Board of Directors - Public

SUMMARY REPORT	Meeting Date:	25 September 2024
	Agenda Item:	12

Report Title:	**Use of Force Annual report**	
Author(s):	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 (MHLC) Quality Assurance Committee (QAC) Executive Management Team (EMT)
	Date:	4 September 2024 11 September 2024 19 September 2024
Key points/ recommendations from those meetings	The committees approved the report for onward presentation to Board of Directors for publication on the Trust website.	

Summary of key points in report

- Requirement of the Use of Force Act to summarise the Trust's work over the year which has aligned with the 3-year end of the strategy.
- There has been a significant reduction in Restrictive Practice which has been driven by a focus on clinical engagement, therapeutic relationships and working with patients who are distressed.
- The work recognises the importance of working with communities, service users, carers, and significant others, and as a result, culture change is taking place across the organisation

Appendices attached:
Appendix 1 – Use of Force Annual report

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 asked to be assured through this review of the years progress that we have delivered on year 3 of our Least Restrictive Practice Strategy.

Board is 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:				
Effective Use of Resources	*Yes*	***X***	*No*	
Deliver Outstanding Care	*Yes*	***X***	*No*	

Great Place to Work	*Yes*	***X***	*No*	
Ensuring our services are inclusive	*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) NHSE standard Contract Health and Social Care Act

Have these areas been considered ? YES/NO					If Yes, what are the implications or the impact? 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

Least Restrictive Practice
Use of Force Annual Report

April 2023 – March 2024

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

Authors:
Lorena Cain, Nurse Consultant for Restrictive Practice;
Salli Midgley, Director of Nursing, Professions and Quality and Responsible Person for Use of Force;
Greg Hughes, Respect Professional Lead
Henry Harrison Strategy and Quality Performance Manager
Gambinga Gambinga, Race Equity Officer
Claire Reed, Expert by Experience

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Executive Summary from the Responsible Person for the Use of Force

Welcome to our third annual report which reflects on our progress from April 2023 to March 2024. This was the final year of our three-year strategy to address restrictive practices, and I am delighted to introduce this report which evidences fantastic progress by our teams on this agenda.

2023 to 2024 has been another busy year for Sheffield Health and Social Care Trust, our focus has been unrelenting on driving reductions in the use of restrictive practices within our inpatient teams and starting to focus on restrictions within our community and crisis services.

We are incredibly proud of the achievements within the year, building on the success from 22/23 we have seen our wards continue to be upgraded and work complete across Dovedale 2, Burbage and Stanage to provide improved single gender care without seclusion rooms being built into the specification. The Health based place of safety moved out of its location within Maple ward which is a significant milestone in delivering appropriate care.

In reflecting on our data across the year it is evident that as we have reduced our use of seclusion, our clinical teams and supporting staff have also reduced or sustained the use of other restrictive practices, this is fantastic work as it is usual to see increases in other uses of force and restriction when a focus is taken in relation to reducing one particular intervention.

We have seen incredible practice in some of our acute wards with Stanage (male acute) achieving zero restrictions for 16 days. Our low secure service at Forest Lodge participated in the Mental Health Act improvement focus with a focus on race equity, which has had a significant impact on the culture and care at Forest Lodge.

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 moved into the RESPECT team to focus the work and has a strong presence in our wards and drives post incident reviews with patients and carers.

The cultural advocates that we have invested in with the Pakistan Muslim Centre in early 2023 are now embedded into visits out of hours on our wards, promoting the rights and cultural needs of all communities. They have a route of escalation through to the engagement team and into the Quality directorate; this also improves access to external agencies and reduces potential for closed cultures to develop.

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

Salli Midgley, Executive Director of Nursing, Quality and Professions and Responsible Person for Use of Force.

1.0 Introduction and Background – The Use of Force

Our Least Restrictive Practice Strategy and workplan commenced in 2021 following the appointment of a Nurse Consultant for Restrictive Practice and the alignment of the Respect team to the Quality Directorate. We commenced the programme in April 2021 with the launch of our clinical model "SafeWards" with sessions being delivered across the clinical teams by one of the National Leads, Geoff Brennan. Our first annual report covered June 2021 – June 2022 with our 2nd being April 2022 to March 2023. This is our final annual report for the 3-year strategy, and we look forward to reviewing and developing our next 3-year workplan.

The report sets out the key objectives identified and achieved for Year Three (April 2023 – March 2024), 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 (Least Restrictive Practice Strategy June 2021).

This final year indicates what we have achieved

Delivery of the strategy has 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 have achieved these responsibilities through:

- Providing effective, robust policies and procedures that reflect best practice.
- Human Rights Officer has delivered training and support to staff and inform our policies and procedures, now being embedded into services and teams.
- Undertaking regular review and audit
- Delivery of training and development 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 along with the Restraint Reduction Network standards.
- 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.
- Working with partners such as the Pakistani Muslim Center and Sheffield African Caribbean Mental Health Association to deliver targeted support to our users, enhancing staff knowledge and understanding.

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)
- Health Based Place of Safety (HBPoS)

> *"The least restrictive practice work has energised us and made us feel we can really make a difference. Least restrictive practice is our teams watch word. Patients are safer in the least restrictive environment; safer care means collaboration to keep restrictive practice to a minimum. Restrictive practice is a change of mindset"*
>
> *Vin Lewin, Mental Health Nurse, Patient Safety Specialist*

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 Executive Director of Nursing, Professions and Quality/Responsible Person for Use of Force, the Deputy Director of Nursing and Quality, 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, 3 RESPECT Trainer Practitioners and 1 Expert by Experience.

Delivering the strategy has also been supported by our Strategy & Quality Performance Manager, Quality Directorate, 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. Other teams who have supported include the Quality Improvement team and the Clinical Effectiveness team.

> *"We have transformed from the Respect training Team to The Least Restrictive Practice team, and we see ourselves as a support service helping out where we can so that we, as a whole service, can achieve our goals through hard work, positive attitude, want and courage to try. It has been difficult at times but a pleasure to work alongside so many service users, carers, staff and everyone we come in contact with. We are constantly learning and sharing, which is one of the most rewarding aspects of working with this team and their enthusiasm has never waned. We look forward to continuing in supporting the workplans to reduce restrictive practice which will improve the lives of our service users and our staff".*
> ***The Respect Team***

The work of Sheffield Health and Social Care 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.

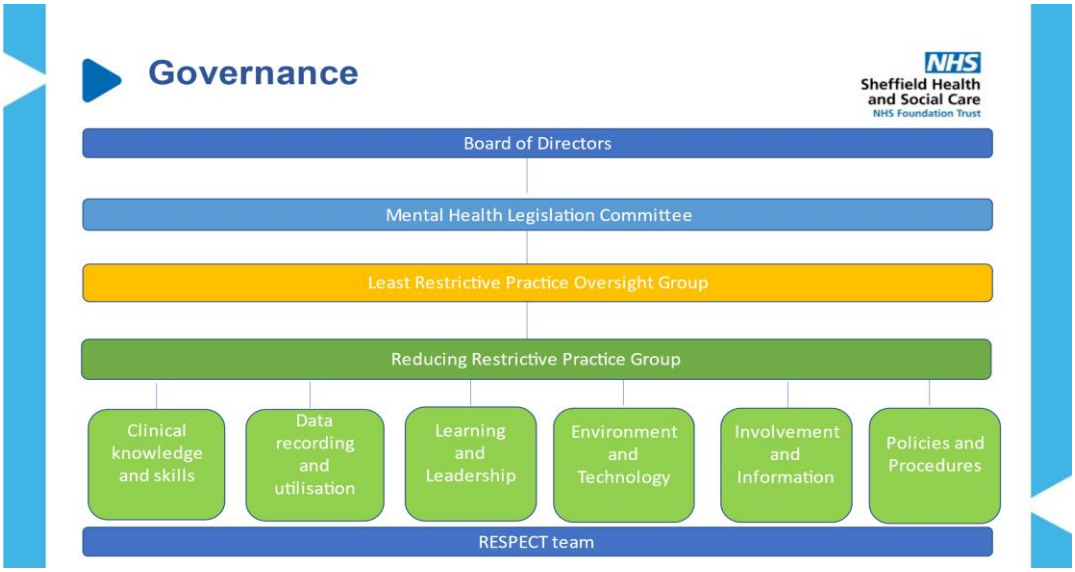
The activity of the Respect team this year lay not only in the training and continued support for out inpatient areas:

- In October we were shortlisted for the Health Service Journal Awards in 2 categories – Safety Improvement of the year and Patient Safety Team of the year and we won the Highly commended award for the latter of these two.
- We have completed a team composition and skill mix review with recommendations to be implemented in the next year.
- We were supported in our running of a staff wellbeing day for the team which was a huge success and will be repeated next year.
- Supported in the planning and delivery of the ward moves.
- Became part of the Use of Force Community to share practices across trusts around the country.
- Shared learning with numerous other trusts with regard to moving away from seclusion and reducing the need for restrictive practice.
- Presented Human Rights Act work and Psychological Restraint at the Restraint Reduction Network (RRN) national conference in Bristol.
- Attended the European Network for Training in the Management of Violence and Aggression and was able to bring learning back from this.
- All members of the Respect team and appropriate clinical staff from clinical areas became HOPES practitioners.

- Attended the Positive and Safe Network in Liverpool and Sheffield to share good practice.
- Developed links with Sheffield Teaching Hospitals who are now using Respect.
- Supported in the planning and provision of care for pregnant service users in our clinical areas and while at the maternity hospital.

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 2023 – Quarter Four
- August 2023 – Quarter One
- November 2023 – Quarter Two
- February 2024 – Quarter Three
- May 2024 – Quarter Four

In addition to this several 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 regarding 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 an 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 three experts by experience have continued to work alongside us as we have developed and delivered sessions of awareness raising, training and local projects. This has included the development of information for service users, families and carers.

We have continued to work on building connections and work with Sheffield Voices, Disability Sheffield, Statutory Advocacy, Sheffield Flourish, SACMHA and the Pakistani Muslim Centre throughout Year three 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. The Equity Officer post with SACMHA was integrated into the Respect team in Year 3 and aligned to the Least Restrictive Practice workplan with a primary focus on post incident support, learning, prevention and care planning.

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. A particular focus this year has been post incident support and the Mental Health Act Reform project at our Low secure unit.

There is an already established network of collaboration with the Restraint Reduction Network and Navigo who support our developments and implementation plan. We joined the Community of Practice for the Use of Force.

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.

The service user voice is at the heart of the training package related to psychological restraint developed during Year 2 and delivered across Year 3. It has proven invaluable in raising the awareness of coercion and its impact on patients and staff, giving time to reflect and think about how this may be considered and reduced in practice.

Feedback from the training has been positive:

"this has made me think, understand and be more aware of my practice"
"It just goes to show the impact of our words and actions – the way we speak to everyone really matters"
"We need to understand and be more respectful and give people choice.

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.


Sheffield Health and Social Care NHS Foundation Trust

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 tranquillisation.

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).

