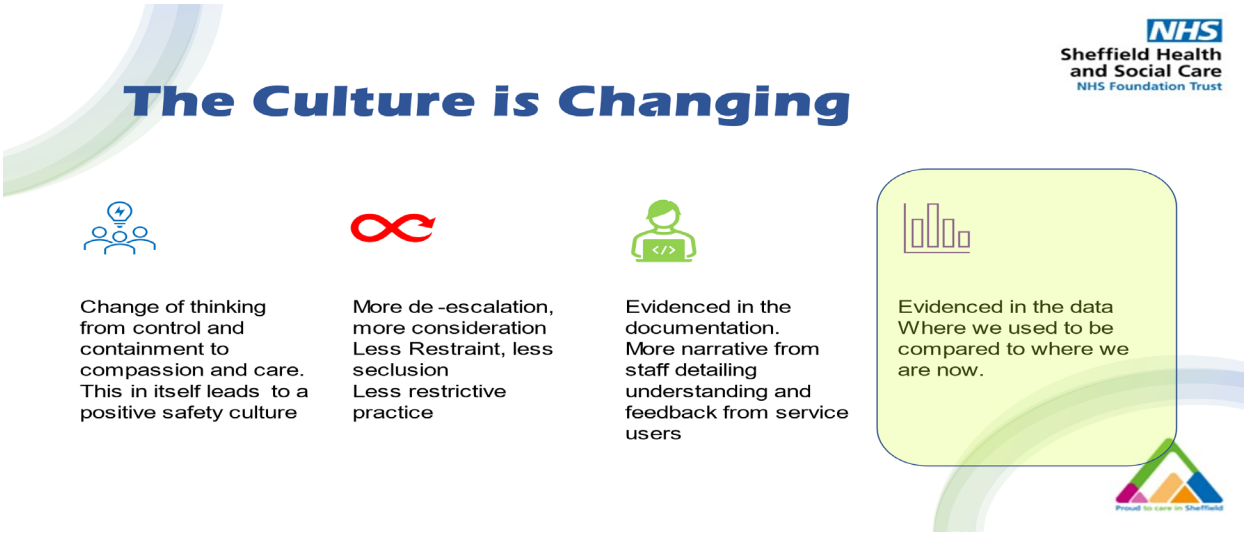
**Key improvements**

The most significant success during year 2 has been removing seclusion from the dementia ward and from Burbage Ward, introducing the Broset tool to risk assess the risk of violence and establishing an Urgent PICU Pathway to support this work.

There has been a reduction in restrictive practices, most notably rapid tranquilisation and seclusion and we are improving the quality of data we record around restrictive practices to further our understanding and develop meaningful action plans to address issues or areas of concern.

Whilst reducing any restrictive practice is a positive, there is also an acknowledgement that rapid tranquilisation does offer treatment as well as risk management and would in most circumstances be considered preferable to seclusion and/or physical restraint which offer only risk management and containment. Therefore, we need to further explore the reduction in rapid tranquilisation to be assured that this is appropriate and related to alternative proactive measures such as de-escalation and oral medication being utilised effectively.

As we conclude Year Two of our Three-year strategy, we believe we can demonstrate our cultural change:



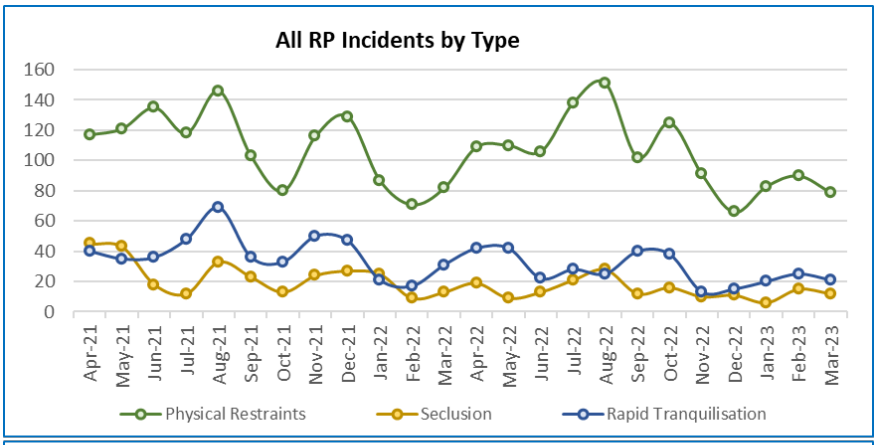

## 3.0 Data

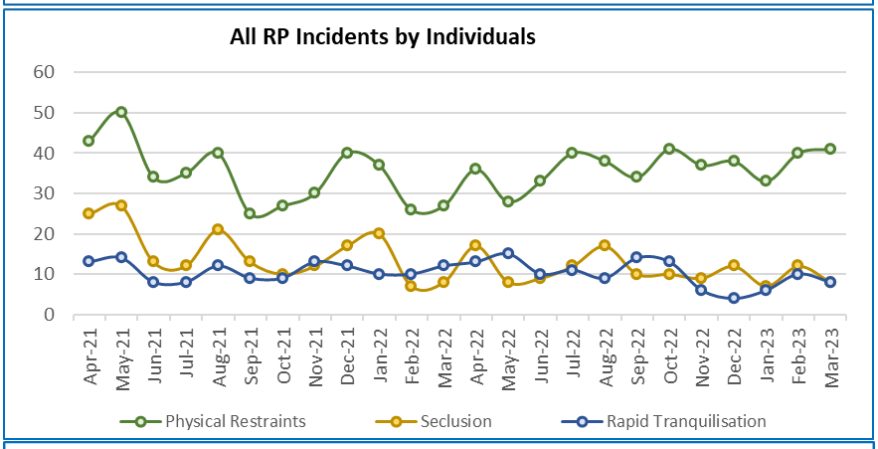
### 3.1 Collecting and using data: summary of improvement:

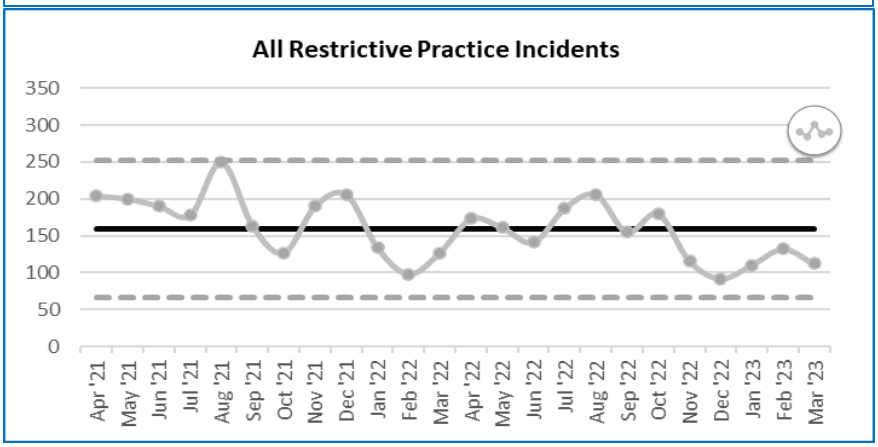
During Year One the need was to develop and implement Service to Trust level dashboards, which was achieved. Teams continue to receive the monthly data in a timely fashion and this data is used in local governance meetings. Ward Managers, Matrons and a range of staff are invited to a monthly Least Restrictive Practice Data Meeting where this information can be discussed in more detail.