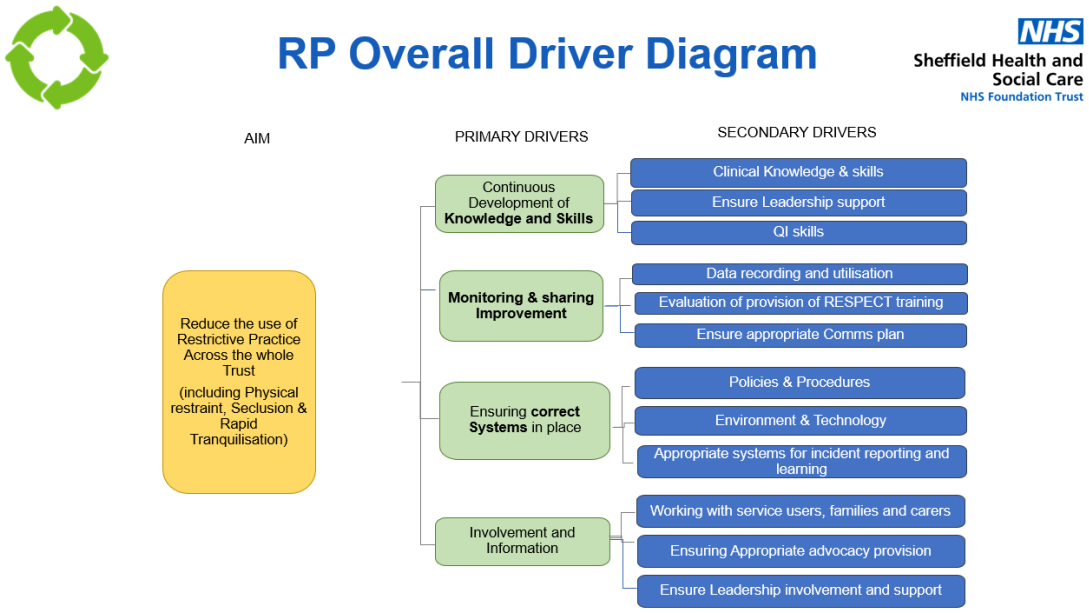
Use of Force Requirements	
1. Service providers operating a mental health unit to appoint a 'responsible person' who will be accountable for ensuring the requirements in the Act are carried out	Achieved in Year one and two Remains compliant in Year three.
2. The responsible person for each mental health 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	Achieved in Year one and year Remains compliant in Year three The Use of Force Policy was reviewed and republished in April 2024

	minimise) the use of force by staff who work in the unit.	
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 with full implementation achieved in Year 2. Booklet and poster produced led by service users and staff and delivered to ward teams. Recording documentation developed and integrated into EPR. Used within training. 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 and remained compliant in Year two following review of RESPECT training programme and additional sessions provided. Further training has been developed and delivered related to care planning, human rights, SafeWards, psychological restraint 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. 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. Continues into Year 3 with a focussed project on ethnicity recording. Proportionality was included in data reporting in Year 3. 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 Compliance continued in Year two with evidence of further investigations and learning, which were used to inform policy and procedure review. Year 3 saw the implementation of PSIRF.
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 the police is incident reported and shared as necessary with our police liaison. Our incident reporting system enables us to record the involvement of police and the reasons why.

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 Three 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.

Year three actions have progressed with the majority of these being achieved and closed. This was celebrated by the hosting of a Least Restrictive Practice conference in April, where national expert speakers gave us ideas for our next strategy workplan and our teams shared their progress over this last year, being proud and celebrating what they had achieved together. A number of partners joined us and several people with Lived Experience presented their feedback.

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. Further detail about the Quality objectives can be found under "Key Findings related to Protective Characteristics" (section 3.3)

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 Three the Least Restrictive Practice strategy focussed on:

1. Ward moves and working without seclusion – using staff skills and knowledge in proactive care planning, de-escalation and alternatives to the use of force
2. Post Incident reviews
3. Learning from incidents and audit
4. Training on Human rights and psychological restraint
5. Developing and delivering practice development sessions focused on key elements of policy requirement such as seclusion reviews and prolonged restraint

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

- Reduction in seclusion provision and taking the steps to “work without seclusion” on all of our acute inpatient wards.
- Commissioning and receipt of resources with the Restraint Reduction Network to highlight the impact of psychological restraint and the embedding into our restraint reduction training (RESPECT)
- Development of RESPECT training to include human rights and psychological restraint 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 with a focus on post incident support and follow up for both staff and service users
- Mental Health Act Reform project
- Sustained Restrictive practice oversight and operational groups with focused inreach support to individual teams or professional groups such as preceptee nurses and new Doctors
- System of review and support to teams and individuals via the daily incident huddle
- Continued safe wards project and monthly forum.
- Audit schedule and quality improvement projects
- Development of standard operating procedures. Using learning, to support practice and policy implementation and local training sessions to support this
- Review and update of all relevant policies (Use of force and Seclusion) with planned review of the remaining later into 2024. Relevant guidance documents have also been updated or developed to support practice at team level such as “caring for the pregnant service user”

Key improvements

The most significant success during year 3 has been the enhancement of ward environments, provision of de-escalations spaces and plans for the removal of seclusion from our last acute ward, introducing the Broset tool to risk assess the risk of violence and establishing an Urgent PICU Pathway to support this work. Reduction in use of seclusion in a sustained way and use of restraint. Greater understanding of other forms of restrictive practice with improved reporting, such as search.

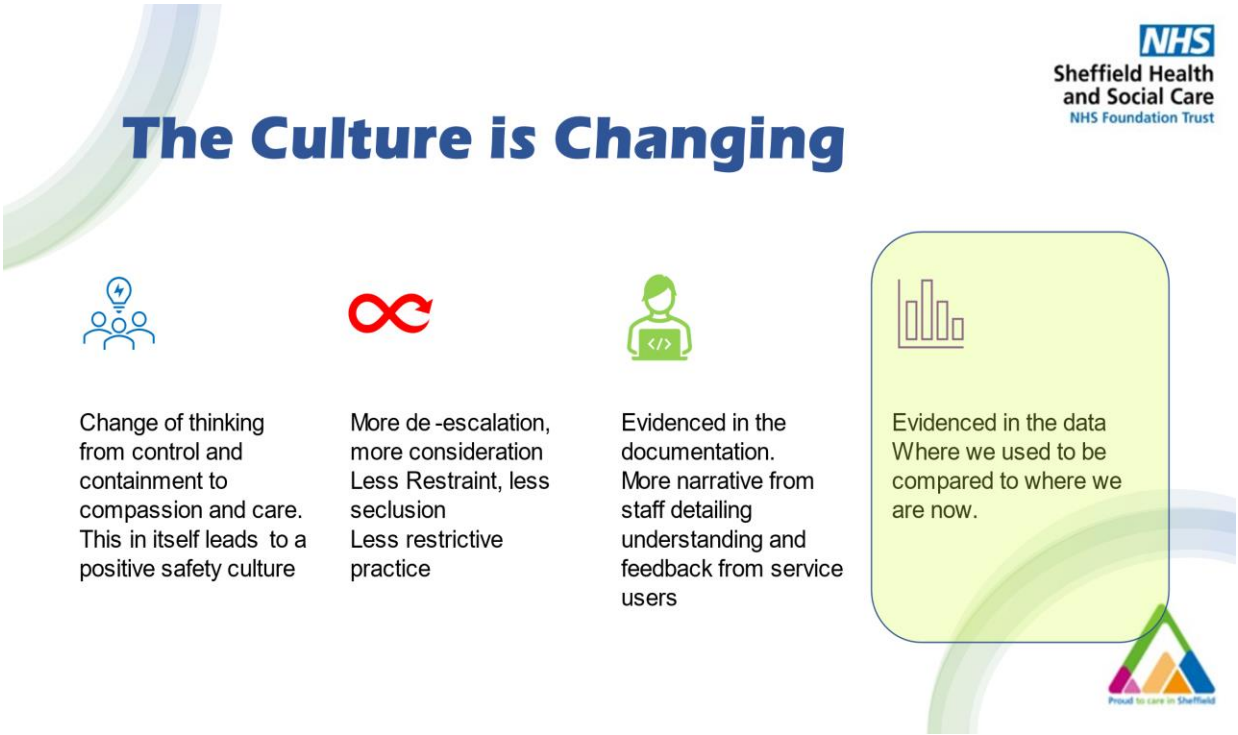
Our Relationship and co-working with others has deepened and progressed, working alongside SACMHA, Pakistani Muslim Centre and the Statutory Advocacy service.

There has been a reduction in restrictive practices, most notably seclusion and restraint and we continue to improve 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 continue to keep a watchful eye on 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. From our incident reporting system, we are able to see that staff are using oral medication for distress in the first instance and using their skills to encourage service users to take this rather than using rapid tranquilisation. We are mindful that this approach may involve an element of coercion and will review this in the next workplan as we receive the results of the rapid tranquilisation POMH (prescribing observatory for mental health) audit undertaken in January 2024.

> *"Two years ago, the staff on Stanage were told they were going to seclusion free. The reaction was one of horror. Last week on Maple when staff were told the same news after the move, they welcomed it. That's evidence of change of attitudes"*
>
> **Conference attendee**

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

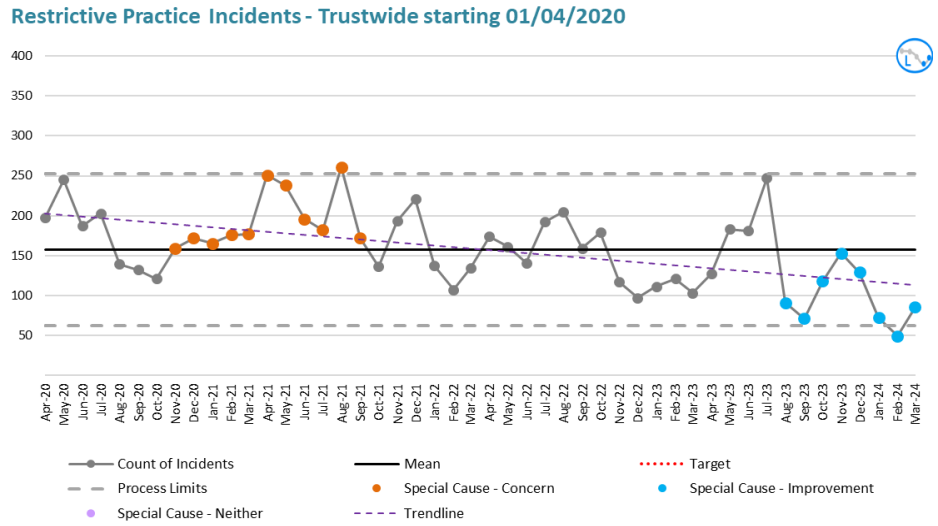


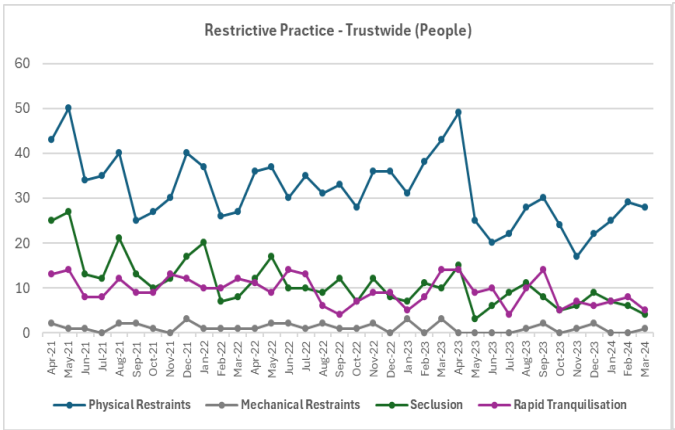
3.0 Data

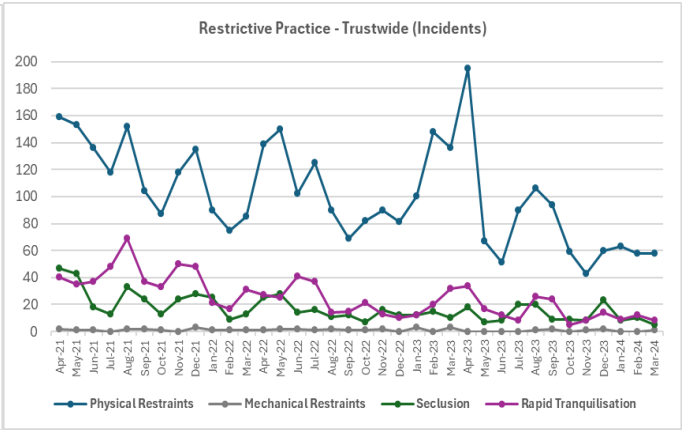
3.1 Collecting and using data: summary of improvement:

During Year One the need was to develop and implement Service to Trust level dashboards, which has been achieved with progressive improvements seen in the recording and analytics of various types of restrictive practice and the different communities we care for. Year Three sees us with advanced data, scrutiny, being inquisitive and learning the stories behind the data. The Post incident review work has provided us with real life accounts from our patients and staff, helping us think about what else we might need to consider.

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.







The charts above illustrate our data in regard to restrictive practices

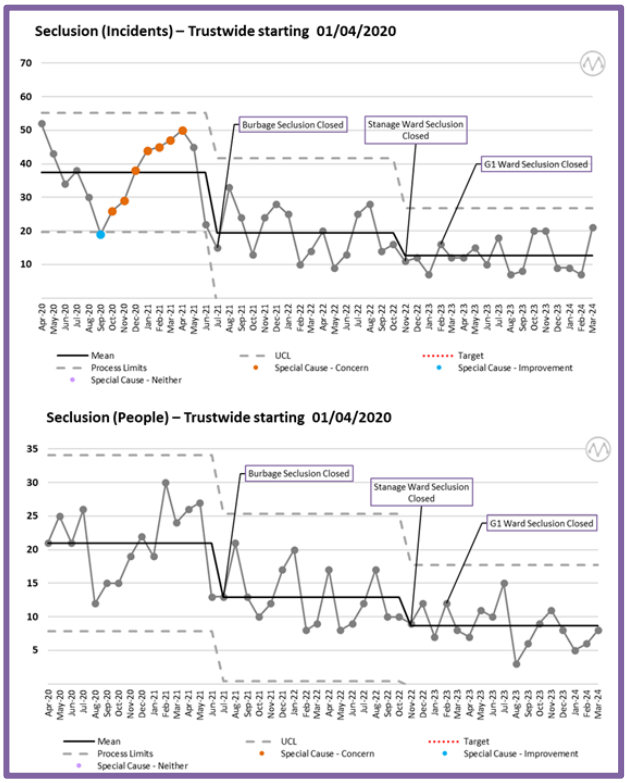
The standard within the organisation is to provide two years rolling data to enable comparison between the year being reported on and the previous year; however, to illustrate progression through the 3 years of our Least Restrictive Practice Strategy, we have expanded this data to start from April 2021 to March 2024.

Its reflected above, that while there have been fluctuations in the number of incidents throughout the 4 years, the trendline shows the work being done to improve the care we provide is showing success and decreasing the amount of restrictive practice used in our services. As we continue to improve the care we provide, we expect the data will also reflect our continual improvement in 2024/2025.

Seclusion

Seclusion Room Closures:

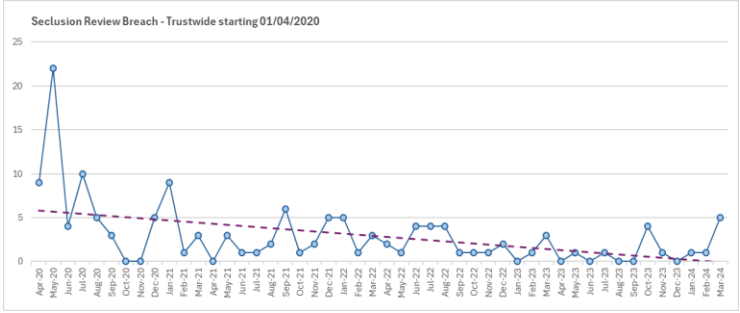
- Burbage Ward (July 2021)
- Stanage Ward (November 2022)
- G1 Ward (February 2023)
- Maple (planned June 2024)



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.

Our overall use of seclusion has reduced from an average of 38 episodes (21 people) a month at the start of the Least Restrictive Practice Strategy to an average of 12 episodes (9 people) a month.

Seclusion Reviews

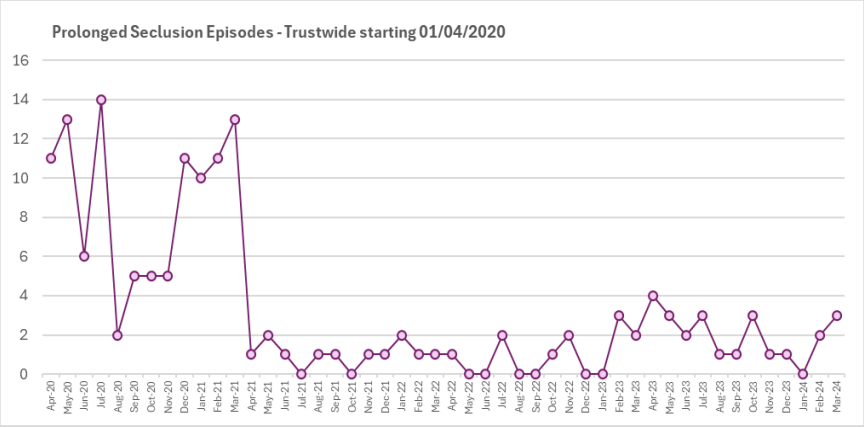


Seclusion review breaches were not accurately or effectively reported prior to the commencement of the Least Restrictive Practice workplan, as the data reflects more reported incidents during this work to improve reporting. With the review and substantial update of the seclusion policy, the development 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



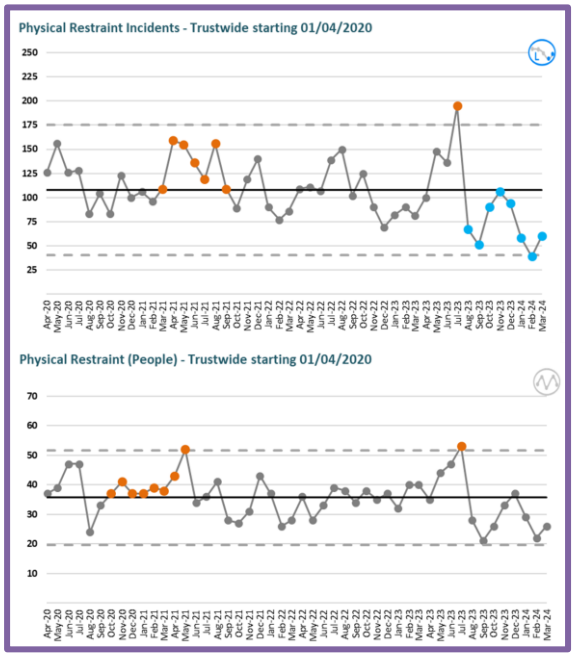
Prolonged seclusions are classified as a seclusion episode that lasts over 48 hours. Incidents are reported at 48 hours, 72 hours and then seven days. A briefing form is required at the 7-day point. On examination during the annual cycle it was identified that men from an ethnically diverse community 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 2 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 Patient and Carer Race Equality Framework (PCREF)
- Race equity sessions on Respect training
- Appointment of Race Equity Officer
- 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.



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.

From reviewing the data, there are 7 consistent months falling below the organisations 2-year average, we are confident in the indication that the beginning of the next year, April 2024 will show this continuing and reflect a trend of low use of Physical restraints.

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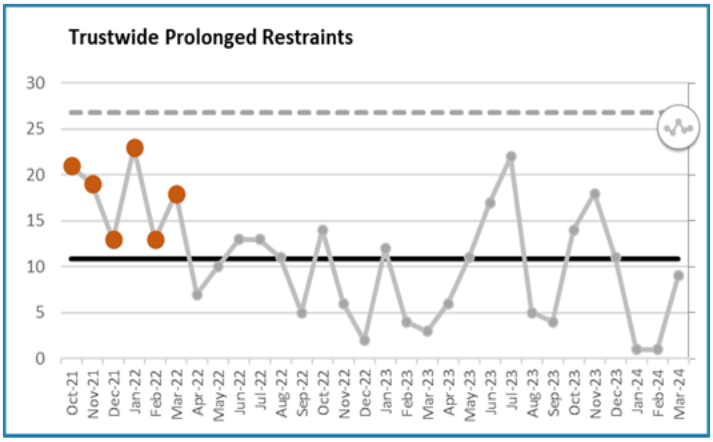
Prolonged Restraint

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 12% across the year have missing timings. This is an ongoing improvement project.



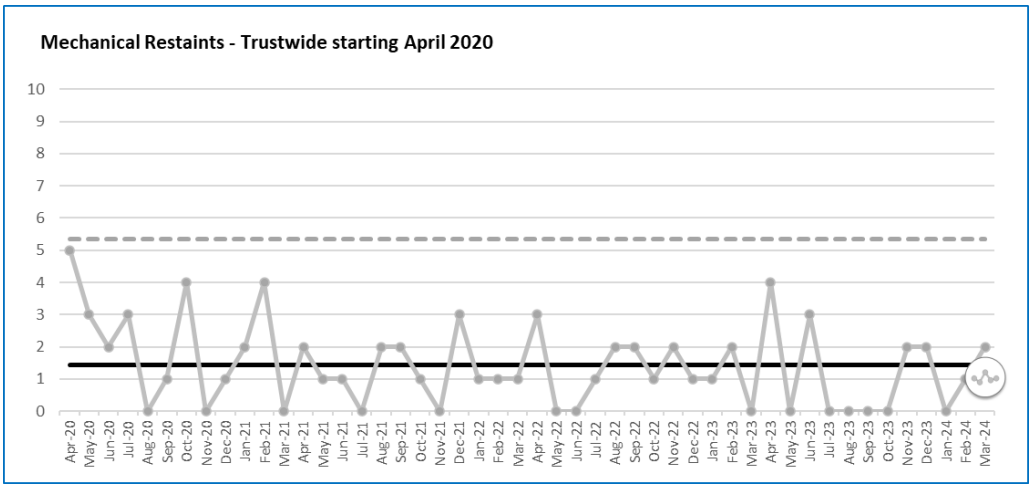
The number of prolonged restraints has reduced since the work on the plan however there continues to be fluctuations mainly related to long restraints for females who are self-harming. Our improvement plan on use of and response to prolonged restraint continued across Year 3 with a planned reaudit later in 2024.

It was suggested that prolonged restraints might increase with the reduction of seclusion rooms on both Burbage ward and G1 ward, 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. 2023/2024 has seen continued attention and follow up to understand each mechanical restraint reported. Links to ensure review with the secure transport provision and the police have been developed. Some of these events went to further investigation. In addition, with the work with PCREF we have commenced detail related to ethnicity.

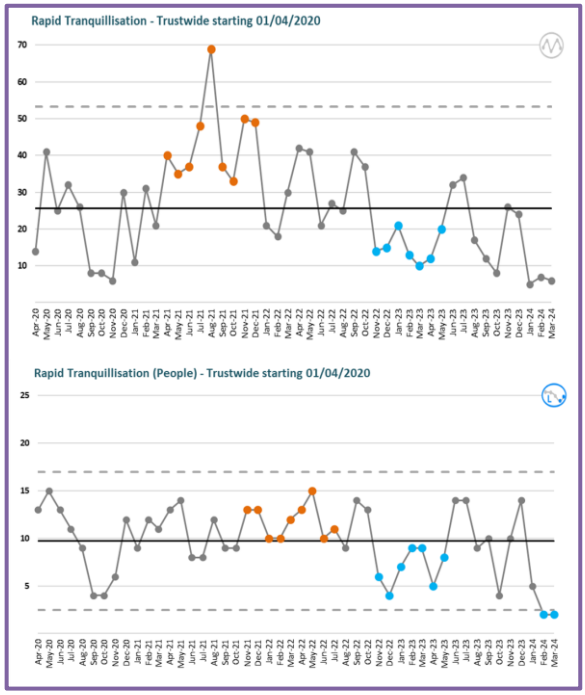


Rapid Tranquilisation

Along with seclusion and physical restraints peaked in the summer months in 2023, rapid tranquilisation showed peaks in the number of instances during this same period.
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 continue to keep a watchful eye on 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. From our incident reporting system, we are able to see that staff are using oral medication for distress in the first instance and using their skills to encourage service users to take this rather than using rapid tranquilisation. We are mindful that this approach may involve an

element of coercion and will review this in the next workplan as we receive the results of the rapid tranquilisation POMH (prescribing observatory for mental health) audit undertaken in January 2024.