## Overall data

The charts below illustrate our Trustwide data in regard to restrictive practices:

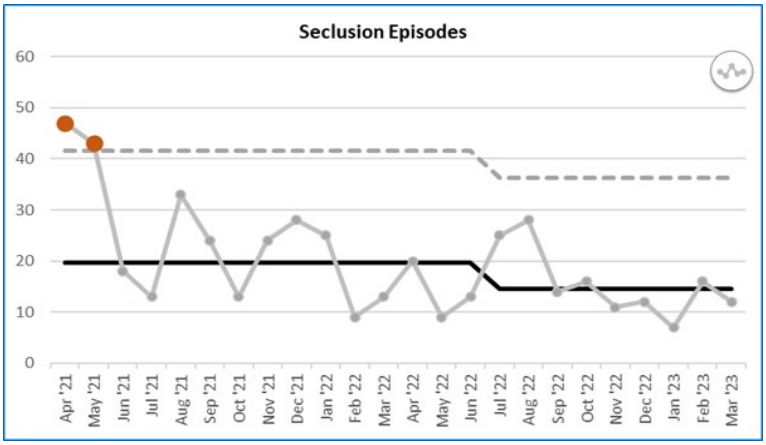



The standard within SHSC is to provide two years rolling data to enable comparison between the year being reported on and the previous year. The charts above reflect an overall downward trend throughout year two, although there have been fluctuations throughout. Statistically we can confirm moving into year 3 that we have seen 6 points of decreased overall use of restrictive practice which confirms that we have seen an overall reduction in the use of all restrictions over the year.

## Seclusion

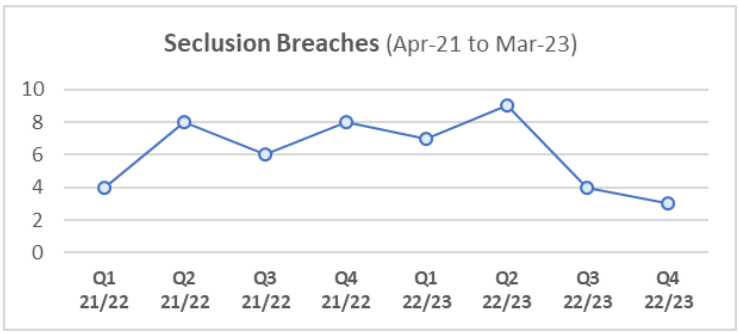



Seclusion Room Closures:

- Burbage Ward (November 2022)
- G1 Ward (February 2023)

This demonstrates an increase in the use of seclusion during the summer months in 2022, which preceded a focus on the use of seclusion, in particular the preparatory work to support the move to no seclusion on Burbage Ward, which gained momentum in September and October of 2022. A brief spike occurred in February 2023 which reduced again in March. It is noted from June 22 that we had a consistent reduction in the use of seclusion of statistical significance that indicates overall use has reduced in the previous 12 months

## Seclusion Reviews



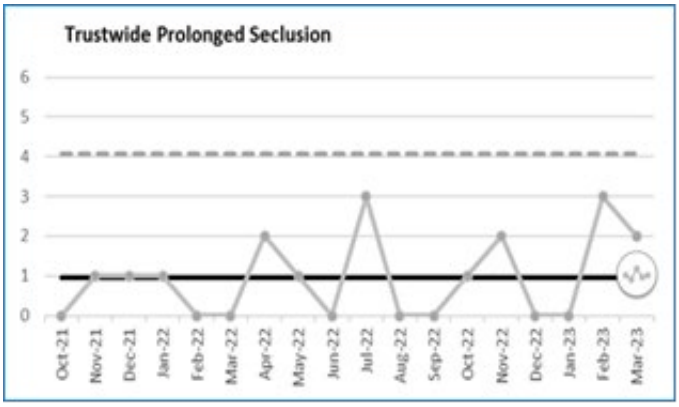

Seclusion review breaches were not accurately or effectively reported prior to the commencement of the LRP workplan, as the data reflects more reported incidents during this work to improve reporting. With the review and substantial update of the seclusion policy, the development of guidance documents and teaching sessions and the introduction

of the daily incident huddle seclusion breach reporting started to improve and data became more accurate.

Types of breach include activity of on call Medics, lack of access to clinical leadership review at weekends, non-reporting of the seclusion to the relevant on call Medic, one medic not being clear on his role. 50% were related to activity and access to completing a medical review.

During quarter 3 further work progressed with an audit taking place, development of a checklist and follow up by Senior leads to address where delays have occurred. Of note the percentage of reported delays remains low (approx. 4% of reviews are reported as delayed). **Since the introduction of this improvement work the numbers of delays have reduced** however this needs to be noted in the context of less seclusion rooms and a reduction in seclusion use.

**Prolonged Seclusion**



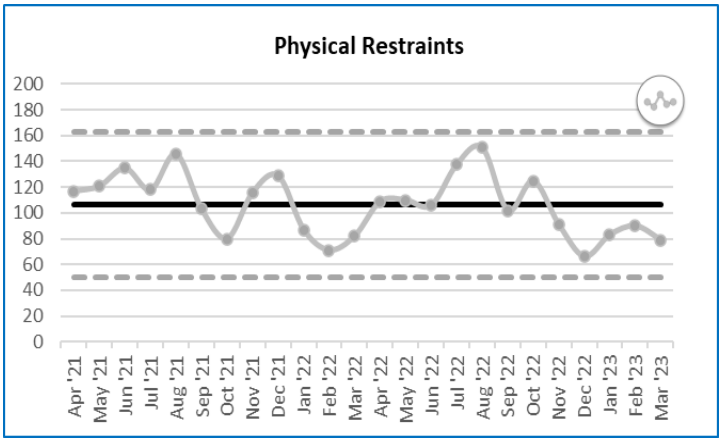

Prolonged seclusions are classified as a seclusion episode that lasts over 48 hours. Incidents are reported at 48 hours, 72 hours and then seven days. A briefing form is required at the 7-day point. On examination during the annual cycle it was identified that men from an ethnically diverse community were more likely to remain in seclusion longer than other patients in seclusion. This was identified to progress as a quality improvement project and as such during year two and into year 3 our improvement objectives have been set related to:

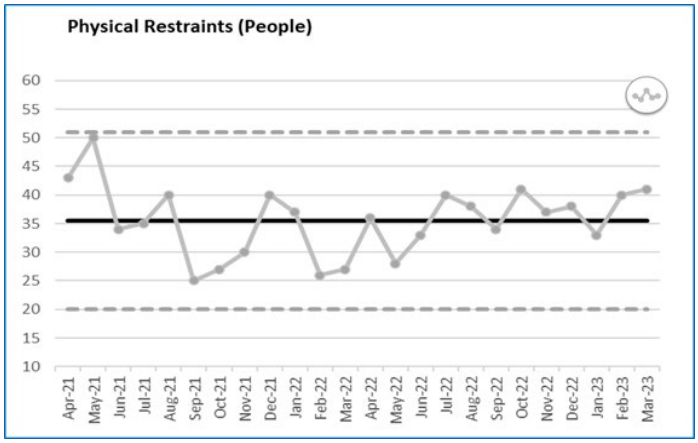
- Work with SACMHA and other organisations supporting cultural diversity
- Post incident support from cultural appropriate services
- Implementation of PCREF
- Race equity sessions on Respect training
- Appointment of race equity community lead
- Cultural awareness training
- Specific and direct support to teams where seclusion is used and prolonged seclusion is occurring. This has included a directorate leadership review and an executive review.

In addition, following examination some of the service users in seclusion for prolonged periods had had this experience previously and links with the community teams and race

equity lead have been made to reflect on this and look at prevention. Some of this has included ensuring a timely admission when the need is identified and proactive treatment and distress plans.

### Physical Restraints



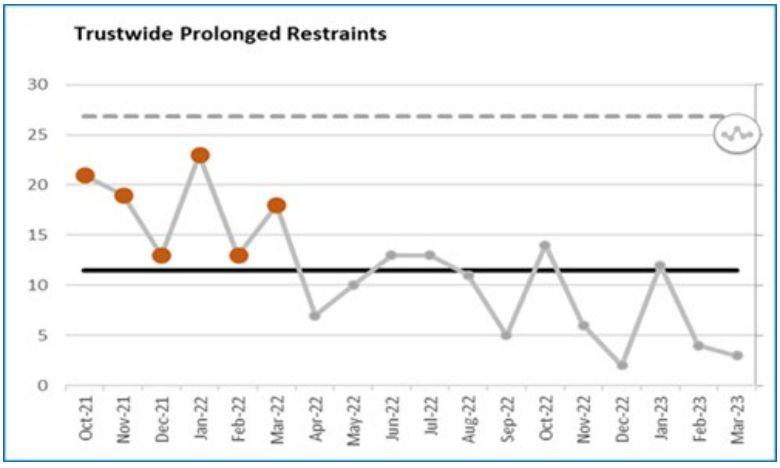




Like seclusion, the use of physical restraints peaked during the summer months in 2022. The fluctuations observe a similar pattern to the preceding 12 months although following a reducing trajectory.