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 2023/2024 training around rapid tranquilisation was 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. In Juen 2024 this training moved to form part of the Immediate Life support training



Whilst there have been fluctuations each quarter on the number of rapid tranquilisations, the trend shows a sustained reduction since July 2022, ending the year with 4 consistent months falling below the organisations 2-year average. We are expecting continuing below average use of Rapid Tranquilisation in April 2024.

3.2 Report of use across types

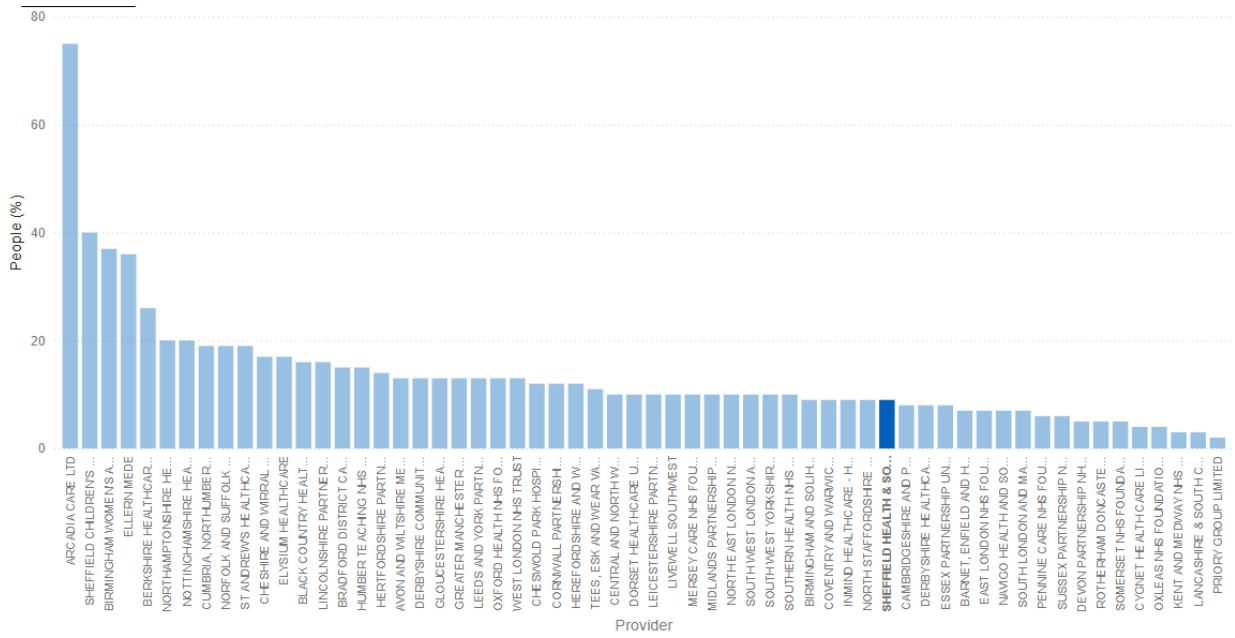
Type of restraint is dictated by the Use of Force Act 2018 which is aligned to the NHS Digital Mental Health Services Data Set (MHSDS). This is a contractual and legal requirement of all providers of mental health services who receive NHS funding. The data is reported publicly on NHS digital as well 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 up until March 2024 where it changed to version 6. 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 Standard Operating Procedure to support practice and gain assurance that we have improved reporting around this.

National Benchmarking

Below demonstrates the percentage of people in hospital who were subject to restrictive interventions.



Source: NHS Benchmarking Network, Inpatient and Community Mental Health Benchmarking 2023/24.

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 and then 31st in February 2024, with movement throughout the year.

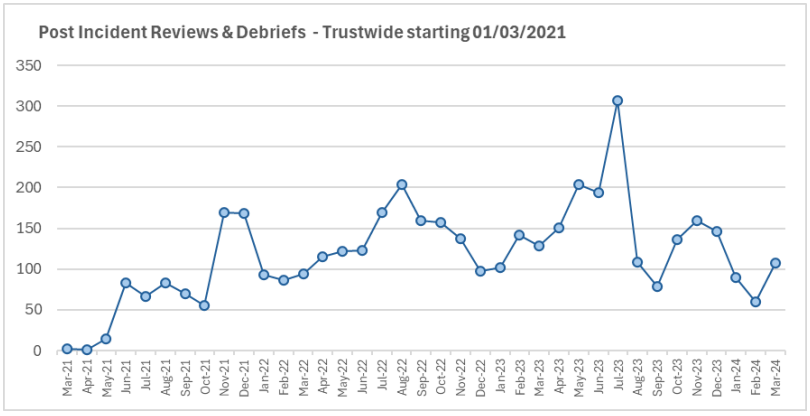
In February SHSC were 31st highest user/reporter of Restrictive Practice (from 48 provider submissions), with 9% of people being subject to restrictive practices. We are unable to demonstrate the position of SHSC in March 2024 due to interruptions in data submissions following version changes of the Mental Health Services Data Set (MHSDS).

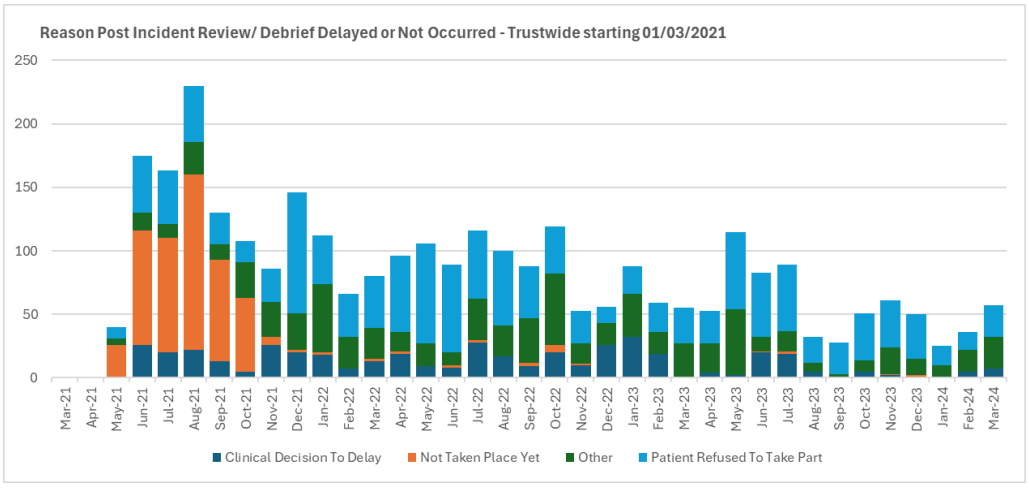
Post incidents review data

*"Being involved in the least restrictive practice work has been an essential part of our journey to creating therapeutic and trauma informed wards. I have valued the opportunity to share my passion with likeminded colleagues and to observe the positive changes that are taking place to improve service user experience and reduce re-traumatisation" (**Dr Stacey Robson, Principal Clinical Psychologist)***

One of the priorities for Year Two was the Post Incident Review Project. During this period we collaboratively reviewed the systems, processes, and practices to enable effective and sustained undertaking of support following a Restrictive Practice event. Year Three has seen this progress, being embedded into the Respect training, data reporting and more importantly across the Trust as part of trauma informed care and practices. We have delivered co facilitated sessions with people with lived experience to teams across the Trust

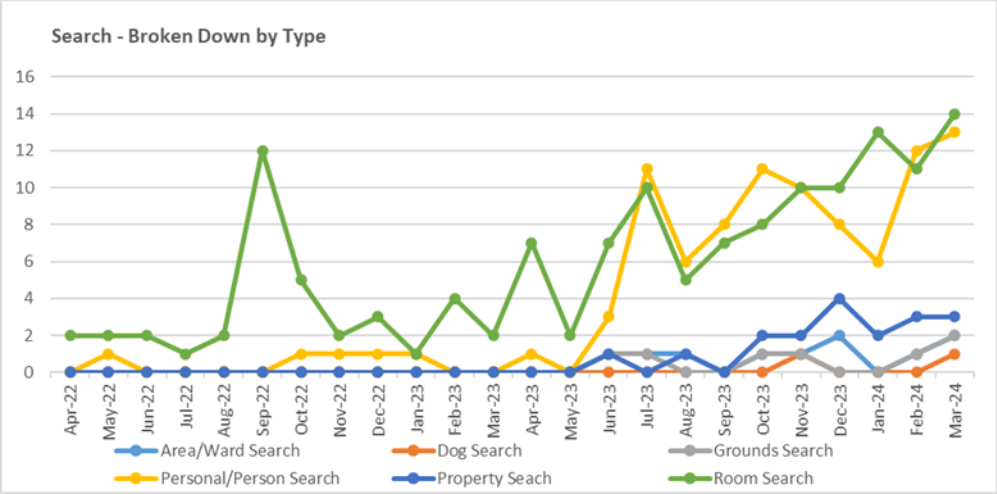
and professional groups such as Consultant leads. Following the audit in Year one, year two has seen a move into an established Quality Improvement project supported by a project group consisting of staff, experts by experience and partners. A tool kit and reference pack along with a dissemination plan 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.





Data collection commenced in May 2021 and reporting started in August 2022 and have provided this until the end of this reporting period, March 2024.

Searches



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

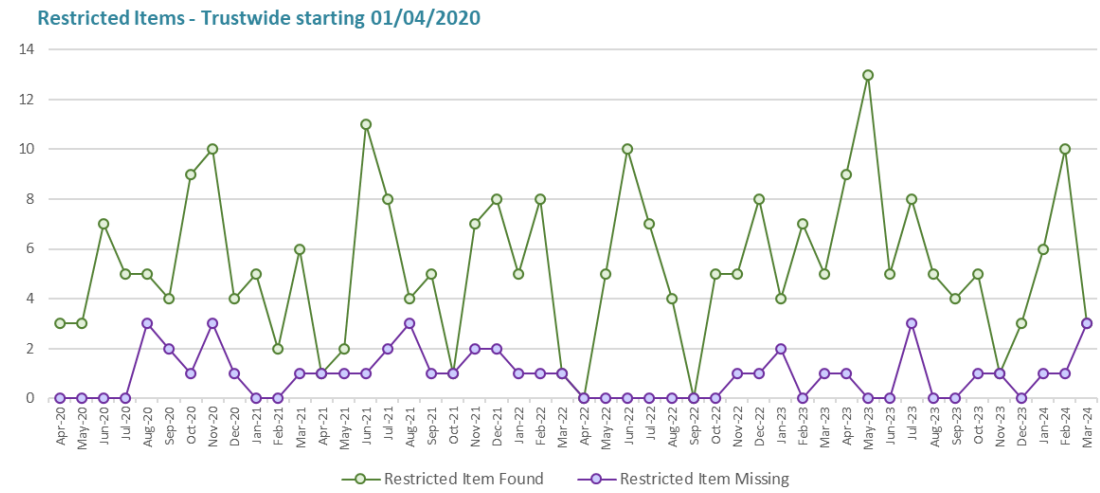
- Restricted items found.
- Smoking breach
- Self-harm
- Security
- Substance misuse
- Search

During the 2023/2024, search training continued to be delivered via the Respect training programme and local sessions provided on request.

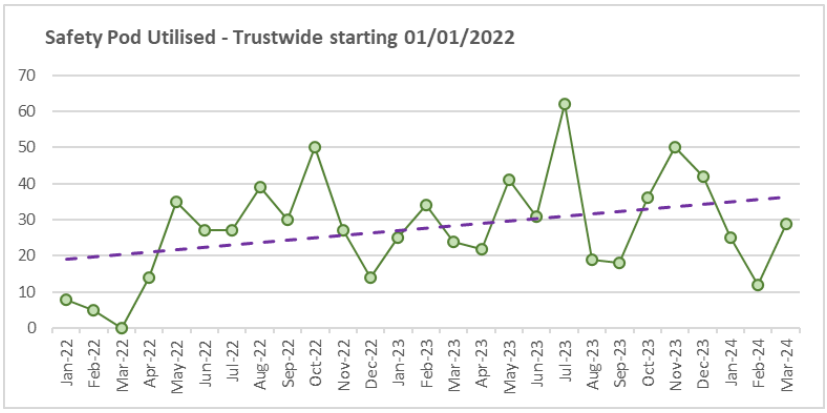
As part of this work, we have seen more detail related to search required and undertaken in the narrative of incident forms. Work on updating the incident form on Ulysses (Electronic Incident and Risk Management system) has seen improvement in the recording of searches and improved the output of data we are able to analyse.

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. A scheduled review of restricted items and blanket restrictions, using learning form incidents and feedback from teams, took place during the annual cycle giving update to the list. Following a blue light alert both aerosols and plastic bags were added to our list of blanket restrictions. the next annual review is due later in 2024



Safety Pod



Use of Safety Pods commenced in January 2022.

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 2 and 3 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 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.

3.3 Key findings related to protected characteristics:

Our quality objectives were set in 2021 as a three-year plan. 2023/24 was our final year to achieve these objectives which build on the progress we had made in 2021/22 to get 'Back to Good', improve the quality of services we deliver and improve safety for service users, staff and communities more broadly.

> *"It's really important that we continue to build connections and work together in treating all our patients with compassion, dignity, and kindness. In co-producing the Least Restrictive policy in partnership with patients, carers, staff and community organisations of colour, green shoots have begun to appear that evidence where positive approaches and timely interventions have been implemented by staff and through the involvement of our Cultural Advocacy Link Workers and the Race Equity Officer have contributed to reducing the need for restrictions to be placed on patients".*
> ***Jenny Hall, PCREF and Carer Strategic Lead***

Quality objective: Over a three-year period demonstrate a measurable and equitable reduction in the use of seclusion and restraint

Why we chose this priority

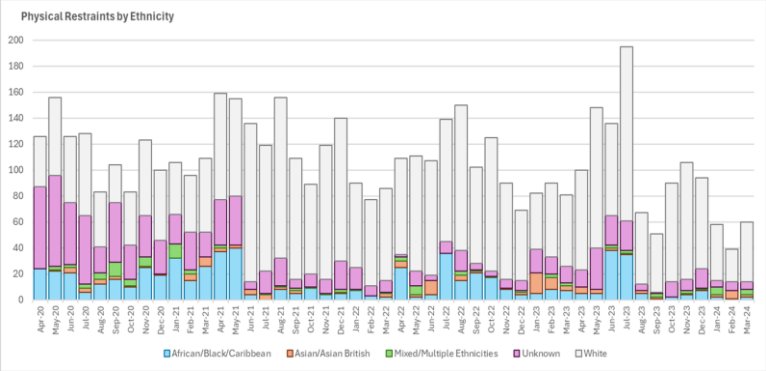
We recognise that we had been above the national average on the use of restraint and seclusion. We had multiple practices that are restrictive across the range of our services, from locked doors, restriction of personal items, use of enhanced observations, high detention rates and high levels of restraint and seclusion in some of our services.

Being restricted is a human rights issue and we recognise that for many of our service users restricting them, either through their movements or by their environment, can trigger increases in anxiety, flashbacks of past trauma and can cause a lack of trust. We are committed to reduce the number of times we restrain and seclude service users, and we want to ensure that this reduction is the same across all service user groups, demographics and protected characteristics.

This objective is aligned to our Least Restrictive Practice Strategy, which is an enabling strategy of the Clinical and Social Care Strategy. It also aligns with our strategic priority 'continuous quality improvement'.

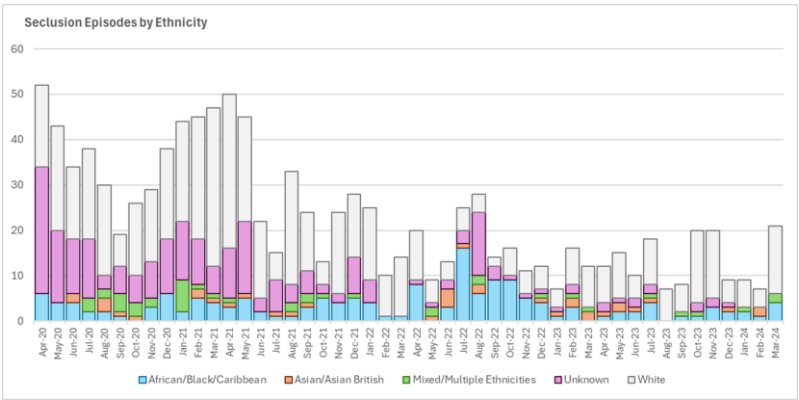
Year three - we said we would:	How have we done?
• Baseline ethnicity data for seclusion 22/23 to measure for reduction 23/24	☑
• Pakistani Muslim Centre commenced Cultural Advocacy from July 2023 to promote cultural awareness within inpatient wards for staff and service user, Qualitative/Quantitative feedback quarterly to Tier 2 assurance groups	☑
• Equity Lead (SACMHA) to commence inpatient liaison work with acute wards to reduce use of restrictions supporting post incident reviews for service users and staff post seclusion and prolonged restraint. 100% of reviews completed.	☑

Going forwards:
Our focus on the inequalities in racialised communities continues to be a major focus for us going forwards in 2024/25 and will report through our race equity work. Whilst it is no longer a specific Quality Objective, addressing inequalities remains a strategic objective for SHSC.



Outcomes:
While the overall number of restrictive interventions has fluctuated since April 2021, improvements can be seen this year in the number of restraints and seclusion episodes for Black British/ African/ Caribbean people

- This year (2023/24), 37 people were restrained compared to 56 people the year prior (2022/23)
  This year (2023/24), 17 people had a seclusion episode compared to 42 people last year (2022/23).



Quality Objectives 3 Year Overview

- We co-produced our Least Restrictive Practice Strategy with the involvement and support of service users, staff and others linked to the Trust to ensure that it represents the needs of those who experience it first-hand.
- We held a Least Restrictive Practice Conference in November 2021 as the platform to formally launch the Least Restrictive Practice Strategy and to celebrate the work underway and share national learning and thinking. We then held another conference in April 2024 celebrating progress, sharing learning, and discussing future planning.
- Ward level dashboards have been developed ensuring local ownership as well as Trust wide dashboards for governance and assurance.
- A system was developed to monitor and report on staff and service user debriefs following incidents of restrictive practice - this enables us to understand the impact that restrictive practice has on service users and staff and helps to strengthen our commitment to reduce their use
- We have removed seclusion on 3 of our wards and we have not seen significant increases in other forms of restrictions as a result. We are moving towards removing another Seclusion room on an acute ward in Summer 2024.
- Revisions to the Level 3 RESPECT training update have been completed in line with the changes to the Use of Force Act and incorporating co-produced Race Equity and Human Rights Training.

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 saw a full review of the RESPECT training program, aligning it to both the RRN standard and the Use of Force Act. A new cycle of training has been agreed following on from last year and will start in September 2024 -

- Level 3 Update – Scenario based training, Incident reporting, record keeping, Physical health monitoring, post incident support.
- Level 3 – Will include an update for the Post Incident review work supported by Our Race Equity Lead.
- Level 1 – Following the success of Human Rights Act Training in the Level 3 Update and linking in with the Least Restrictive Practice work for Community Team this session has been adapted for Level one and will be delivered by SHSC's Human Rights Act Officer.

The RESPECT training programme 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 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. The 2-day update includes a focus on the Use of Force policy and guidance, and this will be on a yearly cycle of change.

Our minimum requirement is to have 3 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

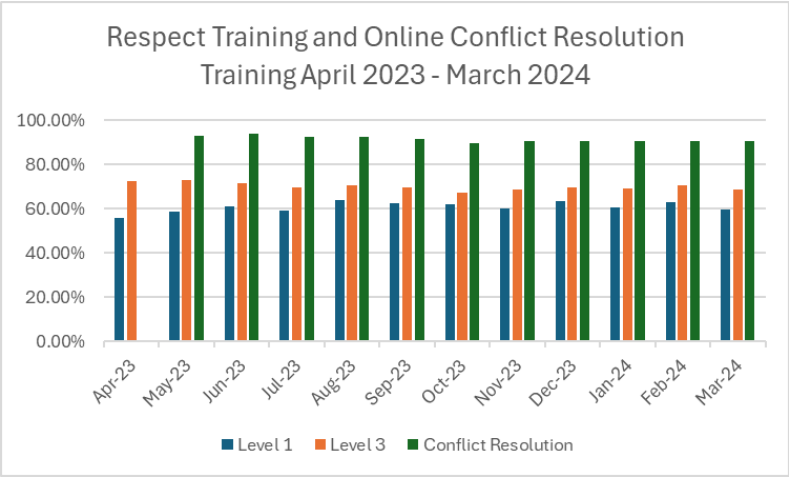
We have introduced a number of training topics either within the RESPECT course or to compliment this:

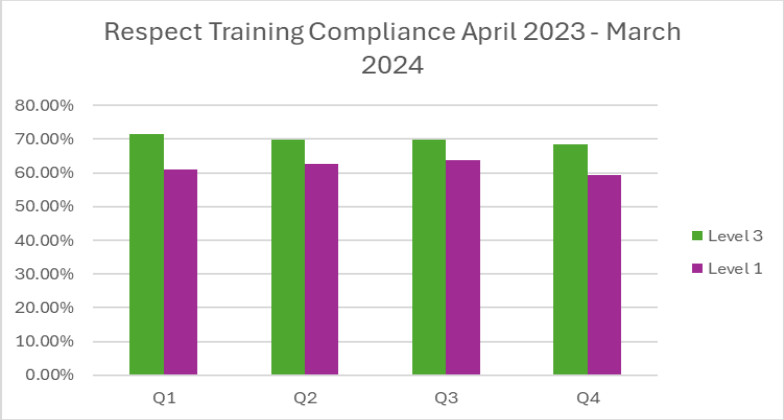
- Human rights
- Psychological Restraint

- Trauma informed
- Autism
- Care planning, equity and race, carers and activity
- Search training
- Seclusion standards
- Cultural Awareness Training
- Doctors/Medics Induction and Continuous Professional Development sessions
- Medicines Optimisation Training (Rapid Tranquilisation)
- Safewards

Training compliance

Substantive Staff





Bank Staff

	Quarter 4 Training Compliance	
Area	Respect Level 1	Respect Level 3
Bank Primary Assignment	**22.99%**	**50.00%**
Bank Nurses Primary Assignment	**21.95%**	**42.31%**

Bank Support Worker Prim Assignment	**28.13%**	**51.43%**

In Year 3 we commenced scrutiny of the data for nonattendance and places not filled at training so we could report to team managers and seek ways to use the places effectively. can be more

Class cancellations have on the whole have been due to staff trainer absence and due to the size of the team this can be more difficult to address however at times we have prevented cancellation by utilising instructors from clinical areas at short notice.

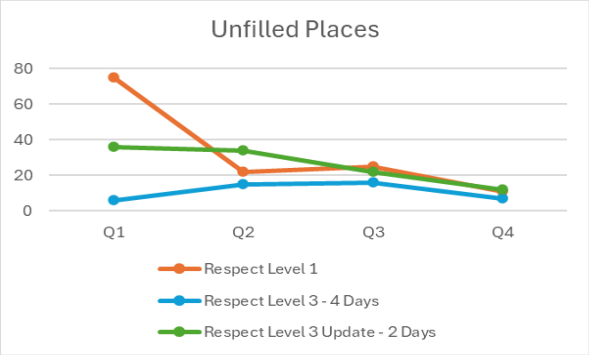
The Level 1 course is where there is the biggest volume of places not filled and DNA (Did Not Attend) occur.