From reviewing the data, there are 5 consistent months falling below the organisations 2-year average, we are confident in the indication that the beginning of the next year, April 2023 will show this continuing and reflect a trend of low use of Physical restraints.

The positive reduction in trend is also emphasised that despite the closure of 2 seclusion rooms during the year, we have not seen this impact on the number of restraints to compensate. However, it is observed that the number of people subjected to restraint has not shown the same trend. Reflection from discussions on this has shown learning from a person's 1st restraint has led to prevention through care planning and treatment plans.

### Prolonged Restraint



Prolonged restraints are 10 minutes or more and increase the risk of harm to service users and staff. During the year there has been ongoing challenges with full completion of the timings of restraint on the incident reporting system, therefore full data is not available. Approximately 15% across the year have missing timings. This is an ongoing improvement project.

The number of prolonged restraints has reduced since the work on the plan however there continues to be fluctuations mainly related to long restraints for females who are self-harming. For year 3 an audit plan and quality improvement plan is to be initiated.

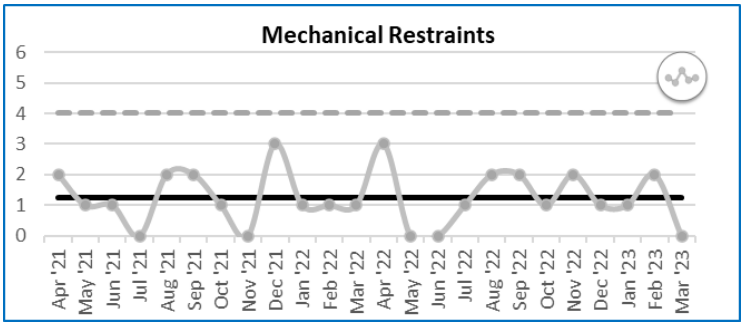
It was suggested that prolonged restraints might increase with the reduction of seclusion rooms on both Burbage ward and G1 but this has not been the case.

During the annual cycle an extensive piece of collaborative work took place to produce and standard operating procedure for prolonged restraint.  this included working across teams such as Respect, physical health and involved service users.

**Mechanical Restraints**

Mechanical restraints are recorded as part of the incident reporting system and include where mechanical restraint has been used by others that are not SHSC staff for example the police or secure transport.

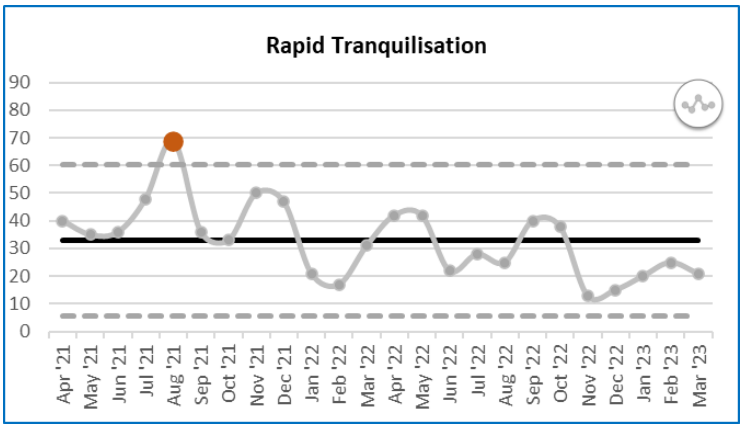
Mechanical restraint forms part of our Use of Force policy and information booklet. Attention was given to mechanical restraint during Year 2 (2022/2023) and included in the data reporting, examining who used it and for what reasons.  Some of these events went to further investigation. In addition, with the work with PCREF we have commenced detail related to ethnicity.




**Rapid Tranquilisation**

Whilst seclusion and physical restraints peaked in the summer months in 2022, rapid tranquilisation reduced during this same time period. Similarly, as rapid tranquilisation increased in the autumn seclusion and physical restraints showed a reduction. As previously mentioned, rapid tranquilisation includes an element of treatment and can be a

means to reduce the need for other restrictive practices such as seclusion, which is why the data needs to be considered in entirety as well as explored by each type of intervention.




A lot of work has gone into understanding our use of rapid tranquilisation so we could be assured this was used appropriately, recorded accurately and administered safely, including all necessary observations being undertaken. The training around rapid tranquilisation is again facilitated face to face and its delivery is supported by the Nurse Consultant for restrictive practice as well as a number of Advanced Clinical Practitioners.

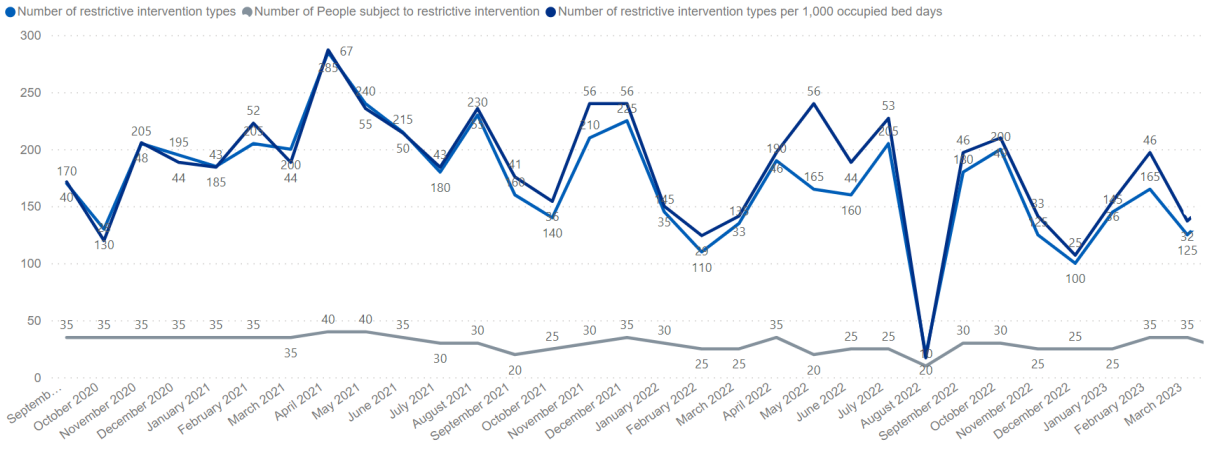
There has been a sustained reduction in rapid tranquilisation incidents since November 2022, with 5 consistent months falling below the organisations 2-year average. We are expecting continuing below average use of Rapid Tranquilisation in April 2023. Continuous improvement with Rapid Tranquilisations will be part of the Improvement Plan (section 1.9).

### 3.2 Report of use across types

Type of restraint is dictated by the Use of Force Act 2018 which is aligned to the NHS Digital Mental Health Services Data Set (MHSDS). This is a contractual and legal requirement of all providers of mental health services who receive NHS funding. The data is reported publicly on NHS digital as well as into NHS England.

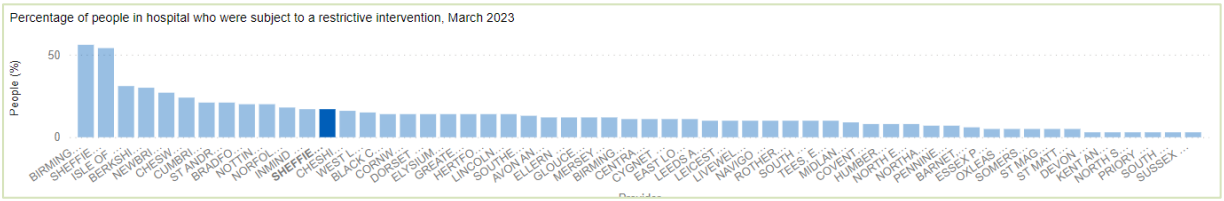
The dataset was revised in October 2021 to align with the Use of Force requirements but also to include specific reporting that supports the health care regulators (CQC) to understand the use of police in NHS premises alongside other key data.