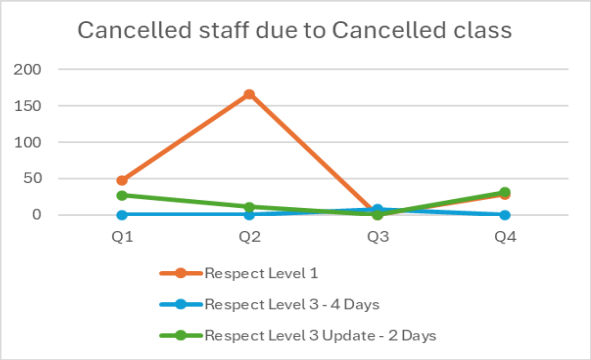
Q1 Apr-Jun23									
Course	Unfilled places	% of unfilled places	Cancelled Classes	Cancelled Staff due to Cancelled Class	Closed (Attended) Classes	Staff Completed	Staff DNA	Staff Did not Pass	Withdrew at short notice (within 3 days of training)
Respect Level 1	75	20.38%	4	48	23	253	40	0	26
Respect Level 3 - 4 Days	6	6.25%	0	0	6	79	5	7	2
Respect Level 3 Update - 2 Days	36	28.13%	2	27	8	88	12	2	10

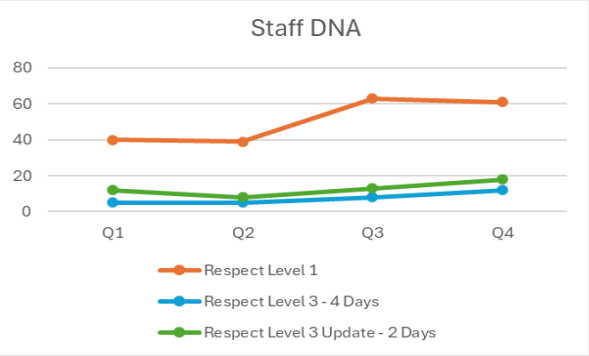
Q2 Jul-Sep23									
Course	Unfilled places	% of unfilled places	Cancelled Classes	Cancelled Staff due to Cancelled Class	Closed (Attended) Classes	Staff Completed	Staff DNA	Staff Did not Pass	Withdrew at short notice (within 3 days of training)
Respect Level 1	22	7.24%	11	166	19	243	39	0	24
Respect Level 3 - 4 Days	15	18.75%	0	0	5	58	5	2	7
Respect Level 3 Update - 2 Days	34	23.61%	1	11	9	98	8	4	5

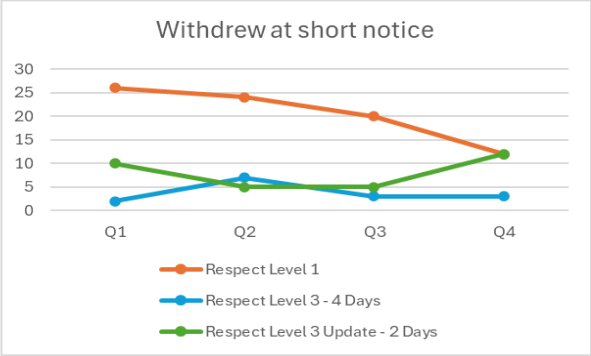
Q3 Oct-Dec23									
Course	Unfilled places	% of unfilled places	Cancelled Classes	Cancelled Staff due to Cancelled Class	Closed (Attended) Classes	Staff Completed	Staff DNA	Staff Did not Pass	Withdrew at short notice (within 3 days of training)
Respect Level 1	25	5.76%	0	0	27	346	63	0	20
Respect Level 3 - 4 Days	16	25.00%	1	8	4	34	8	6	3
Respect Level 3 Update - 2 Days	22	15.28%	0	0	9	106	13	3	5

Q4 Jan-Mar24									
Course	Unfilled places	% of unfilled places	Cancelled Classes	Cancelled Staff due to Cancelled Class	Closed (Attended) Classes	Staff Completed	Staff DNA	Staff Did not Pass	Withdrew at short notice (within 3 days of training)
Respect Level 1	11	2.99%	2	28	23	296	61	0	12
Respect Level 3 - 4 Days	7	8.75%	0	N/A	5	51	12	10	3
Respect Level 3 Update - 2 Days	12	9.38%	3	31	8	95	18	3	12









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.

Quotes from teams, staff and people

"Least restrictive practice is a way of constantly developing and maintain higher standards of patient centred care. In being patient centred and focussed staff can develop strong therapeutic relationships with patients and work in a trauma informed. Promoting interventions such as SafeWards, relational security and implementing practice from the restraint reduction network had a positive effective in reducing the frequency of restraint on Burbage and Stanage Ward".

Declan Murphy, Senior Nurse Practitioner

"It's made staff think of every possible alternative. The positively wall has helped make new service users feel hopeful and the "get to know you wall" has definitely brought up some interesting conversations which has channelled the thoughts of distressed service users to something else".

Elle Forde, Senior Nurse Practitioner

"Least Restrictive Practice implementation has made us look at care delivery via a different angle. What may seem 'routine' or 'the norm' to complete the task may seem completely different when you are on the receiving end of it. Implementing lesser restrictions has enabled us to open up the personal experience for our residents and their relatives, increasing engagement and therapeutic relationships, all of course being underpinned by legislation".

Emily Blakeman, Manager

"Working collaboratively to reduce the use of seclusion on Maple ward has allowed us to provide a safer therapeutic environment, that is conducive to improving the patient experience and promoting long-term recovery".

Ryan Marsden, Ward Manager

"The quote from us at Beech is "Active minds, leaves negativity behind!".
We've given this a lot of thought as restrictive practice is at a minimum here, however we want our service users to have a positive experience and feel supportive so that they are able to continue with their recovery and move on from us being equipped to manage their next step in the community".

Mark Walton, Unit Manager

"When someone is detained or deprived of their liberty, it is important to recognise that this puts their other fundamental human rights at risk. However, we can prioritize their human rights by following the principle of least restriction even when they are receiving treatment under coercion. This approach allows us to provide treatment while still honouring their dignity and autonomy. With empathy and respect, we can work together to ensure that individuals are supported in an environment that upholds their fundamental human rights".

Tallyn Gray, Human Rights Officer

"The least restrictive practice work has meant that the Therapeutic Environments Team have been able to gain a clear steer on what de-escalation on an acute inpatient ward environments should look and feel like, allowing for purposeful design take place of those spaces on our newly refurbished wards, Burbage, Stanage and soon to be Maple ward".

Adele Sabin, Estates Programme Manager

"The successful implementation of the Psychological Restraints project, the introduction of the Broset tool, and the development of Standard Operating Procedures which are co-produced and hold human rights at their core, reflect our commitment to address coercion, promote safety, and create a culture that is supportive and compassionate. We are proud of the positive outcomes achieved through the programme and remain dedicated to the continuous improvement of high-quality care in the least physically, and psychologically, restrictive environments possible".

Simon Barnitt, Chief Nursing Information Officer

"Least restrictive practice model is a priority focus for our inpatient wards and PICU wards to provide quality, safe care in the least restrictive way. All our wards are working in a least restrictive way whilst still promoting safe care. The wards are developing lots of initiatives to work in the least restrictive way, this includes implementation of Safecare, Broset tool, observation and engagement pilot and safety huddles. All wards are implementing post incident reviews so that we can and develop the way we work with our patient population. We work in a trauma informed way and align our service developments with the Clinical and Social Care Strategy".

Gemma Robinson, General Manager

"The hard work and persistence of our clinicians at all grades to provide interventions, care and treatment that is compassionate and keeps everyone's dignity at the centre is great".

Richard Bulmer, Head of Service

"It's been great supporting Lorena in articulating the LRP Long Term Plan, helping keep track of the progress of the plan and ensuring deadlines are met"

Rebecca Goodison; Project Support Officer

"Working with Lorena and the Least Restrictive Practice team in bringing this important work to life has been a privilege; really proud to be on this journey with them!"

Chin Maguire; Programme Manager

5.2 Audit Schedule (based on standards and policy requirements)

During Year Three we have developed and progressed an extensive audit schedule, supported by the Trust Clinical Effectiveness department and delivered by team practitioners. Over this year we have audited

1. Seclusion medical and nursing reviews
2. Seclusion care plans
3. Physical Health monitoring
4. The standards for care following prolonged restraint
5. Safe wards implementation via a peer review

5.3 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.

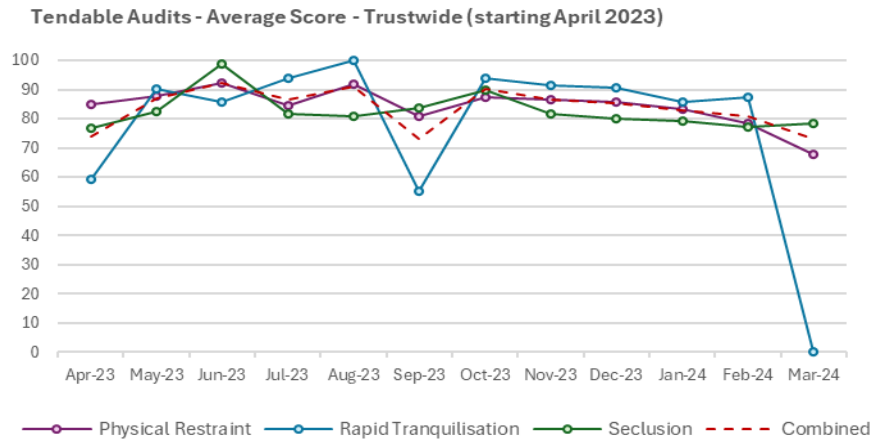
This works formed part of a Project Management Office project plan during Year two and was closely monitored for compliance. It forms part of the reporting cycle for the Least Restrictive Practice Oversight Group. Phase one of the plan was focused on ensuring audits were completed and testing the audit 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%
Woodland View	No Submission	No Submission	Not Required
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.

Quality Improvement

During Year three several quality improvements projects were established related to the Reducing Restrictive Practice agenda and outcome from audits

1. Improving physical health recording following Restrictive Practice
2. Improving the quality of medical and nursing seclusion reviews
3. Improving the undertaking of post incident support
4. Improving the quality-of-care planning related to the use of seclusion
5. Supporting “moving to a ward working without seclusion”

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.

Quality Improvement project updates

Maple Development support plan
Biweekly meetings have continued to run during the last quarter supporting the leadership team to review incidents and practice using this to inform the improvement plan. This group is a subgroup of the Maple mobilisation group as it moved towards the transition to MCC and working without seclusion. Improvement is significant with a reduction in use of RP, practice development at team level related to use of activity and the Broset tool and the implementation of safe wards. This group will be stepped down following at last meeting following the move in July 2024.

Seclusion review breach project
This work continues by collaborative working with the senior Lead Dr and contributing to Drs induction training 4 times per year. A 2nd audit was undertaken showing improvement in compliance with standards and quality of records. Where breaches occur, these are followed up by the Lead Dr and Nurse Consultant. A 3rd run of the audit if underway lead by junior Drs on Endcliffe ward. Learning from this project has been applied to the Nursing seclusion review work. Evaluation of the training sessions delivered throughout the year have been shared which show evidence of good learning and finding this useful for their practice.

Nursing Seclusion review and care planning action plan
A small task and finish group of RRPOG (Reducing Restrictive Practice Operational Group) was established, following the audit undertaken during Q3 and presented to LRPOG in February 2024. The lead auditors (staff from Endcliffe and Forest Lodge) have progressed the action plan and a nursing seclusion review template and seclusion careplan are now in place, supported by local training sessions to aid implementation. There is a plan to reaudit later in the year. Links have been reestablished with the RIO team to ensure this is bulit into digital systems.

Physical Health monitoring action plan
An audit was undertaken in Q3 which indicated that staff were not completing all physical health observations as per standard. An action plan has been developed to improve the taking and recording of physical health via training and team-based support. The implementation of RIO across the service will also support this. This has been done in conjunction with the Physical Health team. A rerun of the audit is planned for later in the year.

Endcliffe seclusion practices work
Following a number of concerns related to seclusion standards and use of seclusion, a session was held by the Nurse Consultant for RP with the Endcliffe leadership team. Work to improve has been led by the Advanced Clinical Practitioner and the newly appointed Senior Practitioner, overseen by the Matron. Improvement has been noted during the quarter. Endcliffe will form part of the first phase of the “Culture of Care” work programme.

Rapid Tranquilisation reporting
Attention was given at team level via the relevant matrons and supported by pharmacy, team governance officers and the patient safety team. This has included guidance and videos, individual follow up and sessions at team level.

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.

Risk Register

There is one open, corporate risk (5220). “Inpatient care is not delivered in the least restrictive way due to a lack of RESPECT trained and skilled staff on duty on the inpatient wards, 24/7 and 7 days a week.” Following a review of budgets and team composition capacity in the RESPECT Team has been increased by 0.6 practitioner time to work into the clinical teams and deliver training. This post was appointed to as a 6-month secondment from April and has enabled more courses to be put on. DNA and places unfilled are being monitored and reported to Department Leads for actioning as this is still having a significant impact on compliance levels.

7.0 Key priorities from 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 (2022/23 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

Coming to the End of the 3-year strategy

The LRP strategy and workplan is due to come to conclusion towards the end of 2024. A small number of actions remain outstanding (Appendix 2) as per the work plan report and work is underway to bring them to conclusion or to take up within the next workstreams over the next 3 years from January 2025

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

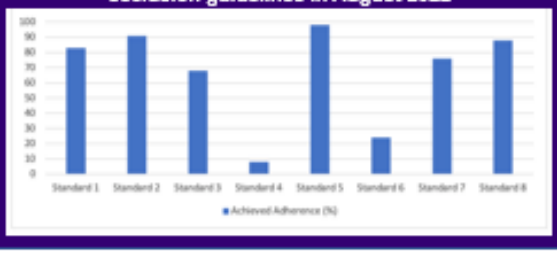
Overall Aim

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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Poster publication date: 23/02/2023

Appendix 2

1. Clinical Knowledge and Skills

Action	Ref.	Start Date	End Date	Status
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	n/a	n/a	
Review and amend routine Human Rights Policies and templates	LT1.2.3	01/08/2023	31/07/2024	On track
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	05/07/2022	~~05/07/2023~~ 31/05/2024	On track
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	05/01/2023	31/12/2024	On track
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	01/07/2023	31/12/2023	On Hold

2. Data Recording and Utilisation

Action	Ref.	Start Date	End Date	Status
Audit of care plans to establish the key components	LT2.2.1			Not Started
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	01/05/2023	30/06/2024	On track
Reduction in the use of seclusion and prolonged seclusion for those people from black and afro Caribbean ethnicities	LT 2.3.1	01/01/2023	~~31/12/2023~~ 30/06/2024	On track

3. Learning and Leadership

Action	Ref.	Start Date	End Date	Status
Post incident reviews inform practice, staff feel supported and led by clinical leaders. Outputs are demonstrated through staff survey and audits.	LT3.3	01/05/2023	~~31/10/2023~~ ~~30/06/2024~~ 30/08/2024	On track
Ensure LRP lead role contributes to other strategy improvement plans	LT 3.5	01/01/2023	31/12/2024	On track

4. Environment and Technology

Action	Ref.	Start Date	End Date	Status
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	01/03/2023	~~01/02/2024~~ 30/12/2024	On track

5. Involvement and Information

Action	Ref.	Start Date	End Date	Status
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 strategy and engagement team workplan)*	LT5.1	30/11/2023	31/12/2024	On track
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	01/07/2022	~~30/09/2023~~ 30/03/2024	Delayed
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 strategy and engagement team workplan)*	ST5.1	01/05/2023	01/06/2024	On track
Health based place of safety - support the development of practice and operating procedures for new build specific to restrictive practice		01/06/2023	~~30/11/2023~~ ~~19/01/2024~~ 31/05/2024	Delayed

6. Policies and Procedures

Action	Ref.	Start Date	End Date	Status
NEW - Review and Refresh of LRP Strategy and workplan (2024-2027)		TBC	TBC	
NEW - Annual Report (2023-2024)		01/03/2024	30/09/2024	

Appendix 3 – Use of Force Poster

Proud to care in Sheffield

NHS
Sheffield Health and Social Care
NHS Foundation Trust

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.

Appendix 4 – PMC / SACHMA Advocacy Poster

Meet our Inpatient Cultural Advocacy Link Workers

NHS
Sheffield Health and Social Care
NHS Foundation Trust

Sayyam Rabbani
PMC "Being There" Worker
sayyam.rabbani@shsc.nhs.uk

Available on the wards:
Mon 4pm - 9pm MCC
Tues 6pm - 9pm Longley Centre
Sat 4pm - 9pm MCC
Sun 12pm - 7pm Forest Close, Forest Lodge

Call 0114 243 6091 Mon to Thurs 11am - 5pm

Tahmina Miah
PMC "Being There" Worker
tahmina.miah@shsc.nhs.uk

Available on the wards:
Mon 9am - 2pm Longley Centre
Tues and Thurs 9am - 2pm MCC

Call 0114 243 6091 Mon to Thurs 11am - 5pm

Pakistan Muslim Centre (PMC) "Being There" Workers - Inpatient Cultural Advocacy Link Workers

We are here to:

Meet the cultural and religious needs of service users.
Help advocate for the care and treatment you may need.
Provide emotional and practical support for you and/or your family.
Direct you to activities that can help you to recover.
Signpost you and your family members to other services that can provide help and support.
Help promote a positive outcome during your admission.
Liaise with the Home Treatment Service.

Gambinga Gambinga
SACMHA Race Equity Lead
g.gambinga@sacmha.org.uk

Call 07483 917501
Available on the wards:
Mon and Tue 9am - 5pm Debrief on wards
Wed 1pm - 4pm MCC
Thurs 1pm - 4pm Longley Centre
Fri 1pm - 4pm Forest Lodge, Forest Close

Meet our Race Equity Lead

Sheffield African Caribbean Mental Health Association (SACMHA) Race Equity Lead

I am here to:

Help understand and reduce the use of restrictive and secluded practices.
Support you following any post-incidents.
Explore interventions with you to avoid further incidents.
Talk to staff and service users minoritised by race.
Provide more information about my role.

Why Contact us?
You have the power to change how you, and others receive care on the wards.

How to contact us?
Email or call us as above

Appendix 5 – Broset Tool

National Patient Safety Improvement Programmes

Mental Health

Reducing Restrictive Practice – Broset Tool on Burbage Ward

Sheffield Health & Social Care NHS Foundation Trust

NHS Sheffield Health and Social Care NHS Foundation Trust

INCEPTION

Burbage Ward is a busy acute mental health inpatient ward with 16 beds. Due to the high levels of violence and aggression on the ward, Dr Brody Patterson was asked to undertake a review and made recommendations to reduce restrictive practice. One of the suggestions was to incorporate the Broset Tool within daily communications to identify early signs of potential escalation & highlight clear future planning to decrease anxiety of the unknown

BROSET TOOL

The Broset Violence Checklist (BVC) is a risk assessment tool which assists in the prediction of imminent violent behaviour with 6 questions

Monday / /	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

These are scored at an agreed time each shift with each present behaviour scoring 1. A score of 0 indicates risk of violence is low, score 1-2 the risk is moderate and a score above 2 indicates the risk is very high enabling preventative measures to be implemented.

TEAMWORK & IMPLEMENTATION

The ward has always had good teamwork despite the challenges they have faced and although staff felt that incorporating the Broset tool was a good idea, it took time and perseverance to embed the changes by linking it into ward process's – formulation meetings, greater focus on safety huddles and making the changes together. This has helped strengthen the team, improving communication and ultimately patient care with a reduction in restrictive practice.

Broset works by bringing concerning patients to the forefront of everyone's mind, to be extra vigilant but also to offer more support where it is most needed'
'We aim to treat in the least restrictive way and deal with any deterioration ASAP rather than wait'
Judith Buck – Ward Manager

IMPACT & SPREAD

Identifying early escalation signs with regular review via twice daily safety huddles allows the team to implement their care plans early ensuring all the team participate in keeping plans up to date so actions can be taken promptly.

The Ward Manager is supporting a sister ward at the Trust to implement the Broset tool, sharing her experience and expertise. This is being supported by the Trusts QI team who are working on a plan for spread to other wards.

The ward is planning to shift their focus slightly to verbal abuse as they feel this has increased, adapting their safety huddles to incorporate this and develop some interventions.

Health Innovation Yorkshire & Humber

NHS England

IMPROVING MENTAL HEALTH SAFETY
Reducing restrictive practice

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Appendix 6 – Safewards 10 Interventions

Safewards —10 iejaukšanās pasākumi

Safewards ir modelis, kas sastāv no 10 iejaukšanās pasākumiem Šī modeļa mērķis ir mazināt konfliktus un ierobežojošus pasākumus pakalpojumu sniegšanas laikā. Tālāk ir norādīti 10 Safewards izmantotie iejaukšanās pasākumi.

Skaidras savstarpējās gaidas — tās ir **ikvienas** personas (pacientu un darbinieku) gaidas. Piemēri var ietvert šādus apgalvojumus: "mēs piekrītam cienīt citu cilvēku viedokļus" vai "pret visiem attieksies godīgi un vienlīdzīgi atbilstoši viņu aprūpes plānam".

Iejūtīgi vārdi — īsi ieteikumi, kas pausti iejūtīgi, ieklausoties jūtās un atzīstot tās.

Spriedzes mazināšanas metodes — spriedzes mazināšana konflikta laikā, runājot mierīgi un izmantojot neapdraudošu ķermeņa valodu.

Pārliecības sniegšana — individuāla saruna pēc sarežģītiem incidentiem vai brīžiem un skaidrojums par notikušo (ievērojot konfidencialitāti). Cerības došana un mērķu izvirzīšana nākotnei.

Savstarpējās palīdzības sanāksmes — regulāras tikšanās visiem darbiniekiem un pacientiem, lai dalītos ar informāciju un uzzinātu, kā citiem klājas. Tas var ietvert "paldies" apli, dalīšanos ar jaunumiem, ieteikumiem, lūgumiem utt.

Slikto ziņu ietekmes mazināšana — ietver aktīvu reaģēšanu uz sliktām ziņām. Sliktu ziņu savlaicīga atklāšana, kā arī spēja izprast, kā tās ietekmē citus. Tas ietver arī praktiska atbalsta piedāvāšanu.

Pozitīvi vārdi — uz stiprajām pusēm balstīta pieeja, kuras laikā par katru pacientu tiek pateikts kaut kas labs, kad viņš/viņa tiek uzticēts citam aprūpētājam, atzīstot sasniegto progresu un konstruktīvu uzvedību.

Nomierināšanās metodes — alternatīvu piedāvāšana (piemēram, pastaiga, mūzika, relaksācijas nodarbība). "Nomierināšanās kaste", no kuras var aizņemties dažādas lietas.

Izrakstīšanās ziņas — paziņojumu dēlis ar pozitīvām ziņām no bijušajiem pacientiem.

Zināšanas par citu cilvēku metodēm — dalīšanās ar informāciju par pacientiem un personālu. Piemēram, mīļākais ēdiens, skaņdarbs vai sporta veids. Lai palīdzētu iepazīt citus ne tikai kā "darbiniekus" vai "pacientus".

Safewards – 10 Interventions

Safewards is a model made up of 10 interventions. The aim of the model is to reduce conflict and restrictive measures in services. Below are the 10 interventions used in Safewards.

Clear Mutual Expectations – These are expectations of **everyone** (staff and patients). Examples can include, "We agree to respect our individual opinions" and "Everyone will be treated fairly and equally, according to their plan of care".

Soft Words – Short advisory statements that use empathy and listening and acknowledge feelings.

Talk-Down Methods – Defusing conflict using calm words and non-threatening body language.

Reassurance – Speaking to people individually after difficult incidents or times and explaining what happened (adhering to confidentiality). Giving hope and setting goals for the future.