SHSC submits data as required to NHS Digital aligned to version 5. We can say with confidence that we accurately and effectively report all of our Use of Force incidents, with the exception of our older adult dementia ward (G1) due to their use of force to support with meeting personal care needs. Throughout the year we have worked on supporting them with a SOP to support practice and gain assurance that we have improved reporting around this.




*Source: NHS Benchmarking Network, Inpatient and Community Mental Health Benchmarking 2022/23.*

## National Benchmarking



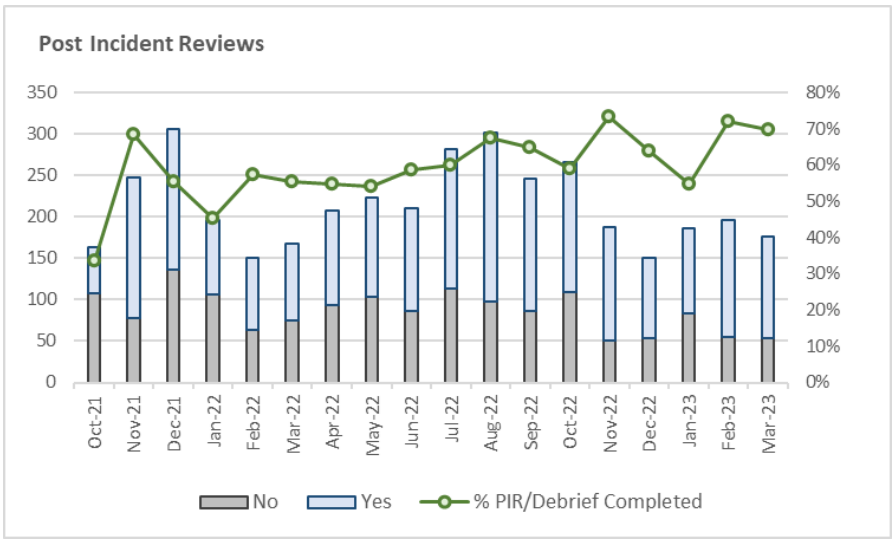

*Source: NHS Benchmarking Network, Inpatient and Community Mental Health Benchmarking 2022/23.*

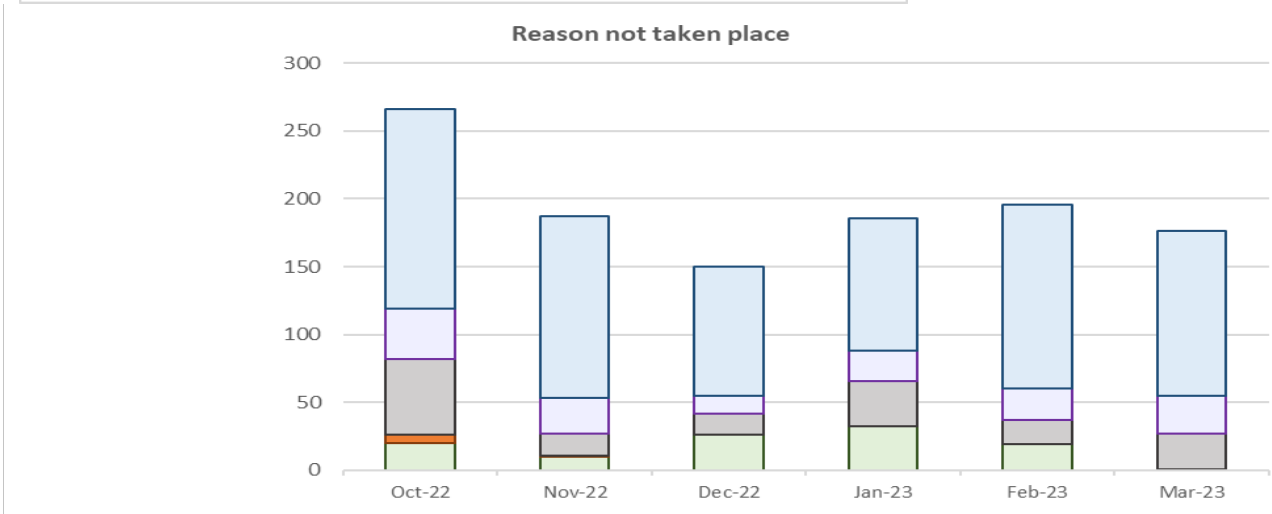
From national benchmarking we were historically one of the highest users of detentions under the mental health act, although our use of restrictive practice has become lower nationally, moving from 9th highest user in April 2022 to 13th in March 2023, with movement throughout the year.

In January 2023 SHSC were 22nd highest user/reporter of Restrictive Practice (from 48 provider submissions), with 13% of people being subject to restrictive practices. However, in March 2023 the organisation placed 13th out of 48 providers with 17% of people being subject to restrictive practices.

## Post incidents review data

One of the priorities for Year Two was the Post Incident Review Project. Its aim was to collaboratively review the systems, processes, and practices to enable effective and sustained undertaking of support following an RP event. Following the audit in Year one, year two has seen a move into an established Quality Improvement project supported by a project group consisting of staff, experts by experience and partners. A tool kit and reference pack along with a dissemination plan was developed and finalised and Year 3 sees the full implementation of this across the Trust. The Year three audit programme will examine outcomes and impact.

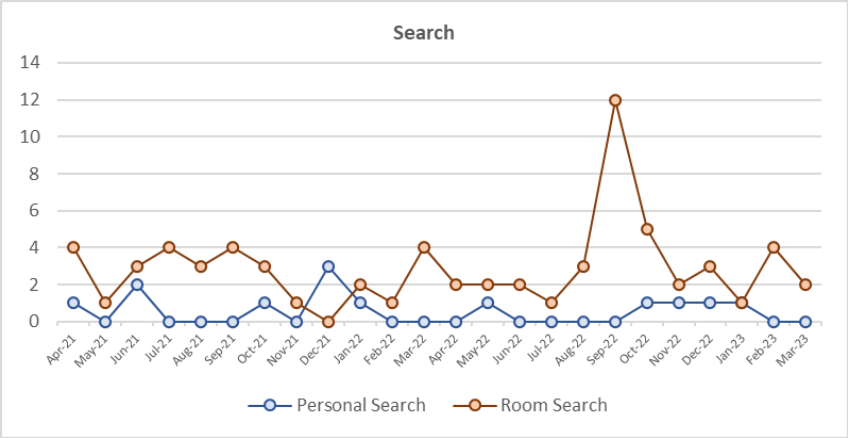



| | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 |
|---|---|---|---|---|---|---|
| No Answer | 147 | 134 | 95 | 98 | 136 | 121 |
| Patient Refused To Take Part | 37 | 26 | 13 | 22 | 23 | 28 |
| Other | 56 | 16 | 16 | 34 | 18 | 26 |
| Not Taken Place Yet | 6 | 1 | 0 | 0 | 0 | 0 |
| Clinical Decision To Delay | 20 | 10 | 26 | 32 | 19 | 1 |

Data collection commenced in August 2022 and have provided this until the end of this reporting period, March 2023. In this time there is no significant change in the percentage of PIR/debriefs being completed. Further work to embed this into practice is scheduled for Year Three.

## Searches




Search reporting often forms part of the narrative of an incident and may be categorised as

› Restricted items found.
› Smoking breach
› Self-harm
› Security
› Substance misuse
› Search

During the year, the search policy was reviewed and revised to include learning and feedback. The use of technology has been clarified to support searches and training was fully developed and intergrated into the Level 3 Respect training with the support of identified champions to also deliver local sessions.

As part of this work we have seen more detail related to search required and undertaken in the narrative of incident forms. However due to the format of existing incident forms, the current way of incident reporting and recording did not extract all the searches undertaken as part of the cause group, therefore is inconclusive.