Mutual-help meetings – Regular meetings for all staff and patients to share information and check how people are. This can involve a round of thanks, round of news, round of suggestions and a round of requests and offers.

Bad news mitigation – This involves proactively responding to bad news. Sharing bad news in a sensitive and timely manner and being mindful of its impact on others. This also includes offering practical support.

Positive Words – A strengths-based approach in which something positive is shared about each patient at all nursing handovers, recognising progress and constructive behaviour.

Calm-Down Methods – Giving people alternative choices (e.g., a walk, music, or a relaxation session). A 'calm down box' with items to borrow.

Discharge Messages – A display board with positive messages from former patients

Know-each-other methods – Sharing information about patients and staff members. For example, their favourite food, music, or sport. To help people know others beyond the label of 'staff' or 'patient'.

Safewards – 10 أساليب للتدخّل

يُعد Safewards عبارة عن نموذج مكوّن من 10 أساليب من أساليب التدخّل. ويهدف النموذج إلى تقليل النزاع والإجراءات المشددة في الخدمات. وفيما يلي 10 أساليب للتدخّل مستخدمة في Safewards.

توضيح التوقعات المشتركة – وهي تُعد توقعات **للجميع** (الموظفين والمرضى). يمكن أن تشمل الأمثلة "نوافق على احترام آرائنا الشخصية" و"سيُعامَل الجميع بنزاهة وإنصاف، وفقًا لخطة الرعاية الخاصة بكل فرد".

الكلمات الرقيقة – العبارات الإرشادية القصيرة التي تستخدم التعاطف والإنصات والتعبير عن مشاعر التقدير.

أساليب الحديث المبسطة – تهدئة النزاع باستخدام عبارات التهدئة ولغة الجسد المسالمة.

الطمأنة – التحدث إلى الأشخاص كلٍّ على حدة بعد مرورهم بأوقات أو حوادث عصيبة وشرح ما حدث (الالتزام بالسرية). ومنح الأمل ووضع أهداف للمستقبل.

اجتماعات المساعدة المشتركة – عقد اجتماعات منتظمة لجميع الموظفين والمرضى لمشاركة المعلومات وتفقّد أحوال الأشخاص. ويمكن أن يتضمن ذلك جولة من الشكر، والاطلاع على الأخبار وتقديم الاقتراحات وإبداء الطلبات وتوفير العروض.

التخفيف من حدة الأخبار السيئة – يتضمن هذا الاستجابة لأخبار السيئة بصورة استباقية. مشاركة الأخبار السيئة مع مراعاة شعور الآخرين وإخبارهم بها في الوقت المناسب والوعي بتأثيرها عليهم. ويتضمن هذا أيضًا توفير الدعم العملي.

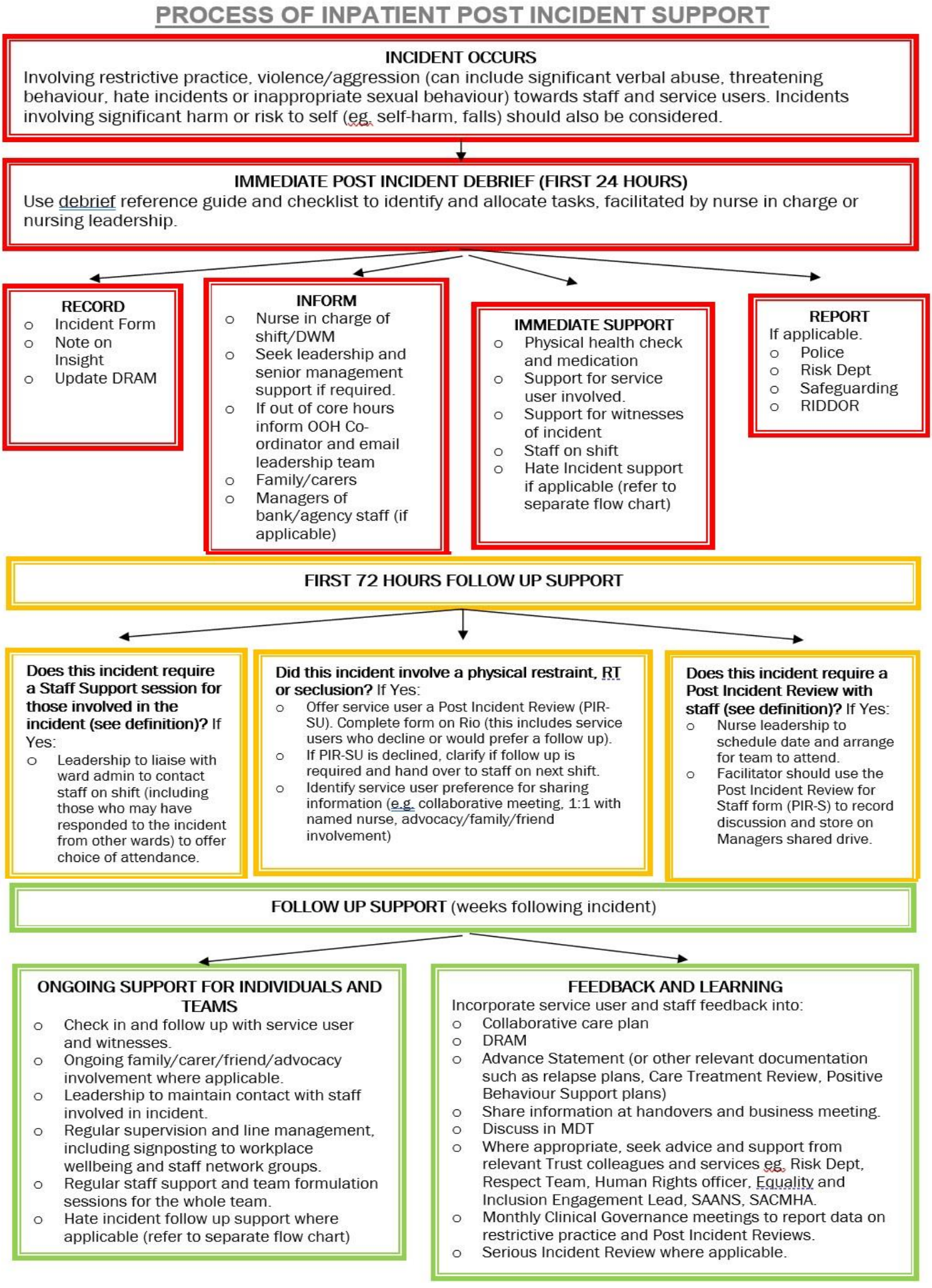
الكلمات الإيجابية – نهج قائم على مواطن القوة تتم فيه مشاركة شيء إيجابي حول كل مريض في جميع عمليات تسليم رعاية المرضى، والاعتراف بالتقدم والسلوك البناء.

أساليب التهدئة – منح الأشخاص خيارات بديلة (على سبيل المثال، المشي أو الاستماع إلى الموسيقى أو إجراء جلسة استرخاء). وتوفير "صندوق مخصص للتهدئة" يتضمن عناصر يمكن استعارتها.

رسائل الخروج من المستشفى – لوحة عرض تحمل رسائل إيجابية من المرضى السابقين

أساليب التعارف – مشاركة معلومات حول المرضى وطاقم الموظفين. فعلى سبيل المثال، الطعام أو الموسيقى أو الرياضة التي يفضلونها. لمساعدة الأشخاص في التعرّف على الآخرين خارج إطار "الموظفين" أو "المرضى".

Appendix 7 – Process of Inpatient Post Incident Support



Appendix 8 – HSJ Awards

Patient Safety Awards (2023)

Patient Safety Team of the Year

The RESPECT team are here to talk about Restrictive Practice – improving safety through conversation, collaborative understanding and action

Patient Safety Awards (2023)

Mental Health Safety Improvement Award

Let's Talk about Restrictive Practice – improving safety through conversation, collaborative understanding and action

YzjWInKM

Appendix 9 – Statistical Process Chart (SPC) Explained

An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation (common cause) in performance and unusual patterns (special cause) in data which are unlikely to have occurred due to chance and require investigation. They can also provide assurance on whether a target or plan will reliably be met or whether the process is incapable of meeting the target without a change.

Special Cause Variation is statistically significant patterns in data which may require investigation, including:

- **Trend:** 6 or more consecutive points trending upwards or downwards
- **Shift:** 7 or more consecutive points above or below the mean
- **Outside control limits:** One or more data points are beyond the upper or lower control limits

	Variation Icons The icon which represents the last data point on an SPC chart is displayed.						**Assurance Icons** If there is a target or expectation set, the icon displays on the chart based on the whole visible data range.		
ICON									
SIMPLE ICON	• • •	• ? H L •	• H •	• L •	• H •	• L •	?	F	P
DEFINITION	Common Cause Variation	Special Cause Variation where neither High nor Low is good	Special Cause Concern where Low is good	Special Cause Concern where High is good	Special Cause Improvement where High is good	Special Cause Improvement where Low is good	Target Indicator – Pass/Fail	Target Indicator – Fail	Target Indicator – Pass
PLAIN ENGLISH	Nothing to see here!	Something's going on!	Your aim is low numbers, but you have some high numbers.	Your aim is high numbers, but you have some low numbers	Your aim is high numbers, and you have some.	Your aim is low numbers, and you have some.	The system will randomly meet and not meet the target/expectation due to common cause variation.	The system will consistently fail to meet the target/expectation.	The system will consistently achieve the target/expectation.
ACTION REQUIRED	Consider if the level/range of variation is acceptable.	Investigate to find out what is happening/ happened; what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened; what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened; what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened; what you can learn and celebrate the improvement or success.	Investigate to find out what is happening/ happened; what you can learn and celebrate the improvement or success.	Consider whether this is acceptable and if not, you will need to change something in the system or process.	Change something in the system or process if you want to meet the target.	Understand whether this is by design (!) and consider whether the target is still appropriate, should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Appendix 10 – Safety Pods

Proud to care in Sheffield

NHS
Sheffield Health and Social Care
NHS Foundation Trust

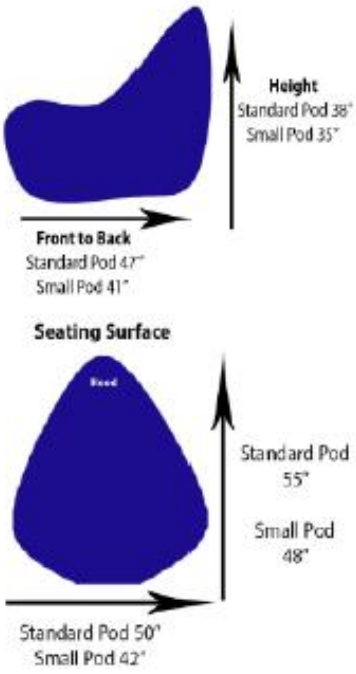
What are Safety Pods?

Our Safety pod chair is more like a bean bag that helps staff to support you if you should become distressed and your risks are heightened.

The pod enables you to be restrained in a dignified, safe and compassionate way whilst being physically supported by trained staff.

Physical restraint will only be used when necessary and, by using the Pod, this will help us keep you and our staff safe.

Being restrained on the floor can feel humiliating, scary, embarrassing and quite often impact on therapeutic relationships.



Here at SHSC our main priority is you and your care and testimony from fellow service users reiterates how much more confident our staff and service users now feel about physical restraint in certain situations.

You can be assured that the Bean bags will be stored, cleaned and maintained in clinical areas.

Beans bags/pods offer head, neck and spinal support which floor restraint doesn't offer. They are designed so you can have a safe exit from seclusion and where appropriate can be left in an individual's room.

Safety pods are not like the Beanbags we are used to; they are of medical standard and tested to the highest specifications and standards.

They don't require any extra staff to be involved in your restraint, reduces the time you may be restrained for and is far less intrusive.

I hope this information helps you to feel assured and, if you would like a demonstration, please ask a member of staff.