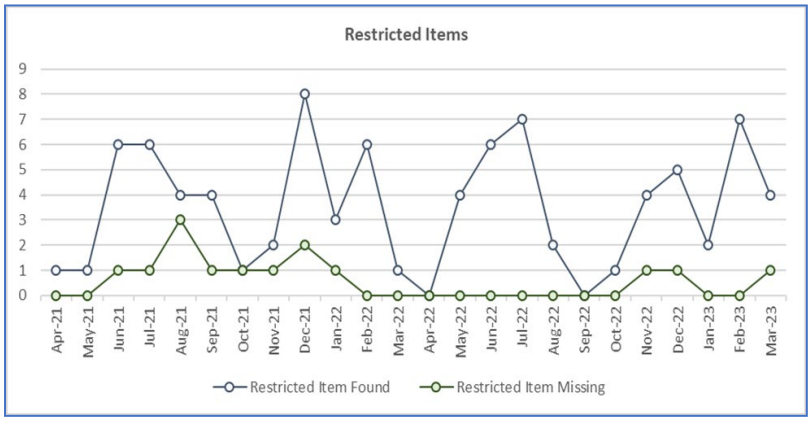
Work has commenced on updating the incident form on Ullysses (Electronic Incident and Risk Management system) to improve recording of searches and improve the output of data we are able to analyse.

Improvements will be seen in the next financial year which will support an audit planned examining compliance with policy such as consent.

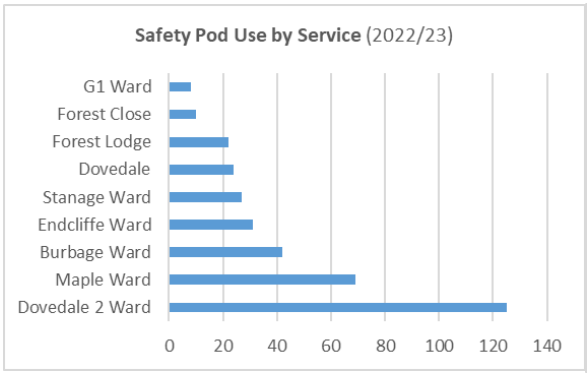
## Restricted Items

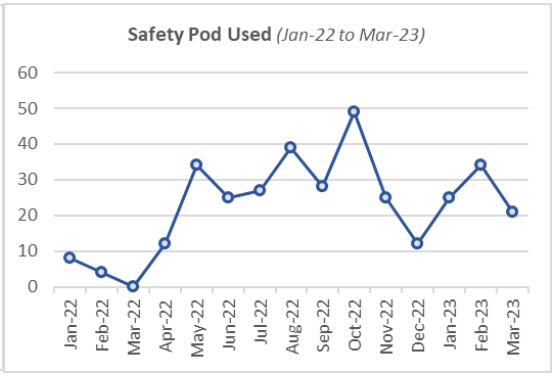
Restricted items range across cigarettes and lighter, metal cans, and own medication brought from home. Restricted item reporting can be aligned to search reporting.
The data shows that over the annual cycle both items missing and items found fluctuate. Reasons for this relate to periods of times where substances brought in have become an issue or where safety checks have not been undertaken sufficiently and items have been found missing. A key issue is related to the continued fluctuating bringing in of cigarettes and lighters either on admission or following leave. Search procedures were not always

effectively followed on some occasions whereas on other times patients had secreted them in places they could not be found.




## Safety Pod




All teams have now 2 safety PODS and training is well integrated into the RESPECT training. We have seen a significant increase in use since their introduction late 2020 with fluctuating use over the annual cycle which often relates to restraint use. The increases, in particular, during quarter 4 are likely attributed to reductions in Seclusion use.

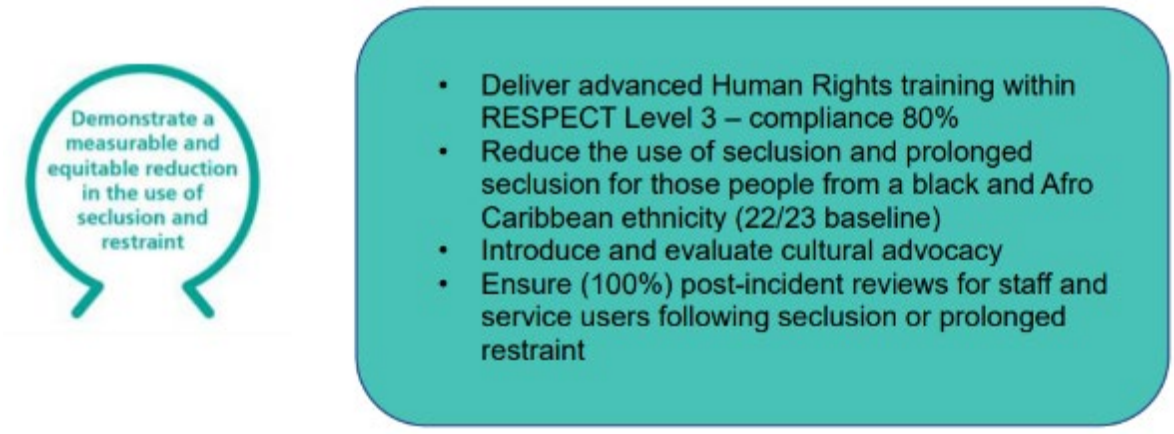
This use of equipment is reported as part of the Physical restraint data and presents a picture of reduced need for floor restraint. Where restraint numbers have reduced, safety pod numbers will reduce accordingly. Feedback is required as part of the LRP workplan to see if this has improved the experience of restraint for service users. Initial feedback is that they are more comfortable for both staff and service users, are more dignified, and more supportive of physical health than floor restraint.

The data indicates that most use is with females who self-harm and require support to de-escalate, followed by the other acute wards. Following discussion, it is reported that some teams are under reporting the use of safety pods and this has been addressed via team based conversations.

### 3.3 Key findings related to protected characteristics:

Since the commencement of the strategy, we have developed our lines of enquiry to understand the protected characteristics of people using our services and the use of restrictive practices. There is continued evidence that nationally people with protected characteristics such as diverse racial backgrounds or having a diagnosis of a learning disability and/or autism are more likely to experience restrictions. In addition to this, we now know that particular groups of people are more likely to experience restrictions in a way that retraumatised and prolongs hospital admission or length or volume of restrictions such as seclusion. This has become the focus of the long-term action improvement plans and quality objectives. One of the outlined Quality Objectives is to Demonstrate

An ongoing challenge is the accurate recording of a person's ethnicity so that this data can be analysed in a meaningful way. We continue to develop our partnership working with FLOURISH and SACMHA along with the PCREF to support improvements in this area. A raising awareness project was established to work with people and communities to improve this and Year three will see the launch of the video and comms to support this along with a focus in our quality objective one for reduction in the use of seclusion and prolonged seclusion for people from racialised communities.




We continue to provide care to most people under the MHA and continue to be concerned that restrictive practices are disproportionally applied to males from an ethnically diverse background. More restraints occur with females compared to males, despite a higher ratio of male patients at any given time. This is commonly in relation to self-harming behaviours, and we are exploring less restrictive options for managing these risks, including adopting a trauma informed approach. This is forming a Trust wide audit and Quality Improvement project in Year three.

## 4.0 Training

### 4.1 Annual stats and training compliance

#### RESPECT training

RESPECT was introduced into SHSC in 2012 and was identified as the appropriate training methodology following consultation with community groups as it avoids the use of prone restraint and overly restrictive interventions.

NHSE issued new contractual guidance in April 2020 that mandates all training with a restrictive intervention component to adhere to national training standards. The training standards are issued by the Restraint Reduction Network and require both the training provider and the commissioner of training (SHSC) to demonstrate a range of requirements in order to achieve certification and approval.

RESPECT is `owned` by Navigo, Community Interest Company and has been established for 20 years as a training provider. RESPECT is certified by both the RRN training standards and the British Institute of Learning Disabilities Association of certified training (BILDACT), More information on RESPECT can be found https://respecttraining.org/

The standards also require suitable programmes to be delivered aligned to service need. The focus of training must be on primary prevention and proactive engagement rather than tertiary intervention skills.

In December 2020 NHSEI released Violence Prevention and Reduction Standards https://www.england.nhs.uk/wp-content/uploads/2020/12/B0319-Violence-Prevention-Reduction-Standards.pdf which provides a risk-based framework that supports a safe and secure working environment for NHS staff, safeguarding them against abuse, aggression and violence.

As part of the above change requirement this annual cycle has seen a full review of the RESPECT training program, aligning it to both the RRN standard and the Use of Force Act. These changes were approved toward the later end of the year and implemented as part of the Year two requirements with the new program coming into effect in July 2022. This has included reviewing competency levels for certain staff groups and teams. This was fully achieved for Year two and a second cycle of update training will commence in Year three covering Human rights and psychological restraint.

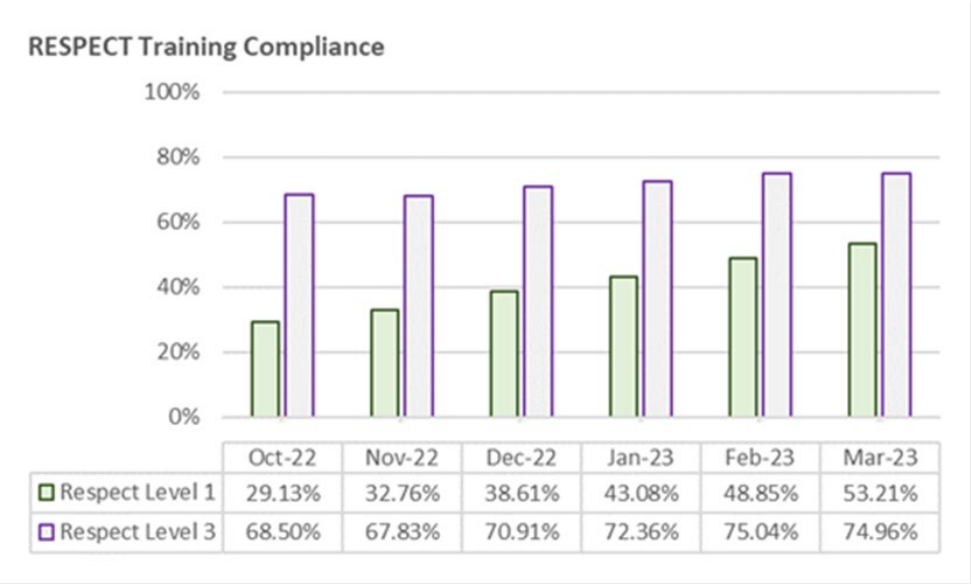
The new offer of RESPECT training is as follows:

- **All Staff** – Everyone will undertake an online conflict resolution training package that will include elements of personal safety. This is a 3 yearly update course. Dependant on job role, this may meet all training requirements other staff may require Level 1 or Level 3 training.
- **Level 1** – This is a 1-day course with a yearly update. It is provided face to face at the RESPECT centre.
- **Level 2** – This has been discontinued
- **Level 3** – This continues to be a 4-day course with a 2-day yearly update. It is provided face to face at the RESPECT centre. Adjustments have been made to the

4-day course to include activity and care planning. The 2-day update now includes a focus on the Use of Force policy and guidance, and this will be on a yearly cycle of change.

## Training compliance

### Substantive Staff




### Bank Staff

| Bank Staff Quarter 4 - Training Compliance | Respect Level 1 | Respect Level 3 |
|---|---|---|
| **Bank Primary Assignment** | 20.55% | 77.88% |
| Bank Nursing Prim Assignment | 12.50% | 57.14% |
| Bank Support Worker Prim Assignment | 30.43% | 81.11% |

Our minimum requirement is to have 3 x Level 3 RESPECT trained staff on all shifts on our inpatient wards. This is a consideration when creating the rota, acknowledging that things can change between rota creation and shifts being worked we have a number of assurances in place to ensure this is achieved. Matrons conduct a fortnightly review of the rota to identify any potential deficits so that these can be resolved in advance. Every weekday morning there is a staffing escalation meeting where amongst other criteria the amount of Level 3 RESPECT trained staff is reviewed, and staff are reassigned across the wards to cover any gaps. On the rare occasion a shift is worked without sufficient Level 3 RESECT trained staff this will be incident reported. Every week a report is completed by Ward Managers and reviewed by the Heads of Nursing to provide further assurance that all shifts worked were staffed by enough Level 3 RESPECT trained staff.

**Other training**

We have introduced a number of training topics either within the RESPECT course or to compliment this:

- Human rights
- Trauma informed
- Autism
- Care planning, equity and race, carers and activity
- Search training
- Seclusion standards

## 5.0 Learning and Reports

### 5.1 Feedback

Feedback over the year has been sought by a variety of means. At times service users ask staff to speak to the restrictive practice teams to give feedback, or via advocates or others who might speak on their behalf. Information is extracted from the Tendable quality of experience questionnaire or is feedback via the engagement and experience team who are visiting wards. Meetings with our partners and statutory advocacy take place regularly and these are a source of feedback often which led to action. Extracting learning from incident investigations or reviews also provides valuable information both from a service delivery and feedback point of view.

Service User feedback
*“I want to come and work with the Respect team; it is so much better than anything else I have had used on me before and I want to share my story about how good things can be!” HA 2023*

*"I am treated with respect and given the time to express how I feel and am not made to feel a burden when seeking help.” CL 2023*

Staff feedback
*Thank you so much for all your support with the training. You were so kind and patient. And thank you for your ongoing support whilst I’m working on the ward*” - AI – Support Worker

“*I have worked for the trust for over 9 years and throughout this time I have found the Respect team to be one of the most valuable assets to SHSC. Not only do they deliver training that is second to none, their support on the wards is unwavering. The Respect team is responsive to requests for support from clinical teams and provides hands on support in live clinical areas during difficult interventions. The Respect team are present from the planning stage, right to the de-brief. We cannot thank them enough”* - OK - Deputy Ward Manager

In the spirit of Safe wards every attendee at the RESPECT training is aksed to leave a message of hope for others coming on the training. Inpatient wards have also implemented this intervention giving service users a space to leave a message.

## 5.2 Audit (Tendable)

Three audits were designed to monitor our adherence to national policy with respect to restrictive practices and were introduced as part of a phased roll-out of Tendable.

1. Physical restraint
2. Seclusion
3. Rapid tranquilisation

All the audits are considered against national policy and local policy as well as NICE guidance. This supports teams at a local level to monitor and to take action against individual audits of restrictions.

The audit plan requires the following:

1. Physical restraint – up to 5 physical restraint audits per week
2. Seclusion – every seclusion must be audited
3. Rapid tranquilisation – every episode must be audited.

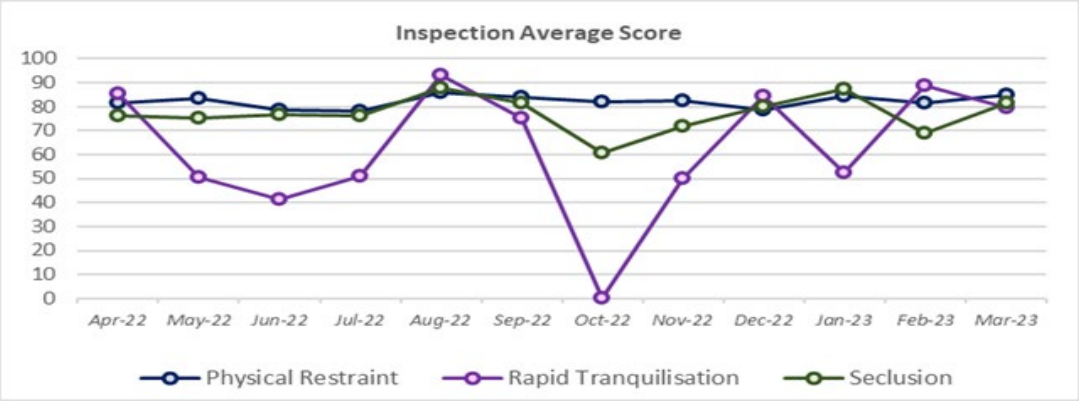
This works formed part of a PMO project plan during Year two and was closely monitored for compliance. It forms part of the reporting cycle for the LRPOG. Phase one of the plan was focused on ensuring audits were completed and testing the audit questions. Phase two is now commencing to review the findings and plan actions to address shortfalls or areas of improvement. Quality improvement plans were developed into Year two and Year three will see a reaudit and review on the impact of these improvement approaches.

There are a number of other audits conducted in relation to restrictive practice, some are part of the tendable schedule as outlined above or other Trust audit programmes, others are stated within the relevant policy, and some are as a result of a local need identified or identified learning.

Audits indicated by policy:

- Use of force
- Seclusion (tendable)
- Search
- Rapid Tranquilisation (tendable)
- Blanket restrictions
- Surveillance (CCTV)

**Outcomes from audits completed**




The table below demonstrates the average score achieved by service during the financial year for each audit. The score is represented as a percentage of compliance against the fundamental standards of quality care. Monitoring of results from these audits are reported and discussed monthly within operational groups and within services Governance meetings to identify action plans for improvements. The average score by service for each of the three audits can be seen below:

| Service | Physical Restraint | Rapid Tranquilisation | Seclusion |
|---|---|---|---|
| Burbage | 75.06% | 76.67% | 85.04% |
| Dovedale 1 Ward | 89.81% | 71.43% | Not Required |
| Dovedale 2 Ward | 81.33% | 76.74% | Not Required |
| Endcliffe Ward | 80.08% | 88.54% | 81.90% |
| Forest Close - Ward 1 | 87.50% | Not Required | Not Required |
| Forest Close - Ward 1a | 100.00% | Not Required | Not Required |
| Forest Close - Ward 2 | 96.88% | Not Required | Not Required |
| Forest Lodge | 89.47% | Not Required | 83.65% |

| | | | |
|---|---|---|---|
| G1 | 97.26% | Not Required | 97.92% |
| Maple Ward | 76.83% | 61.90% | 62.14% |
| **Average Score** | **87.42%** | **75.06%** | **77.70%** |

Subsequently, we have used performance results from audits to help identify quality improvement initiatives. It is also notable that we only have seclusion in 3 units going forwards.

**Quality Improvement**

During Year two several quality improvements projects were established related to the RRP agenda and outcome from audits

1. Improving physical health recording following RP
2. Improving the quality of medical seclusion reviews
3. Improving the undertaking of post incident support
4. Improving the quality-of-care planning related to Use of Force

Year three will report on the outcomes of these QI projects via further audits and review. Part of this is intended to include qualitative feedback from service users and staff. An example is added as Appendix 1 at the end of the report.

**6.0 Risks**

The biggest risk to delivering on our least restrictive practice strategy is staffing. This refers to challenges in leadership posts across service, front line staff and staffing challenges within the RESPECT team.

The staffing challenges are multi-faceted; we need enough consistent staff with the right skill mix, banding and profession to deliver safe and high quality care, we need to have enough staff so that we can release staff to attend training and to engage in QI projects and initiatives within their service and we need enough RESPECT staff to deliver the required training and provide in-reach support to clinical areas.

We have a number of actions in progress which sit within other strategies or workstreams, to address the challenges around safely staffing our clinical areas. This includes ongoing consultation around the clinical nursing leadership across the acute wards, the introduction of Senior Nurse Practitioners across all wards, who will be working within the shift numbers for 80% of their hours to increase nursing leadership and experience across the 24-hour period that care is delivered and there are plans to review the composition of the RESPECT team within Year Three.

The inconsistent completion of tendable audits is another key risk because this detracts from our ability to analyse the audit findings, identify trends and themes and take remedial actions. This is to be addressed within Year Three.

## 7.0 Looking forward – key priorities for 2023/2024

Year Three will focus on bringing together all the progress, learning and outstanding actions from Years One and Two and ensuring that we have a clear plan established. Much of the work done already needs to be embedded into business as usual across clinical services but also within the governance framework.

- Deliver advanced Human Rights training within RESPECT Level 3 – compliance 80%
- Reduce the use of seclusion and prolonged seclusion for those people from a black and Afro Caribbean ethnicity (22/23 baseline)
- Introduce and evaluate cultural advocacy
- Ensure (100%) post-incident reviews for staff and service users following seclusion or prolonged restraint
- Implement training and resources on psychological restraint

### Plans for Year Three

A table has been provided at Appendix 2 which outlines the Year Three plan of the strategy.

In addition to what is outlined in the plan, the following projects have been identified for Year Two and Year Three to underpin the strategy and monitor our progress.

- A SafeWards Peer Led Survey began in Q4 2022/23, and this will continue into Q1 and Q2 2023/34.

- Audits and learning from the move to no seclusion continues into Year Three for Dovedale 2, Burbage and G1, with this work due to commence on Maple during the year.

- During Year Three we will be introducing further audits on prolonged restraint and post incident reviews, to measure the adherence to the SOPs introduced during Year Two and the benefits to service users and staff.

During year three we also need to begin the consultation process for the next Reducing Restrictive Practice Strategy, which will come into effect in April 2024.

**Appendix 1**

Quality Improvement

NHS Sheffield Health and Social Care NHS Foundation Trust

# Improving the quality of medical seclusion reviews on Endcliffe Ward - an Adult Psychiatric Intensive Care Unit

Dr Rosie Oatham (rosie.oatham@nhs.net)

## Background

Endcliffe Ward is a purpose built psychiatric intensive care unit (PICU) that provides twenty-four-hour care for people in a mental health crisis who require a safe, controlled environment with high intensity nursing care.

As with all PICU settings, incidents of medical "seclusion" and subsequent reviews are a common occurrence on Endcliffe Ward . Seclusion is a tool used by primarily to manage aggressive and disturbed behaviour that is presumed to be due to the patient's mental disorder. [1]

There are clear Trust and national guidelines that must be adhered to when healthcare professionals use seclusion that are designed to maximise a patient's freedoms and protect their liberty while providing a safe environment.[1,2] The standards used at Sheffield Health and Social Care (SHSC) are outlined in Figure 1.

This work aligns with SHSC's Trust-wide priorities around ensuring the that staff are supported to provide best practice in relation to the use and prevention of force where possible, to help manage situations that may lead to violence and aggression.

**Figure 1: Table outlining the current standards of medical seclusion reviews [2]**

| | |
|---|---|
| 1: Review of service user's physical health | 5: Review of observations required |
| 2: Review of service user's psychiatric health | 6: Assessment of risk to others posed by the service user |
| 3: Assessment of currently prescribed medications | 7: Assessment of risk to self posed by the service user |
| 4: Assessment of adverse effects of medications | 8: Assessment of the need to continue seclusion or apply less restrictive measures |

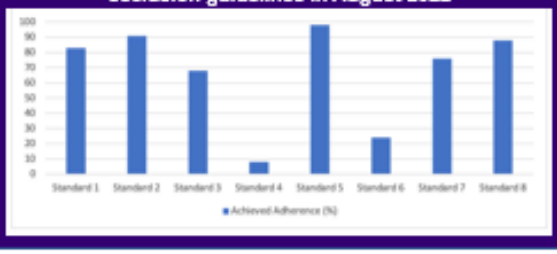
## Overall Aim

The overall aim of this work was to understand and improve current medical seclusion practice. An initial audit was undertaken to assess current practice and a survey undertaken to establish levels of understanding amongst medical staff. A "SMART" aim has been developed based on audit findings and colleague discussions. SMART aims are Specific, Measurable, Achievable, Realistic and Timely.

## Initial Assessment

A service evaluation in August-December 2022 demonstrated sub-optimal adherence to medical seclusion review standards, with a mean adherence of 66.72% (Figure 2). Results from this evaluation highlighted that documentation of medical seclusions was poor, making it difficult to assess adherence to guidelines. In particular, medical seclusion reviews lacked documentation of prescribed medications, adverse effects of medications and risk to self.

**Figure 2: Graphic representation of adherence to medical seclusion guidelines in August 2022**




## SMART aim and objectives of QI project

Based on the results of the service evaluation, this project sets out to improve the quality of medical seclusion reviews performed by doctors of all grades on Endcliffe Ward. We aim to achieve a 90% adherence rate to seclusion guidelines within a 12-month period. Greater adherence to all elements of medical reviews outlined by the Seclusion and Segregation Policy, will enhance the quality of care provided to service users who undergo seclusion on Endcliffe Ward.

**Figure 3: Driver Diagram**

## How will we know we are improving?

The Driver Diagram (Figure 3) summarises the areas that are being focussed on. To measure improvement over a 12-month period, a random sample of seclusion entries will be taken each month, with adherence to guidelines subsequently analysed. The mean adherence rates for standards will be presented onto Statistical Process Control charts, to enable us to see whether the changes implemented lead to improvements. Our benchmark for improvement is an increase in the overall mean adherence from current 66.72%, to 90%.

A number of process measures will be reviewed to monitor improvement, this includes; overall adherence, the time taken to document medical reviews and staff experience. A structured survey to all medical doctors performed on a 4-monthly basis (to align with 4-monthly rotations for foundation trainees) should enable us to monitor improvement in understanding of guidelines and perceived time to document reviews. The structure of this survey will mirror the survey performed as part of the service evaluation in 2022.

## Acknowledgments

Thank you to Dr Bhavana Kama (Supervisor), Rosina Muir (Clinical Effectiveness), Dr Parya Rostami & the Continuous Improvement Team.

## References

1) Newton-Howes, G. (2013). Use of seclusion for managing behavioural disturbance in patients. Advances in Psychiatric Treatment, 19(6), 422-428. doi:10.1192/apt.bp.112.011114
2) Sheffield Health and Social Care (March 2022). Seclusion and Segregation Policy (Inc Long Term). (NPCS 666).
3) Sheffield Health and Social Care (April 2022). Use of Force Policy – Prevention and Management of the Use of Force Safe and positive care. (NPCS 030 V6).

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**Appendix 2**

**Improvement Plan - Reducing Restrictive Practice - Long Term Goals**

## 1. Clinical Knowledge and Skills

| Action | Ref. |
|---|---|
| Continue to embed SafeWards and demonstrate impact through evaluation and measurement | LT1.1 |
| **Embed the use of a human rights framework to assess the provision of care and treatment to people in our care through LT1.2.1 to LT 1.2.3** | LT1.2 |
| Embed developed training package into RESPECT Training | LT 1.2.1 |
| Gather sign off and authorisation for HR Training. Develop a plan for roll out. Conduct Training. | LT1.2.2 |
| Review and amend routine Human Rights Policies and templates | LT1.2.3 |
| Demonstrate the impact of training on restrictive practice. Understand the data we need and where this sits to measure the impact meaningfully. | LT1.2.4 |
| Develop and implement specific training related to the psychological harm of Restrictive practice in RESPECT | LT 1.4.1 |
| Clear training plans and accessible development to equip staff with skills to work within services; implementation of a staff competency framework | LT1.5 |
| Delivering personal care and restraint awareness through the strategy (includes RESPECT but not limited to this) | LT 1.5.1 |
| Demonstrate cultural and race sensitive monitoring and performance indicators to clearly illustrate the use of restrictive practices. *<consider moving to PCREF to avoid duplication and siloed working>* | LT1.6 |
| Demonstrable evidence of shared and involved care planning, advanced plans and engagement *<links to Person Centred WS, Clinical and Social Care Strategy>* | LT1.7 |
| Staff feel safe at work through staff survey. *<links to Trauma Informed workstream Clinical and Social Care Strategy, Staff Engagement work>* | LT1.8 |
| Use of medication is aligned to prescribing and administration guidance, patients are supported to be concordant and where rapid tranquilisation is utilised, monitoring is undertaken in line with NICE guidance. | LT1.9 |
| Agree an approach which includes working with SACHMA and Flourish, Disability Sheffield to raise awareness training. *(Links to PCREF work)* | LT1.10 |
| Activity: local ward inductions to include the role, importance and value of meaningful activity. Transition of ward support worker roles from band 2 to band 3; roles to include engagement of service users in and the provision of meaningful activity in relation to delivering MDT care plans | LT1.11 |
| Self-harm and use of restrictive practice - develop a QI project based on data to improve the knowledge and skills of staff, use of restrictive practice and alternatives to care | LT 1.12 |

## 2. Data Recording and Utilisation

| Action | Ref. |
|---|---|
| Acquire learning from national data sets based on confident data quality submissions. Compliance with Use of Force Act 2019. | LT2.1 |
| Teams across SHSC access, utilise and can speak to their data on the use of restrictions. There is evidence of regular MDT debriefings and practice | LT2.2 |

| | |
|---|---|
| development forums to critically analyse incidents. Robust coproduction of care plans and engagement of patients in reflective practice to support advanced care planning. Summaries of care including restrictive practices are handed over on discharge *(links to LT 1.7)* | |
| Strong working alliances between the Trust and other agencies (e.g., advocacy, SACHMA, STH etc) to reduce use of force, demonstrable learning from practice through lessons learnt. | LT2.3 |
| Reduction in the use of seclusion and prolonged seclusion for those people from black and afro Caribbean ethnicities | LT 2.3.1 |
| Robust audit and quality improvement schedule which is in line with National Guidance and local policy *<links to Evidence led workstream of Clinical and Social Care Strategy>* | LT2.4 |

### 3. Learning and Leadership

| Action | Ref. |
|---|---|
| Teams achieve annual pledges which are supported by a robust communications and engagement plan. Opportunity is available to celebrate improvement, showcase good practice and give pride in the work that staff and patients are involved in. *(links with QI whiteboards initiative)* | LT3.2 |
| Post incident reviews inform practice, staff feel supported and led by clinical leaders. Outputs are demonstrated through staff survey and audits. | LT3.3 |
| Good practice is shared, a least restrictive conference is held to celebrate progress and quarterly reports demonstrate improvements. | LT3.4 |
| Ensure effective and regular clinical supervision and reflective practice for ward teams, introduce peer support/mentoring forward managers with time given to focus on least restrictive practice *< links to Trauma Informed WS>* | ST3.3 |
| Post incident reviews - see **Post Incident review implementation plan - refer to post incident support plan** | ST3.5 |
| Ensure LRP lead role contributes to other strategy improvement plans | LT 3.5 |

### 4. Environment and Technology

| Action | Ref. |
|---|---|
| Wards are calming, therapeutic environments which support individuals to have person centred care and risks within the environment are minimised enabling staff to practice with minimal restrictions. Green room space is available on every ward with capacity to support more than one individual in distress at any time. | LT4.1 |
| Technology is integrated into practice aligned with national guidance, human rights and best practice. Auditable trails of the use of technology by staff are reported Annually. | LT4.2 |

### 5. Involvement and Information

| Action | Ref. |
|---|---|
| Clear approach to coproducing all aspects of the strategy, workplan and individual improvement plans with people who use services and their families. *(Linked to lived experience and engagement team and strategy)* | LT5.1 |
| People who use our services are involved in all aspects of their clinical care and have individualised processes and plans to support them at times of crisis which are collaborative, clearly documented, accessible and recorded for the | LT5.2 |

| | |
|---|---|
| service-user and staff team. *<links to Person Centred WS, Clinical and Social Care Strategy>* | |
| Individuals who may be subject to restrictive practices will be given clear accessible information about the range of restrictive approaches approved and authorised within the service, the circumstances which govern their use, and whom to complain to if there is concern about how these measures are implemented. | LT5.3 |
| To contribute to the review and audit of the advocacy service. | LT5.4 |
| Introduce the use of involvement standards with aligned training and support for staff to implement these. Staff are recruited in line with Trust values and training is mandated to drive the involvement and rights *(linked to lived experience and engagement team and strategy) agenda* | ST5.1 |
| Introduce cultural advocacy service from the Pakistani Muslim centre to promote cultural awareness within inpatient wards | LT 5.5 |
| Health based place of safety - support the development of practice and operating procedures for new build specific to restrictive practice | LT5.6 |

## 6. Policies and Procedures

| **Action** | **Ref.** |
|---|---|
| Review and develop appropriate standard operating procedures and governance channels to support this | LT6.1 |